JOB ACTION SHEET
DETENTION HOSPITAL
JOINT TASK FORCE
GUANTANAMO BAY CUBA

MANPOWER POOL COORDINATOR
Primary: Senior Psych Tech
Alternate: Admin YN

____ Muster in Manpower Pool.

____ Receive briefing from Medical Commander

____ Obtain radio

____ Make assignments of the following personnel:

___ 1st provider to Triage (if not already filled)
___ 2nd provider to Immediate
___ 3rd provider to Delayed
___ Medical Regulator to Triage [redacted]
___ Transportation Coordinator [redacted]
___ Immediate Team [redacted] Senior Nurse acts as Team Leader
___ Delayed Team [redacted] Senior Nurse acts as Team Leader
___ Minimal Team Leader [redacted]
___ Litter Bearer Team Leader [redacted]
___ Immediate Team Leader Det.Hosp [redacted]
___ Expectant Team Leader [redacted]
___ Assign Ambulance drivers [redacted]

b(2)

____ Maintain accountability of manpower staffing from manpower pool

____ Coordinate excess personnel to needed areas

0050062

Appendix F

MASS CASUALTY IN CAMP 5

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

_____ _____
Officer In Charge Date

IMPLEMENTED BY:

_____ _____
Director for Administration Date

_____
Senior Enlisted Advisor Date

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ENTIRE SOP SUPERSEDED BY:

Title:
SOP NO:_____ Date:_____

005064

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

Title: MEDICAL INTERVENTION FOR HELMINTHIC INFECTIONS

SCOPE: Detention Hospital

SOP NO: 030

Page 1 of 3
Effective Date: 21 Mar 03

REF:

(a) AFMIC MEDIC CD-ROM
(b) Control of Communicable Diseases Manual, 17th Edition, 2000

I. PURPOSE:

To establish Detention Hospital policy regarding the initial evaluation of detainees and interventions to treat potential helminthic infections in the detainee population.

II. PROCEDURE:

1. After review of data available found in references (a) and (b) it is reasonable to expect that a number of the detainees will arrive at Detention Hospital with helminthic infections. It is also reasonable to expect that treatment of these helminthic infections may benefit the general health of the detainee population. The improvement in nutritional status could improve wound healing and ability to resist potential infections. Therefore, all detainees will be treated for the potential of helminthic infections. Detainees will have stool collected for ova and parasite screening prior to treatment in order to better assess the epidemiological validity of this treatment protocol.

2. Treatment for potential helminthic infections will consist of a single dose of 400mg of oral albendazole.

3. All detainees will be requested to provide a stool sample for screening for ova and parasites. If the detainee is unable to provide a sample, processing will continue. The screening for ova and parasites is not to collect clinical data on the specific detainee. The screening of the stool specimens for ova and parasites, collected from the subset of detainees able to provide a stool sample, are intended to provide epidemiological validation of the treatment protocol.

4. Results of the screenings for ova and parasites will be maintained in a database by the Preventive Medicine Detachment. Data will include the percentage of detainees that provide stool samples, and the percentage of samples screened positive for helminthic infections.

5. All medications received by detainees will be entered appropriately in the detainee medical record.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

_____ _____
Officer in Charge Date

IMPLEMENTED BY:

_____ _____
Director for Administration Date

_____ _____
Senior Enlisted Advisor Date

ANNUAL REVIEW LOG:

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ENTIRE SOP SUPERSEDED BY:

Title:
SOP NO: Date:

00506?

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

Title: LATENT TUBERCULOSIS MANAGEMENT

SOP NO: 031

Page 1 of 10
Effective Date: 16 Jul 03

SCOPE: Detention Hospital

Each: (1) Latent Tuberculosis Infection Management Algorithm
(2) Initial/Annual Tuberculosis Patient Questionnaire
(3) Guidelines for Liver Function Test monitoring While on INH Therapy
(4) INH Therapy Monthly Patient Questionnaire
(5) INH Therapy Medical Provider Review

I. BACKGROUND:
Identification and treatment of latent tuberculosis infection (LTBI) in detainees offers improved Force Health Protection for Joint Task Force personnel in close contact with the detainee population by decreasing the probability of tuberculosis disease among detainees, and protects other detainees from the potential spread of disease between detainees. The policies and procedures stated in this SOP have been coordinated with the Centers for Disease Control (CDC) and the United States Public Health Service.

II. POLICY:
This is a revision of the Latent Tuberculosis Infection Management in Detainees SOP dated 21 Mar 03 and supercedes that document. This SOP should be used in concert with the SOP for Active Tuberculosis Management. Exceptions to this policy must be based on compelling clinical evidence and will be discussed with the Infectious Disease staff physician prior to implementation.

III. PROCEDURES:

- As per the Active Tuberculosis Management SOP, all detainees will be screened for clinical and radiological evidence of active tuberculosis; this includes placing a Tuberculin Skin Test (TST). The plan for identification, evaluation, treatment, and monitoring of LTBI in detainees is demonstrated in enclosure (1). Detainees that have been ruled out for active tuberculosis disease will enter the LTBI flowchart at the point were previous evaluations ended.

00506-8

- The following sections deal with the description, definitions, and amplification of the Latent Tuberculosis Infection Management flowchart. The areas involved in current operations and many of the potential areas considered as possibilities for future operations have high incidences of tuberculosis. Foreign-born persons that migrate to the U.S. continue to demonstrate incidences of tuberculosis that reflect the level of the country of origin for as long as five years after migration. This would result in a number of cases of tuberculosis disease in the detainee population with subsequent potential exposure of JTF personnel. Identification and treatment of LTBI in detainees will decrease this potential.

- All detainees will receive a TST in conjunction with inprocessing upon arrival. TST screening will use 5TU of Purified Protein Derivative (PPD) in the standard Mantoux method. The medical staff responsible for detainee healthcare should insure that all personnel placing and reading the PPD are trained adequately and understand the importance and limitations of this test.

- The classification of the PPD reaction depends on the clinical situation of the detainee. Most detainees are recent arrivals from high-prevalence countries and will be considered abnormal with a reaction of 10mm or more. Detainees considered positive at 5mm of induration should have the reason for this deviation from standard documented in the health record. For example, detainees with chest x-ray findings of fibrotic changes consistent with old healed tuberculosis, those with recent active TB contacts, and those with HIV infection or other immunocompromising conditions should be considered PPD abnormal with induration of 5 mm or more.

- Detainees with a negative PPD on initial testing will have the PPD repeated at the next monthly weigh-in. Implementation of the 'two-step PPD' will identify detainees with prior tuberculosis infection and is standard for persons enrolled in a periodic PPD screening program. Two-step testing is used to reduce the likelihood that a boosted reaction will be misinterpreted as a recent infection. If the reaction to the first test is classified as negative, a second test should be done. An abnormal reaction to the second test probably represents a boosted reaction (past infection or prior BCG vaccination). On the basis of this second test result, the person should be classified as previous infected and cared for accordingly. This would not be considered a skin test conversion. If the second test result is also negative, the person should be classified as uninfected. In these persons, an abnormal reaction to any subsequent test is likely to represent new infection with *M. tuberculosis* (skin test conversion). Two-step testing should be used for the initial skin testing of adults who will be retested periodically.

- Detainees with the second PPD classified as negative will be enrolled in an annual PPD program. This does not preclude the routine clinical use of the PPD as an adjunct to appropriate clinical evaluations.

- Detainees classified as having a positive PPD on initial or second testing.

normally ≥ 10mm induration will be evaluated for signs and symptoms suggestive of tuberculosis disease [enclosure (2)].

- If there is suggestion of tuberculosis disease, the detainee will undergo an appropriate clinical evaluation as outlined in the Active Tuberculosis Management SOP. If evaluation is not suggestive of tuberculosis disease or if the clinical evaluation for active tuberculosis disease is negative, the detainee is evaluated for treatment of LTBI.

- Evaluation for LTBI treatment should include an attempt to document any history of treatment for LTBI or disease. This history may be difficult to obtain and unreliable. Determine if there are any preexisting medical conditions that are a contraindication to treatment or are associated with an increased risk of adverse effects of treatment. Review current and previous drug therapy for potential adverse reactions or interactions. Baseline laboratory testing is not routinely indicated for all patients at the start of treatment for LTBI. Baseline hepatic measurements of serum AST (SGOT) or ALT (SGPT) and bilirubin are indicated for patients whose initial evaluation suggests a liver disorder. Baseline testing is also indicated for persons with a history of chronic liver disease (e.g., hepatitis B or C, and others who are at risk of chronic liver disease). Testing should be considered on an individual basis, particularly for patients who are taking other medications for chronic medical conditions [see enclosure (3)]. Active hepatitis and end-stage liver diseases are relative contraindications to the use of isoniazid or pyrazinamide for treatment of LTBI. Use of these drugs in such patients must be undertaken with caution.

- If there are no contraindications for LTBI treatment, the standard course for detainees will be isoniazid, INH, 900mg, twice weekly for nine months. Peripheral neuropathy, caused by INH's interference with metabolism of pyridoxine, is uncommon at a dose of 5 mg/kg. However, in this detainee population, where some may be malnourished, treatment with pyridoxine could be considered (i.e. Pyridoxine 100 mg twice a week given with INH). In persons with conditions in which neuropathy is common (e.g., diabetes, uremia, alcoholism, malnutrition, and HIV infection), pyridoxine should be given with INH.

- All detainees on LTBI treatment will be monitored at least monthly [see encl. (4 and 5)]. This evaluation will include screening for signs and symptoms of active TB disease, and signs or symptoms of hepatitis. Routine laboratory monitoring during treatment of LTBI is indicated for persons whose baseline liver functions test are abnormal and for other persons with a risk of hepatic disease [see enclosure (3) for further details]. There should be laboratory testing, such as liver function studies for detainees with symptoms compatible with hepatotoxicity or a uric acid measurement to evaluate detainees who develop acute arthritis, to evaluate possible adverse reactions that occur during the treatment regimen.

- Discontinuation of INH should be considered for detainees with liver functions three times normal levels with symptoms, liver functions five times normal levels without symptoms, or when otherwise clinically indicated.

- Please refer to encl. (5) concerning detainee refusals of medication. After completion of LTBI treatment detainees will be screened annually [encl. (2)].

- Detainees with contraindications for LTBI treatment should be re-evaluated. The risk-benefit of LTBI treatment must be considered. Alternate regimens, per reference (b) should be considered. If clinically appropriate, treatment should proceed. These cases may require more frequent or more robust monitoring. If LTBI treatment is contraindicated, these contraindications will be documented in the detainee health record. The detainee will be followed with annual screenings. A sample questionnaire for these annual screenings can be found in enclosure (2).

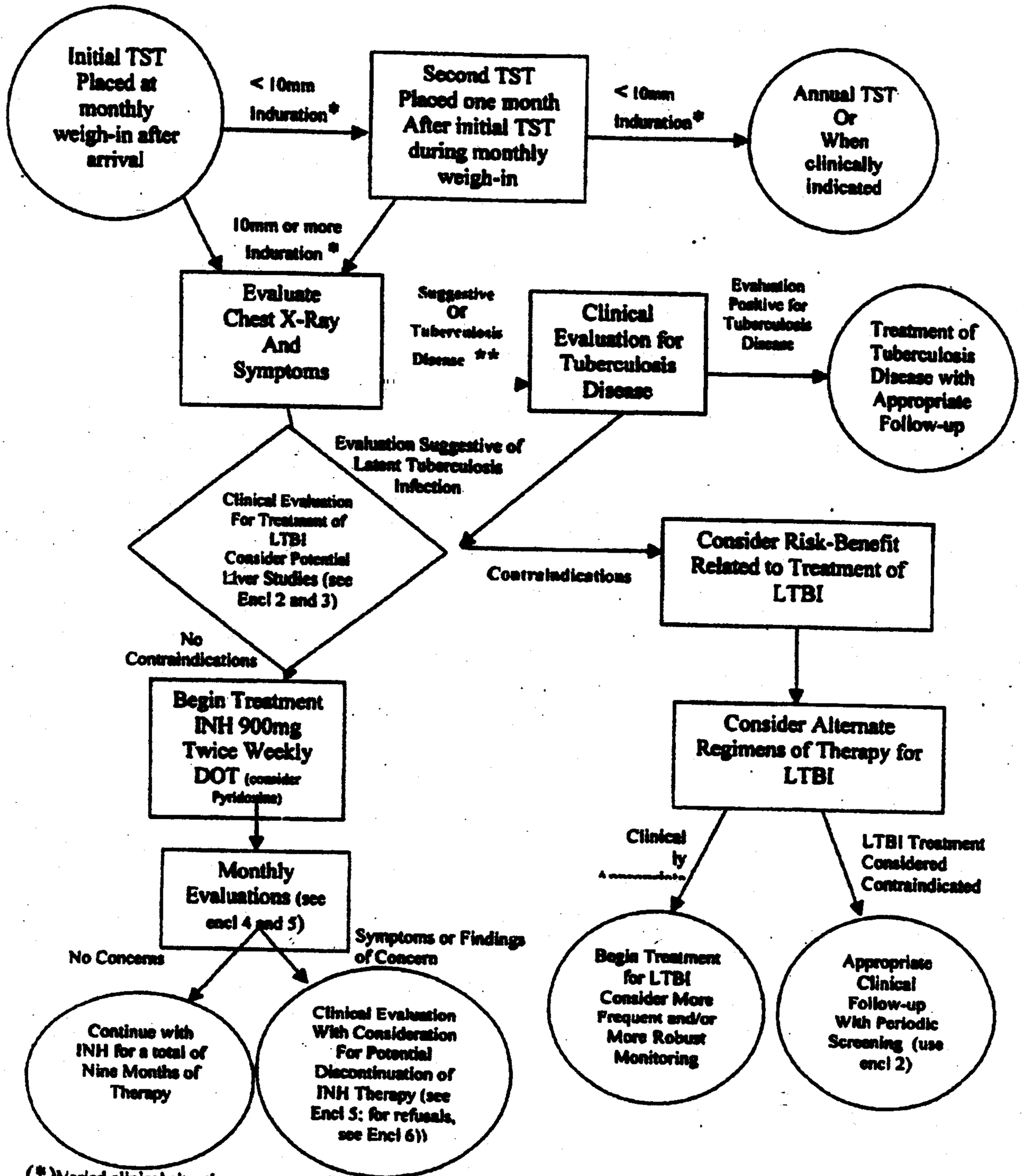
- Application of the Latent Tuberculosis Infection Management program will require tracking of PPDs, medications, and monitoring in a database/spreadsheet that will provide reports to the JTF Surgeon periodically on the status of the program.

- For detainees who refuse medication for LTBI, the following considerations will be used in determining the appropriate course of action:

  - There is no risk of inducing INH resistance in detainees who periodically refuse INH. The goal of therapy is to have the detainee take at least a total of 52 doses in 9 months or 76 doses in 12 months. If the total number of doses meets these guidelines, therapy is considered to be complete.

- Detainees continually refusing medications will not be required to take INH per SOUTHCOM policy. They will be screened annually with a medical screening questionnaire on the yearly anniversary of their negative chest x-ray, generally obtained at their in-processing date.

LATENT TUBERCULOSIS INFECTION



(*)Varied clinical situations recommend LTBI Treatment a different parameters of induration. Ten millimeters is the level for most of the detainees received.

(**)In cases where signs and symptoms are highly suggestive of tuberculosis disease, begin treatment concurrent with laboratory evaluation and confirmation.

27 May [redacted]

Detainee Number: _____ Age of Detainee: _____ Date: _____

Initial/Annual Tuberculosis Patient Questionnaire

Are you experiencing any of the following problems:

Fever for more than 7 days	Yes	or	No
Cough for more than 2 weeks in a row	Yes	or	No
Sweating at night for more than 7 days	Yes	or	No
Coughing up bloody phlegm	Yes	or	No

<u>Medical Provider Review:</u>

History of TB, previous treatment for TB, or BCG vaccine in past? _____

History of liver disease/hepatitis/jaundice?

Date and Result of Last PPD (no need to repeat once positive)

Results of hepatitis/HIV screening at inprocessing

Current Medications: Allergies:

Medical officer evaluation (if indicated from above symptoms):

Are repeat/new LFT monitoring recommended?

Date drawn _____ Results

Is a repeat CXR needed (if annual screening, repeat is recommended)? _____

Ordered? _____ Result of CXR?

Have AFB smears/cultures been or are being collected? _____ Results: _____

Further actions required/Medications Prescribed?

Enclosure (2)

005073

Guidelines for Liver Function Test Monitoring While on INH Therapy

Baseline LFTs for:
- History of liver disease
- Hepatitis B surface Antigen positive or Hepatitis C Antibody positive
- Concurrent therapy with other possible hepatotoxic medications
- Signs or symptoms of liver disease
- HIV Infection
- Pregnancy/Less than 3 months post-partum

Monthly LFTs indicated for:
- History of elevated LFTs at baseline (discontinue monitoring if asymptomatic and LFTs normalize)
- Persons at risk for hepatic disease (i.e. persons with Hep B/C with elevated LFTs at baseline, h/o chronic liver disease, etc.)

All persons should be screened monthly for signs of hepatotoxicity [see INH Therapy Monthly Patient Questionnaire enclosure (2)]. The medical officer in charge of the LTBI program will complete or review the INH Therapy Medical Provider Review [enclosure (3)]. Persons identified as having signs or symptoms of possible hepatotoxicity will be evaluated further by a medical officer to decide whether further testing and/or discontinuance of the medication is indicated.

Detainee Number: _____ Age of Detainee: _____ Date: _____

INH Therapy Monthly Patient Questionnaire

Are you experiencing any of the following problems:

Fever for more than 7 days	Yes	or	No
Cough for more than 2 weeks in a row	Yes	or	No
Sweating at night for more than 7 days	Yes	or	No
Coughing up bloody phlegm	Yes	or	No
Nausea or vomiting for more than 7 days in a row	Yes	or	No
Abdominal pain for more than 7 days in a row	Yes	or	No
Yellow discoloration of skin	Yes	or	No

Detainee Number: _____ Age of Detainee: _____ Date: _____

INH Therapy Medical Provider Review:

MAR Review: Number of doses refused in last month?

Does their course of medication need to be extended?

Signature of staff modifying the MAR

Medical officer evaluation (if indicated from above symptoms):

Are repeat/new LFT monitoring recommended?

Date drawn

Results

Is a repeat CXR needed? _____ Ordered?

Result of CXR?

Further actions required?

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

_____ _____
Officer In Charge Date

IMPLEMENTED BY:

_____ _____
Director for Administration Date

_____ _____
Senior Enlisted Advisor Date

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005077

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

Title: Standard Operating Procedures for Emergency Response Teams (ERT)

SCOPE: Detention Hospital

SOP NO: 032

Page 1 of 5
Effective Date: 23 Jan 2004
Reviewed 8 Mar 2004

Background: The Detention Hospital (DH) is responsible for emergency response 24/7 at Camp Delta, Camp Echo and Camp V. This requires a skilled and coordinated effort by all medical staff. [redacted] b2 The personnel making up the ERT teams will come from the staff assigned to the Delta Medical Clinic. The ERT team exists to provide immediate response to any medical emergency that takes place in Camp Delta. The ERT is also utilized to provide standby medical support in the event of mobilization of the JDOG Force Cell Extraction Team. On the occasion of a detainee needing to be engaged by the IRF teams, Delta Medical Clinic will dispatch an ERT team to the incident. Ongoing training for all Delta Medical Clinic staff regarding emergency response is essential to ensure readiness.

General Procedures:

- At the beginning of each shift the Shift Leader shall assign [redacted] to both ERT teams with one team responding to any emergency (Code Blue) that could happen at the Detention Hospital. Any time the assigned personnel are out of the clinic they shall ensure they have a radio and an ERT medical jump bag with them. b2

- ERT team members shall inventory the ERT medical jump bags and restock any missing supplies at the beginning of each shift.

- **Responding to IRF**

  - Once the IRF is activated, the ERT member will immediately respond to the scene notifying Delta Medical Clinic that they are enroute. A Gator vehicle may be utilized for travel.

  - Upon arrival, the ERT will make contact with the Guard Commander and notify Delta Medical Clinic that the ERT has arrived on station.

  - The ERT shall assess the scene and provide appropriate treatment on scene to both guards and detainees. If in their assessment they determine additional medical assets (i.e. personnel, supplies or emergency vehicles) are necessary, they shall send all requests through the Delta Medical Clinic.

- The ERT shall remain on scene until secured by the Guard Commander. Once properly secured the ERT shall notify the Delta Medical Clinic that the IRF has been secured and report back to Delta Medical Clinic for debrief, to restock any used supplies, and to write a note in the Medical Record regarding any interventions.

- **Responding to Medical Emergency/Self Harm**

  - The ERT team will respond to any and all medical emergencies at Camp Delta. When a call is received in the Delta Medical Clinic, phone or mobile radio, an ERT team will respond with an ERT medical jump bag and be ready to provide emergency medicine and, if necessary, transport to the Delta Medical Clinic.

  - In the event of a Self Harm (Snowball), or attempted Self Harm, an ERT team will respond. Spine boards and cervical immobilization devices are located in the Emergency Response locker located in each causeway. ***C-spine precautions must be maintained with any hanging or detainee found unresponsive and until cleared by appropriate medical personnel.*** [redacted]]b2

  - **Personal safety is paramount.** [redacted] b2

- **Assignment to ERT:**

  - All personnel working in the Delta Medical Clinic will require orientation to the ERT. Everyone will receive a PQS to ensure understanding of the requirements and procedures for this assignment.

  - Only upon completion of PQS and signature of Delta Clinic LCPO will any Corpsman be assigned to such duty.

- **Training:**

  - The Section Leader shall conduct ERT PQS training at the start of their first shift of the 2-day rotation. The scheduled training shall focus on the above outlined procedures; communication procedures, C-spine precautions, and nature of injuries expected to be encountered i.e.; human bites, pepper spray, trauma, unresponsiveness, and self-harm.
  - All training will be recorded on standard in-service documents and forwarded to the admin office to be filed in member's training record.
  - All completed PQS forms will be kept filed with training record in admin office.

Emergency Response Team
Performance Qualification Standards (PQS)

Name: **Date:**_____

Rank:_____

Initials/Date	
____/____	Universal Precautions
____/____	Infection Disease Issues
____/____	Personal Safety Criteria
____/____	Orientation to Radio Procedures.
____/____	Orientation and Jump Bag Check off
____/____	Familiarization of Delta Blocks
____/____	Airway Management ____/____ Nasal Airway Placement ____/____ Oral Airway Placement ____/____ BVM Technique ____/____ O2 use ____/____ Non-Rebreather ____/____ Nasal Cannula ____/____
____/____	Hemorrhage Control
____/____	Splinting

I have read and understand the policy for being assigned to the ERT. I further understand my responsibilities to myself and my partner to ensure our safety at all times. I fully understand the above covered Procedures and Medical Interventions.

Signed: **Date:**_____

Two-Day Orientation:

Trainer: Day 1:

Signed **Printed Name and Rank**

Day 2:

Signed **Printed Name and Rank**

005080

Emergency Response Bag Check-Off Sheet

BVM (1)_____
Adult Mask (1)_____
Pocket Face Shield (1)_____
BP Cuff (1)_____
Clean Gloves (6 pr)_____
Stethoscope (1)_____
C-Collar (1)_____
Surglube (1 tube)_____
Oral Airway – sizes 9,10,11 (1 ea.)_____
Nasal Airway (1)_____
5cc Syringe (2)_____
10cc Syringe (2)_____
Epi-Pen___Exp____/____
Sharps Container (1)_____
Trauma Scissors (1)_____
Kerlex (2)_____
4 x 4 Gauze (4)_____
Cravat (3)_____
IV NS (2)___Exp____/_____
IV Tubing (2)_____
18ga IV Catheter (2)_____
16ga IV Catheter (2)_____
Alcohol Pads (10)_____
Tourniquets (2)_____
1" Tape (1)_____
2 x 2 Gauze (4)_____
Tegaderm (4)_____
O_2 Tank_____PSI_____
Adult Nasal Cannula (1)_____
O_2 Tubing (1)_____
Adult Mask (1)_____

Print Name:
Signature:

Discrepancies:

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge _____ Date

IMPLEMENTED BY:

Medical Officer of Delta Clinic _____ Date

Senior Enlisted Advisor _____ Date

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DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 037

Title: IN-PROCESSING MEDICAL EVALUATION

Effective Date: 24 Sep 03

SCOPE: Detention Hospital

Encl: (1) In-processing Order Sheet
(2) Report of Medical Examination

I. BACKGROUND. Detainees arrive from highly endemic areas for infectious diseases including tuberculosis, malaria, and parasitic infections. This section provides a detailed description of the medical screening and treatment for incoming detainees.

II. POLICY. Treatment and care provided will be humane and will follow the guidelines provided by the articles of the Geneva Convention. Specifically, each detainee will undergo screening and treatment for diseases common to the Middle East region.

III. GENERAL PROCEDURES:

A. Upon arrival to Camp Delta, each detainee will be searched, showered, and administratively processed. Hair may or may not have been cut prior to transfer to Guantanamo Bay, thus a hair inspection for lice will be completed. Treatment for cutaneous infestations will be administered as needed. Clothing, which has been pre-treated with permethrin, will be issued.

B. Each detainee will be brought into the medical clinic individually accompanied by a security force escort team. The specific order of detainees will be based on triage performed prior to administrative in processing. Detainees will be placed in a higher triage category if their condition deteriorates prior to arrival at medical.

C. The detainee will receive a pre-made medical record with the following forms: Report of Medical Examination (*see enclosure 1*), SF 88, SF 508, SF 600, SF 601, SF 603, DA 2664-R, NAVMED 6150/20, and DA Form 4237-R. A CHCS medical record number will be assigned beginning with 888-0X-XXXX. The name will be recorded as D, JTFXXXXX. The patient category will be K66.

D. A history and physical examination will be recorded on the Report of Medical Examination on enclosure (1). The physical exam serves both as a general screening exam and a confinement physical. A separate record of body weight including body mass index calculation will also be maintained (DA 2664-R). Please refer to weight management and nutrition program (SOP 014).

E. Psychiatric screening during the initial medical examination will include:

1. Previous psychiatric treatment (diagnosis, pharmacotherapy, psychotherapy)
2. Previous suicidal attempts or serious suicidal intention/plan.
3. Previous self-mutilation/ self-injurious behaviors
4. Previous homicidal or assaultive behaviors.
5. History of substance dependence/abuse,
6. Current suicidal/ homicidal ideation, emotional distress or odd behavior.
7. A psychiatric team member will immediately triage any detainee presenting with suicidal or homicidal ideation, emotional distress or odd behavior during the in-processing evolution.

8. Detainees who endorse any of the items listed above will be referred to Psychiatric Services via a consult for more in depth assessment within the week.

F. A dental examination form (SF 603) will be kept within the medical record but a detailed dental examination will not be performed at the time of in processing. Those presenting with a dental issue will be added to the dental list and evaluated in a prioritized manner.

G. Detainees with a visual complaint will be screened for visual acuity and referred for optometry consultation.

H. Immunizations administered will include Td (tetanus-diphtheria), MMR (measles, mumps, rubella), and influenza vaccines to all detainees. Those with tetanus-prone wounds may also receive TIG (tetanus immunoglobulin) as per SOP # 024.

I. Laboratories obtained include a Hepatitis A IgG, Hepatitis B surface antigen (HbSAg), Hepatitis B surface antibody (HbSAb), Hepatitis B core antibody (HbCAb), Hepatitis C serology, HIV ELISA and malaria smears. The malaria smears will be screened at NH GTMO, and results confirmed at NH Portsmouth. An extra serum sample will be drawn and held for future use.

J. Each detainee will receive a screening chest X-ray and a PPD to assess for signs of tuberculosis (See SOP's #002 and 031). Repeat positive PPD will not need to be performed if previously documented on the transfer summary.

K. Left hand and wrist radiographs will be obtained after approval by the JTF Surgeon on new detainees meeting the following two criteria:

1. The detainee states his/her age is less than 16 years, and
2. Based on the physical examination, the detainee has clinical characteristics that suggest that he/she is less than 16 years of age.
3. Regarding the clinical findings, each health care provider performing physical examinations will be provided with a copy of the Tanner staging to estimate the detainee's maturity. It is recognized that the Tanner staging provides a clinical measure of age between 9 and 15 years and that clinical finding of sexual maturity are quite uniform above the age of 15 years. It is also recognized that Tanner staging assumes genetic, racial, and nutritional background similar to the study group that this staging was based on, and that endocrine abnormalities may influence the time of maturation.

4. Bone radiographs obtained will be digitally forwarded to the AFIP for reading using the Greulich and Pyle standards of bone age determination.

L. Each detainee will receive empiric treatment for intestinal helminthes (albendazole 400 mg once) and malaria (mefloquine 1250 mg, split into 2 doses). Please refer to SOP 030 for details.

M. Upon completion of the above, treatment of any condition requiring immediate attention will be addressed.

005085

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

_____ _____
Officer in Charge Date

IMPLEMENTED BY:

_____ _____
Director for Administration Date

_____ _____
Senior Enlisted Advisor Date

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Title:_____
SOP NO:_____ Date:

005056

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

[redacted] Department,

(updated 24 September 2003//sed)

STANDARD INPROCESSING ORDERS FOR DETAINEES:

1. Mefloquine 750 mg PO now, 500 mg PO in 12 hours

2. Albendazole 400mg PO once

3. Chest X-ray: PA

4. **LABS:**

Hep A IgG
Hep B surface antigen and antibody
Hep B Core antibody
Hep C
HIV
Malaria Smear (pre-screen at NAVHOSP GTMO prior to mail out to NH Portsmouth)
Serum (draw 1 extra red top)

Immunizations

1. Td .5ml IM once

2. PPD – read in 48 to 72 hours
3. Influenza 0.5 ml IM once
4. MMR 0.5 ml SC once

Consults: (circle as needed)
Needs reading glasses? Y or N
Optometry
General Surgery
Psychiatric Services
Orthopedic Surgery
Dental

Additional Orders Circle if Indicated

1. AFB Smear Q AM x 3

2. If age may be ≤ 16 years old: confer with JTF Surgeon for approval to
   Obtain Left hand & wrist x-rays for bone age determination.

Staff Signature:_____ **Provider:**

PATIENTS IDENTIFICATION *(Use this space for Mechanical Imprint)* Typed Form in lieu of SF-600

NAME:
SSN:
STATUS:
DOB:

005087

Standing Orders for routine sick cell complaints at Camp Delta Clinic.
The following medications may be dispensed by NC or HN Corps Staff at Camp Delta Clinic. * **IMPORTANT. Consult MO if detainee requires more than 4 doses in a 1 week period.**

Complaints of minor aches, pains, headache:
*Tylenol (acetaminophen) 650 mg or 500mg PO q 4-6 hr PRN
Contraindications/cautions: Impaired liver or renal function, caution if G6PD deficiency.

Complaints of heartburn, indigestion.
*Mylanta (aluminum hydroxide/magnesium hydroxide)15 – 30 ml PO q 4 hr PRN

Complaints of rhinorrhea , sneezing, watery eyes, itchy rashes.
Benadryl (diphenhydramine) 25 – 50 mg PO q 6 hr PRN
Contraindications/ cautions: acute asthma, CV disease, increased IOP

Complaints of moderate pain, headache:
*Motrin (ibuprofen) 400 mg – 800 mg PO TID PRN
Contraindications/cautions: Hx of ulcers/UGI bleed, HTN, kidney disease

Complaints of foot tinea pedis (athlete's foot), tinea cruris (jock itch)
Tinactin (tolnafate) 1% cream topical AAA BID x 2 weeks do not repeat 2 weeks without consulting the M. O.

Complaints of nasal congestion.
*Sudafed (pseudoephedrine) 30 – 60 mg PO QID PRN
Contraindications/cautions: HTN, CAD, Diabetes.

Complaints of sore throat.
*Cepacol Lozenges dissolve 1 lozenge in mouth q 4- 6 hours PRN

Complaints of inflamed itchy rashes, inflamed bug bites:
Hydrocortisone Topical 1% Cream, Apply to affected area 3 times a day, X 2 weeks

Complaints of heartburn, acid indigestion, occasional constipation.
*Milk of Magnesia As antacid – 1 – 3 teaspoons (with water) up to 4 times/day
As laxative – 2 – 4 teaspoons (with 8oz of water)

Complaints of sore muscles/ body aches.
*Bengay (Analgesic Balm) Apply to affected area 3 times a day for 7 days.

Complaints of flaky, itchy scalp.
Selsun Shampoo, small amount to hair then rinse after 15 minutes, no more than twice per week.

MO Signature_____ Staff Signature
DETAINEE IDENTIFICATION: Typed Form in lieu of Standard Form 508
ISN:

005088

MEDICAL RECORD	Report of Medical Examination	DATE OF EXAM

1. LAST NAME-FIRST NAME-MIDDLE NAME		2. IDENTIFICATION NUMBER
3. COUNTRY OF BIRTH	4. AGE	5. SEX ☐ MALE ☐ FEMALE
6. PRIMARY LANGUAGE		7. SECONDARY LANGUAGE

History of Present Illness

Currently have/ever had: (*please circle, leave blank if unknown*)

Asthma	Yes	No	Hyperlipidemia	Yes	No
Diabetes	Yes	No	Hypertension	Yes	No
Heart Disease	Yes	No	Malaria	Yes	No
Hepatitis	Yes	No	Mental Illness	Yes	No
HIV	Yes	No	Renal Disease	Yes	No
Other:			Tuberculosis	Yes	No

Family History of: (*please circle, leave blank if unknown*)

Asthma	Yes	No	Hepatitis	Yes	No
Cancer	Yes	No	Hyperlipidemia	Yes	No
Diabetes	Yes	No	Hypertension	Yes	No
Heart Disease	Yes	No	Mental Illness	Yes	No
Other:			Renal Disease	Yes	No

Ever Been Hospitalized? No____ Yes____, Explain:

Current Health: Good____ Fair____ Poor____
Any special health requirements? No____ Yes____, list:

Current Medication(s):

Known allergies to medication(s):

Other Allergies:

Chemical Dependence? (alcohol, drugs)

Tobacco use? No____ Yes____, amount:

Do you have any pain? No____ Yes____
If Yes: Where? How often does it occur?

Transfer PPD results: Negative____, Positive_____ (number of mm)
Transfer CXR results: No acute disease_____, Abnormal____
Comments:

Review of Systems

Do you experience any of the following: (*please circle*)

General: fever chills night sweats weight loss

Skin: rash skin discoloration

Respiratory: cough duration? hemoptysis sputum

Cardiovascular: chest pain

Gastrointestinal: nausea vomiting abdominal pain diarrhea

Neurologic: headache seizure dizziness

Psychiatric: suicidal/homicidal tendencies hallucinations

Comments:

005089

IDENTIFICATION NUMBER

PHYSICAL EVALUATION

MEASUREMENTS AND OTHER FINDINGS

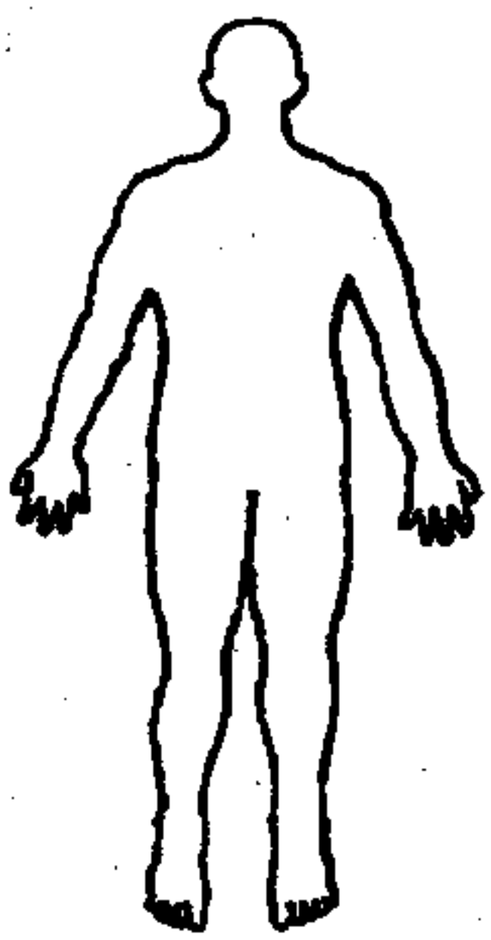
HEIGHT	WEIGHT	BMI	HAIR COLOR	EYE COLOR	BUILD
					☐ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE

Temperature:_____ Respirations:_____ Pulse:_____ Blood Pressure:_____

CLINICAL EVALUATION

	Normal	Abnormal	Not Done		Normal	Abnormal	Not Done
A. HEAD				I. ABDOMEN			
B. EYES C. EARS D. NOSE				J. RECTAL K. PROSTATE L. GENITALS			
E. MOUTH AND THROAT				M. UPPER EXTREMITIES			
F. NECK				N. LOWER EXTREMITIES			
G. LUNGS AND CHEST				O. SKIN/LYMPH			
H. CARDIOVASCULAR				P. NEURO			
				Q. PSYCH			

Comments: (*Describe every abnormality in detail. Enter pertinent item letter before each comment. Use additional sheets if necessary*)



SUMMARY OF ASSESSMENT AND PLAN

TYPED OR PRINTED NAME OF PROVIDER

SIGNATURE

TYPED OR PRINTED NAME OF PHYSICIAN

SIGNATURE

005090

MEDICAL RECORD — Chronic Disease Medical Flow Sheet

1. IDENTIFICATION NUMBER

3. BIRTH DATE / AGE

2. CHRONIC DISEASES / DATE OF DIAGNOSIS

____DIABETES ____
____HYPERLIPIDEMIA ____
____HYPERTENSION ____

Date: / / / / / / / / / / / /

History/Physical	every visit						
Weight	every visit						
Blood Pressure	every visit						

Hypertension control	every visit						
Serum Potassium	6-12 mo						
Serum Creatinine	6-12 mo						

Chol							
HDL							
LDL							
TG							

Blood pressure Systolic <130 mm Hg/Diastolic <80mm Hg	every visit						
Lipid Profile Chol < 200 mg/dl TG < 200 mg/dl LDL < 130 mg/dl HDL > 35 mg/dl	Annual						
HbA1c	3-6 mo						
Urinalysis	Annual						
Microalbumin	Annual						
Dilated Eye Exam	Annual						
Foot Exam	every visit						

Influenza	Annual						
Pneumococcus	Recommended						

REFERRALS	As needed						

005091

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 038

Title: HEPATITIS B MANAGEMENT

Page 1 of 4
Effective Date: 11 Mar 03

SCOPE: Detention Hospital

I. ENCL:

(1) Hepatitis B Evaluation and Treatment Data Sheet
\\nb-gtmo-sop\public\Fb20-Riggs\Working SOPs\SOP Enclosures and Attachments\Encl (1) Hepatitis B .doc
(2) Chronic Hepatitis B, AASLD Practice Guidelines
\\nb-gtmo-sop\public\Fb20-Riggs\Working SOPs\SOP Enclosures and Attachments\Encl (2) Hep B.pdf

II. BACKGROUND:

Hepatitis B is endemic to certain areas of the world including the Middle East. All detainees are screened for serologic evidence of hepatitis B for both the identification of this disease in this population and for the Force Health Protection of the Joint Task Force personnel in close contact with the detainee population so that appropriate preventive measures are taken after exposure to a hepatitis positive detainee. All detainees testing positive for HbsAg may represent ongoing active hepatitis, which may be both contagious and may lead to progressive liver damage to include cirrhosis, liver failure, and the development of hepatocellular cancer.

III. POLICY:

Each detainee found to be HbsAg (hepatitis B surface antigen) positive will be offered further evaluation at the medical clinic. Each detainee will be given the appropriate information regarding hepatitis B to make a decision regarding accepting/declining the evaluation and possible treatment of his/her hepatitis. Both the evaluation and treatment will be completely voluntary. The information collected on the evaluation is found on the enclosed data form. The policy thus stated in this SOP has been coordinated through consultation with the Gastroenterology Division, Naval Medical Center San Diego.

IV. PROCEDURES:

- The following sections deal with the description, definitions, and elaboration of the Hepatitis B Evaluation and Treatment Data Sheet. Screening for hepatitis B occurs upon arrival of the detainee at Naval Base Guantanamo Bay, NBGTMO.

005092

- Those found to be positive for Hepatitis B surface antigen represents a possible case of active hepatitis B.

- The detainee with active hepatitis is infectious to other detainees and JTF personnel via contact with the detainee's blood. Saliva, vomitus, feces, and perspiration are not usually contagious unless these secretions contain blood.

- Information regarding the hepatitis B status of each detainee is useful such that if a blood exposure does occur, the hepatitis B status of the detainee may be assessed and appropriate preventive therapy (vaccination and/or immunoglobulin) can be offered in a timely manner.

- Hepatitis B infection may result in resolution of the infection by the immune system or may lead to persistent active hepatitis, which may lead to progressive liver dysfunction. Therefore, each detainee with a positive HbsAg will be offered further evaluation of this medical condition.

- The appropriate work-up will be initiated among those detainees who desire evaluation of their hepatitis B including serologies for hepatitis A, B, C as shown on the data collection sheet. Each detainee will also be asked about potential symptoms related to hepatitis B and undergo a physical examination. Liver function tests, PT/PTT/INR, and hepatitis B DNA viral load will also be obtained.

- A liver biopsy will be offered to those with elevated liver function tests and a high viral load (>100,000 copies/ml). If the detainee refuses this procedure, therapy will still be offered in appropriate cases.

- Based on the results of the aforementioned tests, each case will be discussed with a board-certified infectious diseases and/or gastroenterologist in regards the initiation of therapy.

- If the detainee meets indications for treatment, the patient will be offered either treatment with adefovir if there is no evidence for renal dysfunction (CrCl >60 and Cr<1.0) or lamuvidine. If the patient has or develops renal insufficiency, the patient will be offered therapy with lamuvidine. Therapy for hepatitis B will be administered for a minimal of one-year if the patient complies and desires therapy.

- The patient will be closely monitored for potential side effects of the therapy at routine clinic visits.

- Since the standard of care for the evaluation and therapy of hepatitis B is evolving, the diagnostic testing and drugs may change over time. Detainees should continue to obtain the standard-of-care of hepatitis B management.

- Detainees refusing therapy will be followed with routine medical clinic visits including liver function test approximately every 6 months or as clinically indicated.

- All patients with active hepatitis B, will also be offered vaccination against hepatitis A which is a 2-dose vaccine given at baseline and again in 6-12 months.

- Detainees with evidence of chronic active hepatitis will be offered screening for hepatoma with an alpha-fetoprotein (AFP) and/or right upper quadrant ultrasound every 6-12 months.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

_____ _____
Officer in Charge Date

IMPLEMENTED BY:

_____
Director for Administration Date

_____ _____
Senior Enlisted Advisor Date

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Title:_____
SOP NO: Date:_____

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 039

Title: HEPATITIS C MANAGEMENT

Page 1 of 4
Effective Date: 11 Mar 03

SCOPE: Detention Hospital

I. ENCL:

(1) Hepatitis C Evaluation and Treatment Data Sheet
\\nh-gtmo-app\public\Fh20-Riggs\Working SOPs\SOP Enclosures and Attachments\Encl (1) Hepatitis C Data Sheet for Evaluation and Treatment.doc
(2) NIH Consensus Statement on Hepatitis C
\\nh-gtmo-app\public\Fh20-Riggs\Working SOPs\SOP Enclosures and Attachments\Encl (2) Hep C NIH2002.pdf

II. BACKGROUND:

All detainees are screened for serologic evidence of hepatitis C to identify infection among this population. The prevalence rate of hepatitis C has been approximated as 2% and depends on the prevalence of drug use, blood transfusion, and unsafe medical practices. Hepatitis C is a major cause of cirrhosis, liver failure, and liver cancer. Treatment of hepatitis C may decrease the risk of progressive liver dysfunction and may prolong life.

III. POLICY:

Each detainee found to be hepatitis C positive by the ELISA screening test will be offered further evaluation at the medical clinic. Each detainee will be given the appropriate information regarding hepatitis C to make a decision regarding accepting/declining the evaluation and possible treatment of his/her hepatitis. Both the evaluation and treatment will be completely voluntary. The information collected on the evaluation is found on the enclosed data form. The policy thus stated in this SOP has been coordinated through consultation with the Gastroenterology Division, Naval Medical Center San Diego.

IV. PROCEDURES:

- The following sections deal with the description and elaboration of the Hepatitis C Evaluation and Treatment Data Sheet. Screening for hepatitis C occurs upon arrival of the detainee at Naval Base Guantanamo Bay, NBGTMO.

- Those found to be positive for hepatitis C by the screening ELISA test represent a possible case of active hepatitis C.

- The detainee with active hepatitis C is infectious to other detainees and JTF personnel via contact with the detainee's blood. Saliva, vomitus, feces, and perspiration are not contagious unless these secretions contain blood. Since there is no current preventive therapy for those exposed to potentially contagious secretions of a hepatitis C patient, information regarding the hepatitis C status of each detainee will be used to follow those exposed to monitor for the development of the infection.

- Hepatitis C infection may result in resolution of the infection by the immune system in 15-40% of cases or may lead to persistent active hepatitis in 60-85%, which may lead to progressive liver dysfunction. Therefore, each detainee with a positive hepatitis C ELISA test will be offered further evaluation of this medical condition.

- The appropriate work-up will be initiated among those detainees who desire evaluation of their hepatitis C including assuring that serologies for hepatitis A, B, C are obtained. Each detainee will be asked about potential symptoms related to hepatitis C and undergo a physical examination. Liver function tests, PT/PTT/INR, hepatitis C RNA viral load, and genotype will also be obtained as shown on the data collection sheet (see Enclosure 1).

- Detainees with a positive hepatitis C ELISA and positive hepatitis C viral load will be diagnosed with active hepatitis C. Those with a negative hepatitis C viral load will be re-evaluated at 4-6 months with a repeat viral load measurement; those negative on both viral load tests will be classified as a false-positive ELISA test or someone who has resolved hepatitis C. This later group will not be further evaluated and do not require therapy.

- Those who are potential candidates for therapy will be referred to Behavioral Health for an initial evaluation to identify early any psychiatric problems which may preclude therapy with interferon.

- A liver biopsy will be offered to those with active hepatitis C. If the detainee refuses this procedure, therapy will still be offered in appropriate cases.

- Based on the results of the aforementioned tests, each case will be discussed with a board-certified infectious diseases and/or gastroenterologist in regards the initiation of therapy.

- If the detainee meets indications for treatment, the patient will be offered treatment with peg-interferon and ribavirin. Therapy for hepatitis C will be

administered for 6-12 months depending on the genotype and response to therapy; this assumes that the patient complies with and tolerates the therapy.

- The patient will be closely monitored for potential side effects of the therapy at routine clinic visits. Psychiatry will also follow the detainee while he/she is treated with peg-interferon.

- Since the standard of care for the evaluation and therapy of hepatitis C is evolving, the diagnostic testing and drugs may change over time. Detainees should continue to obtain the standard-of-care of hepatitis C management.

- Detainees refusing therapy will be followed with routing medical clinic visits including liver function test approximately every 6 months or as clinically indicated.

- All patients with hepatitis C, will also be offered vaccination against hepatitis A which is a 2-dose vaccine given 0 and 6-12 months and hepatitis B which is a 3-dose vaccine at 0,1 and 6 months for all those not already immune.

- Detainees with evidence of hepatitis C cirrhosis will be offered screening for hepatoma with an alpha-fetoprotein (AFP) and/or right upper quadrant ultrasound every 6-12 months.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

_____ _____
Officer In Charge Date

IMPLEMENTED BY:

_____
Director for Administration Date

Senior Enlisted Advisor Date

ANNUAL REVIEW LOG:

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ENTIRE SOP SUPERSEDED BY:

Title:
SOP NO: Date:_____

005099

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

Title: VACCINATIONS

SOP NO: 041

Page 1 of 7
Effective Date: 15 Oct 2003

SCOPE: Detention Hospital

I. REFERENCES:

(1) Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings. MMWR, January 24, 2003, vol 52, RR-1. SOP Enclosure Hepatitis
(2) Measles, Mumps, and Rubella – Vaccine Use and Strategies for Elimination of Measles, Rubella and Congenital Rubella Syndrome and Control of Mumps. MMWR, May 22, 1998, vol 47, No. RR-8. SOP Enclosure MMR
(3) Prevention and Control of Influenza, MMWR, 2003, vol 52, RR-08. SOP Enclosure Influenza
(4) Prevention of Pneumococcal Disease, MMWR, 1997, vol 46, RR-08. SOP Enclosure Pneumococcal Vaccine
(5) Vaccine Management: Recommendations for Handling and Storage of Selected Biologicals, Centers for Disease Control and Prevention, Jan 2001. SOP Enclosure Vaccine Management
(6) Recommended Adult Immunization Schedule – United States, 2002-2003, JAMA 2002, vol 288, p 2258-60.

II. BACKGROUND:

Detainees arrive from areas in which childhood vaccinations may not have been received, making them susceptible to several infectious diseases, including tetanus, diphtheria, measles, mumps and rubella. In addition, within the close living conditions of a detention environment, detainees may be at risk for the aforementioned diseases as well as hepatitis, influenza, and pneumococcus. These diseases can cause outbreaks in non-immune populations making the need for mass immunization an important public health measure.

III. PURPOSE:

To define policies and procedures for detainee vaccinations, both during in-processing and during their time within the camp.

005100

IV. PROCEDURES:

A. Tetanus-diphtheria:

1. Each detainee will receive a single dose of Tetanus-diphtheria (Td) upon arrival, which will occur during the in-processing evolution (See SOP 037: *In-processing Medical Evaluation*).
2. Two additional doses of Td will be given to detainees at 1-2 months after the first shot and then again 6-12 months later.
3. Dose is administered IM (intramuscularly).
4. Detainees deficient in the number of Td injections (<3 doses obtained) will be given a dose of Td during out-processing if the vaccine is due at that time.
5. Detainees sustaining a tetanus prone wound will be assessed by medical per SOP 024: *Tetanus Prophylaxis in JTF Detainees*.
6. A Td booster every 10 years will be offered for those completing the 3-dose primary series.

B. Hepatitis:

1. Immunity to hepatitis A and B for each detainee will be ascertained during in-processing by drawing a Hepatitis A IgG level and Hepatitis B core and surface antibody tests.
2. Those found to be immune to both hepatitis A and B will not receive hepatitis vaccination.
3. Those immune to hepatitis A, but non-immune to hepatitis B will receive the 3-dose hepatitis B vaccine series given at 0, 1, and 6 months. This will be given in an involuntary manner to protect detainees from acquisition of hepatitis B.
4. Those immune to hepatitis B, but non-immune to hepatitis A will receive the 2-dose hepatitis A vaccine series given at 0 and 6 months. This will be given in an involuntary manner to protect detainees from acquisition of hepatitis A.
5. Those non-immune to both hepatitis A and hepatitis B will receive the 3-dose hepatitis A and B vaccine (twinrix) series given at 0, 1, and 6 months. This will be given in an involuntary manner to protect detainees from acquisition of both hepatitis A and B.
6. Hepatitis B vaccine is given by IM injection into the deltoid (not in buttocks). Hepatitis A vaccine and twinrix (combined Hepatitis A and B vaccine) are also given IM.
7. Titers for response will not routinely be checked.
8. Possible side effects of hepatitis A vaccination include soreness at the injection site, headache, and malaise; no serious reactions have been

reported. Giving the vaccine to a person who is already immune to hepatitis A does not appear to increase the risk of side effects.

9. Contraindications for hepatitis A vaccination include an adverse reaction to prior hepatitis A vaccination.

10. Possible side effects of hepatitis B vaccination include soreness at the injection site, fever, and anaphylaxis (1/600,000). No deaths have been reported. Giving the vaccine to a person who is already immune to hepatitis B does not appear to increase the risk of side effects.

11. Contraindications for hepatitis B vaccination include an adverse reaction to prior hepatitis B vaccination

12. Those with a serious adverse reaction to vaccination will be reported to Vaccine Adverse Events Reporting System (VAERS) and the vaccine series will be discontinued.

13. For further information regarding hepatitis vaccinations see Encl 1.

C. Measles-Mumps-Rubella (MMR):

1. Detainees from developing countries are unpredictably vaccinated and documentation of prior natural infections is not available; hence, detainees may remain at risk for these infectious diseases unless vaccinated. The CDC recommends that adults without documentation of receipt of MMR vaccine should receive one dose of MMR vaccine.

2. Each detainee who does not have a contraindication for vaccination will receive a single-dose of MMR (0.5ml subcutaneously) on an involuntary basis for protection of measles, mumps and rubella. This is important for the individual protection of detainees as well as the public health of the camp.

3. The MMR vaccine is a live-virus vaccine and is contraindicated in pregnant females and the immunocompromised. Additional considerations for this vaccine are as follows:

a) Each detainee will be screened for HIV upon arrival using a HIV ELISA test. Those who are seronegative and do not have other contraindications for vaccination (immunosuppressed, chemotherapy, steroids or other immunosuppressants) will receive a dose shortly after entrance into the camp.

b) Any detainee who received immune globulin or blood transfusion should wait 3-11 months for vaccination since these products may blunt the immune response to MMR.

c) PPD's should be placed prior to or simultaneously as vaccination with MMR, since the MMR can interfere with the immune response to PPD. Otherwise, the PPD should not be placed for 4-6 weeks after MMR vaccination.

d) Allergies to neomycin or gelatin are contraindications to MMR vaccination; each detainee should be asked about previous severe reactions to vaccinations.

4. Potential adverse events to vaccination may include local pain or edema in the area of the vaccination, fever, rash, or local temporary lymphadenopathy. Uncommon reactions would be joint pain or reactions such as a seizure caused by fever. Extremely rare reactions may include anaphylaxis (<1 case per 1 million doses administered), low platelets (1:100,000), or meningitis/encephalitis (1 case in 2 million doses). See Encl 2.

5. Each medical personnel should be aware of these potential side effects when assessing detainees during the 1-2 weeks after vaccination. Serious reactions will be reported to the chain of command and to VAERS.

D. Influenza:

1. Each detainee will involuntarily receive a single-dose of influenza vaccine during in-processing.

2. Each detainee will also involuntarily receive annual vaccinations during the months of October-December.

3. Dose is 0.5ml IM.

4. Side effects include local pain or swelling; fever and myalgias may occur. Very rarely anaphylaxis has been reported. Allergic reactions are uncommon and may be related to an allergy to eggs.

5. Contraindication to vaccination includes significant adverse reactions to a prior influenza vaccine or allergy to eggs.

6. For further information, see Encl 3 and the CDC Influenza vaccine information at www.cdc.gov/nip/flu.

E. Pneumococcal:

1. Those detainees meeting the Advisory Committee on Immunization Practices (ACIP) criteria to receive the pneumococcal vaccination will be offered this vaccine on a voluntary basis.

2. Indications for vaccination include age>=65 years, chronic medical conditions involving the heart, lung, liver, kidneys (ESRD, nephrotic syndrome) as well as diabetes, cancer, sickle cell disease, immunodeficiency, and asplenia.

3. Dose is 0.5 ml subcutaneously as a single dose.

4. Side effects are typically mild and may include local soreness, erythema or edema. Rarely fever and myalgias may occur. Very rarely anaphylaxis has been reported.

5. Revaccination x 1 after 5 years of the initial dose will be offered to those who are greater than age 65 years, immunocompetent patients with anatomic/functional asplenia, as well as to immunocompromised persons due to HIV-infection, malignancy, or nephrotic syndrome.

6. Contraindication includes prior adverse reaction to the pneumococcal vaccine.

7. See Encl 4 for further information.

F. Vaccine Adverse Reactions:

1. Medical personnel will immediately assess any detainee having a possible adverse reaction to vaccination.

2. Serious reactions will reported to Vaccine Adverse Events Reporting System (VAERS) [1-800-822-7967] and the vaccine series will be discontinued.

3. Reactions to vaccines will be clearly recorded within the detainee's medical record and the chain of command will be notified of the adverse event.

G. Strategies to facilitate vaccine administration in Camp Delta include:

1. Usage of the ID database to track required vaccines for each detainee since not all detainees receive the same shots at the same times. Included in this database is the date of administration and lot number of vaccine, which is also recorded in the medical record. The Internal Medicine/Infectious Disease physician maintains this database.

2. Prior to the exercise, a brief should be performed regarding the plan, proper administration/handling/storage of the vaccine, and potential side effects.

3. Continuous communication should be maintained with JDOG for organization of the vaccine program in terms of the day of the immunization exercise, other scheduled camp activities, movement within the camp, blocks to begin with, appropriate medical escorts, etc.

4. Early involvement with the linguists to announce two to three days in advance of the upcoming immunization; emphasizing the reasons for the vaccine and the benefits offered to each detainee.

5. Supplies include: syringes, alcohol swabs, appropriate vaccine storage containers (on ice if cold chain required), 2x2 dressings, bandages, sharps container, gloves, and an alpha roster of detainees requiring immunization.

6. Just prior to the exercise, preparation of syringes with vaccine maintaining appropriate cold chain storage if indicated.

7. Following completion of the exercise, the immunizations will be transcribed from the database to the medical record.

8. Personnel required for immunization exercises

   a) A nurse coordinator to organize the corpsmen and vaccine supplies

   b) Teams constructed consisting of four individuals (1-2 to administer vaccines, 1 for organization of supplies, and 1 for administrative purposes to log immunizations). Linguists should be available to assist as needed.

   c) An adequate number of corpsmen and nurses (from Detention hospital, the Joint Aid Station, and NH-Prev Med) to administer the vaccines and to then record all the shots in both the medical records and the database.

F. Reporting Requirements: at the end of each month the NCO of the S1 Processing Line will be given an updated disk of the Infectious Disease database. The S1 is housed in [redacted] DR

G. Vaccine Information:

1. CDC, National Immunization Program: www.cdc.gov/nip
2. Reference 1.
3. FDA, Vaccine Adverse Reactions: 1-800-822-7967 or www.fda.gov/cber/vaers/vaers.htm
4. National Network Immunization Information: 877-341-6644 or www.immunizationinfo.org

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge _____ Date _____

IMPLEMENTED BY:

Director for Administration _____ Date _____

Senior Enlisted Advisor _____ Date _____

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ENTIRE SOP SUPERSEDED BY:

Title: _____
SOP NO: _____ Date: _____

NH GTMO AND DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

Title: Severe Acute Respiratory Syndrome (SARS)

SOP NO: 042

Page 1 of 6
Effective Date: 29 Apr 03

SCOPE: Naval Hospital GTMO and the Detention Hospital

Encl:
(1) http://www.cdc.gov/ncidod/sars/infectioncontrol.htm
(2) http://www.cdc.gov/ncidod/sars/exposureguidance.htm
(3) http://www.cdc.gov/ncidod/sars/ic-closecontacts.htm
(4) http://www.cdc.gov/ncidod/sars/factsheetcc.htm
(5) www.cdc.gov/ncidod/sars/
(6) http://www.cdc.gov/ncidod/hip/ISOLAT/Isolat.htm

I. BACKGROUND:

SARS or Severe Acute Respiratory Syndrome is an emerging respiratory infection that was first described in Asia. This is a novel infection among humans, which is caused by a previously unrecognized coronavirus. Infection may occur in all age groups and races; cases have occurred equally in males and females to date. Symptoms include high fevers (>100.4F), headache, malaise, and body aches; these symptoms cannot distinguish SARS from other viral infections. After 2-7 days, some patients may develop a dry cough and dyspnea and hypoxemia. The incubation period from infection to the development of symptoms is 2-10 days.

II. PURPOSE:

Although no cases have been isolated in Cuba to date, a high awareness of this infectious disease is necessary given its rapid global spread. This SOP serves to increase awareness of this infectious disease and to set forth a protocol for isolation and evaluation of a suspected case of SARS.

II. PROCEDURES:

A. General Information:

1. All suspected cases of SARS will be immediately isolated in his/her own room and the healthcare staff will take the appropriate precautions outlined below to prevent the spread of this viral infection.
2. The chain of command will be immediately briefed on any suspected case.
3. The internal medicine and infectious diseases specialist should be consulted on any suspected case of SARS.
4. Preventive Medicine should be contacted regarding suspected cases for public health management of contacts.

B. Case Definition:

1. The CDC case definition for a suspected case:
   a. Temperature>100.4F or >38C
      and
   b. Respiratory illness (cough, SOB, hypoxia, and/or CXR findings)
      and
   c. Travel within 10 days of onset of symptoms to an area* with documented or suspected community transmission of SARS or close contact within 10 days of onset of symptoms with a SARS case. Note: Travel to an affected area includes transit in an airport

   *SARS has occurred in the Peoples' Republic of China (China and Hong Kong); Hanoi, Vietnam; Singapore; and Toronto.

2. The CDC case definition for a probable case:
   a. Radiographic evidence of pneumonia or respiratory distress syndrome
   b. Autopsy findings consistent with respiratory distress syndrome without an identifiable cause.

C. Diagnosis:

1. Patients with respiratory symptoms and the above criteria should be evaluated for SARS.

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2. Initial diagnostic testing should include pulse oximetry, chest radiograph (may show patchy interstitial infiltrates), blood cultures, sputum Gram's stain and culture. An ABG should be considered with a pulse oximetry of <95%.

3. Basic laboratory values should be obtained including a cbc with a differential, chem. 7, liver function tests and CK. Blood counts may reveal normal or decreased white blood count and platelet count. Some patients have developed elevated CK levels and transaminases.

4. Tests for viral respiratory pathogens such as influenza A and B and respiratory syncytial virus should be obtained. A specimen (urine) for Legionella and pneumococcal should also be considered.

5. The genome of this new coronavirus has recently been sequenced making diagnostic testing feasible. Clinicians should save any available clinical specimens (respiratory, serum, whole blood, and stool) for additional testing until a specific diagnosis is made.

6. Inpatients should have nasopharyngeal swab, lower respiratory sample (BAL, pleural fluid, tracheal aspirate), whole blood, serum, and stool sent for evaluation in suspected cases. Outpatients should have the same samples collected excluding the lower respiratory sample. Autopsy specimens may also be submitted.

7. Acute and convalescent (greater than 21 days after onset of symptoms) serum samples should be collected from each patient who meets the SARS case definition. Paired sera and other clinical specimens can be forwarded through State and local health departments for testing at CDC or directly to the Naval Health Research Center in San Diego [Contact information at NHRC: [redacted] b(6)

D. Protection:

1. The exact route of transmission has not been confirmed; infection is likely spread by airborne droplets, however, contact transmission has not been excluded.
2. Suspected cases in the clinic or ED should be identified early and immediately provided with a surgical mask to cover the patient's mouth and nose. He/she should be separated from other patients into a negative pressure or private room.
3. Health care providers are advised to use standard precautions (hand hygiene) as well as airborne precautions using a N-95 respirator (all personnel must have a qualitative fit test) and contact precautions with gowns and gloves. Eye protection should also be worn for patient

contact. Patients should be isolated in a negative pressure room; if this is not possible, a private room is advisable.

4. Cases should avoid interactions outside their hospital room (inpatients) or home (outpatients) and not go to work, school, or other public areas until 10 days after symptom resolution. The duration of infectivity has not yet been defined; therefore, precautions are advised for 10 days after respiratory symptoms and fever have resolved.
5. Health care workers who have unprotected exposure to a SARS patient should watch for fevers/respiratory symptoms for 10 days after exposure. All exposures should be reported to Preventive Medicine.
6. Exposed and symptomatic healthcare workers with fever or respiratory symptoms should seek medical attention and should not go to work.
7. Exposed healthcare workers who remain asymptomatic can perform their normal work duties.
8. Recommendations may change with further data concerning the etiologic agent and its transmission; check the CDC website for the most up-to-date information.
9. Further guidelines are located on the CDC website.
   a. "Interim domestic guidance for management of exposures to SARS for healthcare and other institutional settings" at: http://www.cdc.gov/ncidod/sars/exposureguidance.htm
   b. "Interim guidance on infection control precautions for patients suspected SARS and close contacts in households" at: http://www.cdc.gov/ncidod/sars/ic-closecontacts.htm
   c. "Updated interim domestic infection control guidance in the healthcare and community setting for patients with suspected SARS" at http://www.cdc.gov/ncidod/sars/infectioncontrol.htm
   d. "Information for close contact of SARS patients" at: http://www.cdc.gov/ncidod/sars/factsheetcc.htm

E. Treatment:

1. No specific treatment is currently available. Some patients have been treated with antiviral agents and/or steroids, but the benefits of such therapies are currently unknown.
2. Until a bacterial cause of the infection is excluded, broad-spectrum antibiotics are recommended for those with pneumonia to cover community-acquired pneumonia as well as atypical organisms. Examples of antibiotics include Ceftriaxone 2 grams iv qd and levaquin 500 mg IV/po qd OR Ceftriaxone 2 grams iv qd and Azithromycin 500 mg po qd.
3. Internal Medicine and infectious diseases consultation is recommended.

F. Prognosis:

1. The severity of illness is variable ranging from a mild viral illness to death.
2. To date, the case fatality rate is 3-5% with most deaths attributed to respiratory failure.

G. Case Reporting:

1. All cases should be reported to the chain of command, Preventive Medicine and to the IM/ID specialist.
2. State or local health departments in the U.S., can be notified for U.S. cases (not applicable)
3. CDC at 770-488-7100

H. Additional Information/Contacts Regarding SARS:

1. BUMED: [redacted] b6
2. www.cdc.gov/ncidod/sars/

STANDARD OPERATING PROCEDURES
Guantanamo Bay, Cuba

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DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 050

Title: DETAINEE REFUSAL OF CARE

Effective Date: 07 Aug 03

SCOPE: Detention Hospital

I. ENCL: (1) DoD Policy on Medical Care for Enemy Persons Under US Control Detained in Conjunction with Operation ENDURING FREEDOM,10 April 2002.

(2) U.S. Southern Command Confidentiality Policy for Interactions Between Health Care Providers and Enemy Persons Under U.S. Control, Detained in Conjunction with Operation ENDURING FREEDOM, 6 August 2002.

II. BACKGROUND. The Detainees held at Joint Task Force (JTF) GTMO are not Prisoners of War, they are considered to be unlawful combatants. The Detainees do not qualify for the Geneva Convention Rules; however, they will be treated humanely, in a manner consistent with the principles of the Geneva Convention relative to the treatment of prisoners of war.

III. POLICY:

A. Detainees under U.S. control suffering from a serious disease, or whose condition necessitates special treatment, surgery, hospital care, or rehabilitation shall be provided, to the extent feasible, the medical attention required by their state of health per the policies delineated in enclosure (1).

B. JTF military medical personnel will provide medical care as applicable to military correctional facilities (SOUTHCOM Policy Memorandum 8-02) found in enclosure (2).

IV. PROCEDURES:

A. Detainees may refuse care that is not required to protect their lives, significant health interests (limbs/organs), the lives or health of others, or legitimate security interests of the United States.

B. Detainees will be treated humanely at all times.

C. Force should be avoided whenever reasonable.

D. Do not use force in situations where the risk of danger to the detainee exceeds the risk of not getting the treatment.

E. Do not use medical treatments as a discipline tool in order to modify detainee behavior. Joint Detainee Operations Group and the JTF Commander will handle the discipline of detainees.

F. Time out or a delay in most treatments by 1-2 hours is acceptable to diffuse the

situation, allow the detainee to reconsider, and/or adjust to the realities of his situation.

G. Refusals are usually an expression or an attempt to achieve control by the detainee. These control issues are usually related to a personal issue and not a larger group or philosophy issue.

H. Ramadan is a religious holiday that requires fasting all day for an entire month. Medication and clinic schedules will need to be adjusted during that time period.

I. The detainees come from a barter culture. Excessive discussion and permission seeking for a benign procedure that does not require informed consent is usually counter-productive. The detainees have a generally fatalistic view of life. Threatening the detainee with a shorter life span for not taking his blood pressure medication or lipid-lowering medication will usually not convince the detainee to take the medication.

J. The Bioethics Committee, Naval Hospital GTMO is another source to help resolve significant issues of bioethical conflict.

K. Informed consent with a native language interpreter as the witness will be obtained for all surgeries and use of anesthesia.

L. The Senior Medical Officer will review all requests for the use of force and provide final approval for the use of force in the case of medical treatment or management.

M. JTF Commander has final decision for all medical matters in regards to issues concerning national security.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantánamo Bay, Cuba

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DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 055

Title: HIGH BLOOD PRESSURE MANAGEMENT

Page 1 of 5
Effective Date: 16 Oct 03

SCOPE: Detention Hospital

I. **ENCL:**
(1) Chronic Disease Medical Flow Sheet

II. **REFERENCES**
(1) Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. The Seventh Report of the JNC on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. *JAMA*. 2003; 289(19):2560-72.
(2) National Commission on Correctional Health Care Clinical Guideline for Correctional Facilities – Treatment of High Blood Pressure

II. BACKGROUND

High blood pressure is a disease that causes an increased risk for stroke, heart disease, and renal failure. While traditionally recognized as a problem in the United States, it is a significant cause of morbidity and mortality worldwide that can be reduced by early intervention. It is well established in Western populations, that the risk of stroke, CHD and other common cardiovascular diseases, have multiple determinants such as age, high blood pressure, hypercholesterol, obesity, and family history. How well these factors predict cardiovascular disease in non-Western populations is less certain, although recent evidence from Eastern Asian populations suggests that blood pressure may have a similar association. However, there is little evidence about these factors in other large populations such as in sub-Saharan Africa, India or South America. The evaluation and treatment of these determinants in a similar manner may be beneficial until future research dictates otherwise.
This guideline is adapted from the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure.

III. POLICY

This is the first SOP on high blood pressure management and this program will be conducted by a medical provider on the JTF staff under the guidance of the Senior Medical Officer (SMO). Scheduled blood pressure monitoring will occur to screen detainees for hypertension and to offer further evaluation and treatment.

The Delta Medical Clinic is responsible for providing blood pressure monitoring and medical treatment as clinically indicated for detainees with high blood pressure. The SMO will ensure that the appropriate standards of care for the medical and administrative management of high blood pressure are adhered to.

Definition of Hypertension. The mean of two or more seated blood pressure (BP) readings on two or more occasions with a systolic BP greater than or equal to 140 or a diastolic BP greater than or equal to 90 will be considered hypertensive.

IV. PROCEDURES

A. Correct Measurement of Blood Pressure:
   1. Detainee should be seated for at least five minutes with arm supported at heart level. The BP cuff bladder should encircle at least 80% of the arm. Systolic BP measurement should be noted at the point at which the first sound is heard and the diastolic measurement should be noted at the point just before the sound disappears.

B. In-processing
   1. Initial history: Upon arrival, detainees will have a history and physical examination recorded on the report of medical examination (see SOP 037). History and symptoms of diabetes, heart disease, hypertension, hyperlipidemia, and renal disease will be obtained. Current/past medication use including illicit drugs, alcohol, and tobacco will be obtained.
   2. Physical examination: At least two blood pressure measurements will be obtained using the above-described methods. Elevated measurements will be verified using the contralateral arm. The weight and height of each detainee will be determined with calculation of the body mass index (see SOP 014). Physical examination will include fundoscopic examination, auscultation for carotid bruits, thyroid examination, thorough cardiovascular and lung exam, abdominal examination for bruits, abnormal pulsations, and organomegaly, neurologic examination, and assessment of distal extremities for pulses and edema.
   3. Diagnostic studies: As indicated by the historical or physical exam findings, additional laboratory studies may be obtained to assess for identifiable causes of hypertension or for the presence of end-organ damage. These may include, but are not limited to: complete blood count (CBC), blood chemistries, urinalysis, lipid panel, and 12-lead electrocardiogram.
   4. All detainees will be reassessed for repeat blood pressure measurements within one month, which will be recorded in the medical record and a mean blood pressure measurement determined. Detainees with known hypertension or abnormal findings by examination will be managed per guidelines listed below.

C. Classification of Blood Pressure (from JNC VII)
   1. Normal: systolic BP less than 120 and diastolic BP < 80
   2. Prehypertension: systolic BP 120-139 or diastolic BP 80-89

3. Stage 1 hypertension: systolic BP 140-159 or diastolic BP 90-99
4. Stage 2 hypertension: systolic BP >159 or diastolic BP >99

V. MEDICAL EVALUATION AND MANAGEMENT

A. Management of Detainees with Hypertension
   1. General Guidelines:
      i. All detainees will be educated regarding lifestyle modification. Please refer to SOP 014 for guidelines on the weight management program. Weight control and dietary sodium restriction have been shown to lower BP.
      ii. The blood pressure goal to reduce the risk of cardiovascular disease is a systolic and diastolic BP less than 140/90 mm Hg or less than 130/80 mm Hg for individuals with diabetes or renal disease.
      iii. Current clinical trials have demonstrated efficacy from several classes of antihypertensives including: angiotensin-converting enzyme inhibitors, beta-blockers, calcium channel blockers, and thiazide diuretics. 2 or more antihypertensive medications may be needed to reach the desired BP goal. While thiazide diuretics have been used in the most trials and have demonstrated efficacy both as single drug and in combination, providers should be cognizant of the hot weather climate and the potential risk for electrolyte abnormalities and dehydration.
   2. Detainees with Prehypertension:
      i. Unless there is a medical indication for medical therapy such as: recurrent stroke, heart failure, diabetes, previous myocardial infarction, or high risk for coronary disease, no medical therapy is indicated. Management will include future assessment and lifestyle modification.
   3. Detainees with Hypertension (stage 1)
      i. In addition to lifestyle modification, the use of medication will likely be required to meet the goals.
   4. Detainees with Hypertension (stage 2)
      i. Detainees with stage 2 hypertension will require antihypertensive medical therapy in addition to lifestyle modification.

B. Detainees enrolled in the blood pressure management program will be categorized in the following manner based on the blood pressure classification and degree of control (using NCCHC guidelines):

   1. Poor Control. Includes detainees with hypertension (systolic BP >159 or diastolic BP > 99) or those with significant cardiovascular comorbidities. These detainees will be monitored at least monthly or more frequent as necessary until BP goal is attained. Once BP goal is met and is stable, visits can be done every 3-6 months. Visits should include blood pressure determinations, assessment of medication tolerance, and education. Serum

creatinine and potassium should be obtained 1-2 times each year. Results will be recorded on the *Chronic Disease Medical Flow Sheet* (see enclosure 1).

2. Fair Control. Includes detainees with systolic BP 140-159 or diastolic BP of 90-99. These detainees will be monitored at least every 2-3 months for blood pressure determination, assessment of medication tolerance, and education. Results will be recorded on the *Chronic Disease Medical Flow Sheet* (see enclosure 1).

3. Good Control. Includes detainees with a blood pressure less than 140/90. These detainees should be seen initially every 3-4 months and if controlled and stable, this may decrease to twice yearly. Visits should include blood pressure determination, medication tolerance, and lifestyle education with the results recorded on the *Chronic Disease Medical Flow Sheet* (see enclosure 1).

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Detention Hospital
Guantanamo Bay, Cuba

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DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 061

Title: BLOCK NURSE

SCOPE: Detention Hospital

I. PURPOSE: The nurse assigned to this position provides nursing oversight to care provided outside the Delta Clinic, including Medication Administration and Block Sick Call. The nurse provides an indispensable liaison relationship with the Delta Clinic between the corpsmen and the medical providers. The nurse fulfills one of the main functions of Navy Nurses, that of training corpsmen. Additionally, the nurse serves as an intermediary for issues that arise between the corpsmen and detainees and MPs.

II. NURSING DUTIES AND RESPONSIBILITIES:

- Direct observation of first medication administrations by newly reporting corpsmen.
- Direct observation of the medical care administered during detainee incidents that require the intervention of the Emergency Response Team (ERT).
- Safety observer during evolutions requiring the intervention of the ERT.
- Spot monitoring of corpsmen encounters.
- Serve as resource for the corpsmen.
- Observation of patient encounters, including OpSec, customer service.
- Oversight of block sick call.
- Identification of just-in-time training needs. Provision of group and individual training as needed.
- Documentation of corpsmen performance in anecdotal or narrative format.
- Assist in clinic after completion of morning med pass and sick call. Priorities will be reviewing Medication Administration Records and SOAP notes.
- Early identification of problem areas on blocks, and provision of potential solutions.
- Potentially establish skilled nursing block for patients who require frequent observation, but not hospitalization.
- Establish a relationship with the MP's on the block to establish positive communications channels between medical and non-medical entities.
- Provide continuity of care in a challenging environment.

- Hours will generally be during the daytime (0800-2000), Monday through Saturday. When staffing permits, a block nurse can be assigned to the night shift.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

Title: EMERGENCY MEDICAL TREATMENT SOP

SOP NO: 068

Page 1 of 25
Effective Date: May 2004

SCOPE: Detention Hospital, Delta Medical Clinic

I. MISSION

To provide standardized emergent treatment to military and detainee personnel secondary to illness or injury.

II. OVERVIEW

Accident, injury or illness can occur at any time. By utilizing a standardized set of treatment principles and actions, the overall incidence of morbidity and mortality can be reduced. Also, by providing medical care utilizing protocols emergent treatment can be initiated in the absence of a medical officer and can be continued until a medical provider is contacted via phone or is present at the scene.

III. PROCEDURES

1) All nurses and corpsmen will receive training on protocol usage.

2) Once initial training is completed, shift nurses will be able approve corpsmen on protocol usage and medications specifically administered by hospital corps staff.

3) Newly arriving personnel must be approved on protocol usage prior to being assigned to an emergency response team (ERT).

4) Nurses and shift leaders will conduct ongoing protocol and medical refresher training.

5) Hospital corps staff will have this training annotated in their training record while at JTF GTMO.

6) Protocols are only in effect in the absence of a credentialed medical provider. Medical providers may modify, supercede or negate any protocol once the patient is under his or her care.

ALTERED MENTAL STATUS

Common Causes:
- Alcohol
- Epilepsy
- Infection
- Overdose
- Uremia
- Trauma, Temperature
- Insulin (Hyper/Hypoglycemia)
- Psychogenic, Poison
- Shock, Stroke (CVA)

1) Assure ABC's

2) Provide supplemental O2 to maintain SpO2 > 92%

3) Obtain vascular access

4) If dehydration or hypoperfusion evident, go to **REHYDRATION/SHOCK PROTOCOL**

5) Obtain FSBS:

60-300 mg/dl: monitor
> 300 mg/dl: - give 250 ml NS fluid bolus(s) to maintain SBP > 90 mmHg
< 60 mg/dl: - give 1-2 tubes oral glucose if alert and able to maintain own airway (C)/(N)

If unresponsive or unable to maintain own airway:
- give *Thiamine* 100 mg IVP (N) if malnourished or pt is on hunger strike
- *D50W* 25 grams IVP (N) or *Glucagon* 1mg IM (C)/(N) if IV not established

6) *Naloxone* 0.4-2mg IVP (N) titrated to effect for suspected narcotic overdose

7) If seizures evident, go to **SEIZURE PROTOCOL**

8) Consider *Flumazenil* for barbiturate overdose **

8) Continue to monitor, transport to clinic, and contact MO for medical oversight.

** Contact MO for guidance regarding risk for seizures and dosing amounts

ALLERGIC/ANAPHYLACTIC REACTION

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) Obtain vascular access

4) *Diphenhydramine* 50mg IM (C) or 25-50mg IVP (N)

5) If hypotensive or respiratory distress evident:

- EKG monitor
- *Epinephrine* 1:1000 0.3mg SC (C)/(N) **
- *Albuterol* 2.5mg/5cc NS via HHN (C)/(N)
- 250 cc NS bolus(s) to maintain SBP > 90 mmHg
- *Solumedrol* 125mg IVP (N)

6) Continue to monitor, transport to clinic, and contact MO for medical oversight

HHN= hand held nebulizer

** Use Epinephrine with caution in persons with known cardiac history or > 40y old

BURNS

1) Extinguish flames and ensure scene safety.

2) Go to **ADVANCED AIRWAY PROTOCOL** if inhalation injury present

3) Give supplemental O2 to keep SpO2 > 92%

4) Remove smoldering clothing and constricting jewelry

5) Evaluate burn extent using "Rule of Nines"

6) Attempt to remove offending agent:

- Dry chemical: Brush off. Irrigate for 20 min with H20
- Liquid chemical: Irrigate for 20 min with H20

7) Cover with burn sheets or dry, sterile dressing

8) Obtain vascular access

9) 250 ml NS bolus(s) to maintain SBP > 90 mmHg (Keep I/O total for burn formula calculation)

10) ***Morphine sulfate 2-4 mg IM*** (C) or IVP (N) q 5 min to a max of 10mg for pain control.

11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

CHEST PAIN

1) Assure ABC's

2) If having difficulty breathing, got to **DIFFICULTY BREATHING PROTOCOL**

3) Give O2 2-4 lpm via NC or as needed to keep SpO2 . 92%

4) 3-lead EKG monitor

5) Obtain IV access and draw "Rainbow" lab panel

6) *ASA* 324 mg PO (C)/(N) X (2) doses. (Chew first dose, swallow second dose)

7) NS 250 ml bolus(s) to maintain SBP > 90 mmHg **

8) *Nitroglycerin* 0.4 mg SL (C)/(N) q 5 min up to a max of three doses *

9) 12 Lead EKG

10) *Morphine sulphate* 2-4 mg IVP (N) q 5 min (max 10 mg) titrated for pain relief

11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

* Check blood pressure in between nitroglycerin doses. Withhold nitroglycerin if SBP < 90mmHg

** If evidence of right ventricular failure (hypotension, JVD, pitting edema), withhold nitroglycerin and morphine. Contact MO ASAP for medical oversight.

DEHYDRATION

1) Assure ABC's

2) Vital signs with Tilts. (A decrease in 10 pts for B/P or increase of the HR of 20 points means pt is tilt positive) You may just follow HR and response vice complete set of tilts.

3) Draw CBC, and Chem 7 to be sent stat, if detainee does not respond to 2 liters of IV fluids. May D/C labs if detainee is tilt negative. There is no need for IVF.

4) Two liter bolus of NS or LR.

5) Finger stick. If blood glucose is less than 60 then start second IV line and infuse D5W @ 200cc / hr for total of 400cc and Thiamine 100mg IM/IVPB and call MO.

6) Pulse ox. If pulse ox is less than 95% administer O2 and call MO if hadn't done so already.

7) May D/C to block if re-tilt is negative. You may re-tilt after first IV bag.

8) If re-tilt positive, call MO if hadn't done so already.

9) Please call MO for any concerns or questions.

DIFFICULTY BREATHING

1) Assure ABC's

2) If respiratory failure is imminent, got to **ADVANCED AIRWAY PROTOCOL**

3) Provide supplemental O2 to keep SpO2 > 92%

4) If anaphylaxis is present, got to **ALLERGY/ANAPHYLAXIS PROTOCOL**

5) If rales present or history of cardiac/MI:

- EKG monitor
- Obtain vascular access with "Rainbow" blood draw
- *Nitroglycerin* 0.4 mg SL (C)/(N) q 5 min X 3 doses
- *Lasix* 0.5-1 mg/kg IVP (N)
- *Albuterol* 2.5 mg/ 5cc NS via HHN if active wheezing present

If history of COPD, asthma, wheezes or diminished breath sounds:

- *Albuterol* 2.5 mg/5 cc NS via HHN (C)/(N)

If no improvement:

- *Albuterol* 2.5 mg/5cc NS/ *Atrovent* 0.5mg/5cc NS via HHN (C)/(N)
- Obtain vascular access
- *Solumedrol* 125 mg IVP (N)
- Repeat *Albuterol* 2.5 mg/5cc NS via HHN (C)/(N)

6) Continue to monitor, transport to clinic, and contact MO for medical oversight

HHN= Hand Held Nebulizer

DIVING MEDICAL DISORDERS

Mild Sx's: Extremity pain, itching
Serious Sx: Visual disturbances Ear pain, vertigo Focal weakness Vision difficulty Speech difficulty Numbness, tingling Mental status changes Seizure Cardiac arrest

1) Assure ABC's

2) Obtain diving history:

- depth of dive
- total diving time (time leaving surface until time reaching surface= total dive time)
- time spent at bottom
- ascent time
- type of mixture (air, NITROX, helium/oxygen mixture, etc.)
- any complications during dive

3) NRB 10-15 lpm O2

4) Obtain IV access

5) Transport supine on spine board to NH GTMO for eval

Important Numbers:

Dive Locker: [redacted]

Dive Supervisor:

005131

ELECTRICAL/LIGHTNING INJURIES

1) Ensure scene safety

2) Assure ABC's

3) Consider spinal immobilization

4) If cardiac arrest or bradycardia present, refer to appropriate protocol

5) 3-lead EKG monitor

6) Obtain vascular access with "Rainbow" lab draw

7) 250 ml NS bolus(s) to maintain SBP > 90 mmHg

8) 12-Lead EKG

9) If burn injury present, go to **BURN PROTOCOL**

10) Continue to monitor, transport to clinic, and contact MO for medical oversight

HYPERTHERMIA

1) Assure ABC's

2) If respiratory failure is imminent, go to **ADVANCED AIRWAY PROTOCOL**

3) Remove from environment

4) Provide supplemental O2 to maintain SpO2 > 92%

5) If altered LOC or rectal temp > 104 F:

- FSBS (if less than 60 mg/dl, got to **ALTERED MENTAL STATUS PROTOCOL**)
- obtain vascular access with "Rainbow" blood draw
- Infuse 2 L IV NS bolus (C)/(N)
- Aggressive cooling measures (ice to arm pits and groin, water and direct wind from fan, etc.)
- Discontinue aggressive cooling measures when core temp reaches 101 degrees F

Heat Exhaustion

- Place in air-conditioned environment
- Infuse 2L IV NS bolus (C)/(N)

Heat Cramps:

- Encourage PO intake
- Educate need for increase fluid requirements while operating in hot environment

6) 250ml NS bolus(s) to maintain SBP > 90 mmHg

7) Continue to monitor, transport to clinic, and contact MO for medical oversight

NAUSEA AND VOMITING

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) If dehydration or hypoperfusion evident, go to **REHYDRATION/SHOCK PROTOCOL**

4) Obtain vascular access as needed

5) If active nausea and vomiting present:

- ***Phenergan*** 25mg IM (C)/(N) or 12.5-25mg IVP (N)

or

- ***Zofran*** 4mg IVP (N)

6) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

POISONING/OVERDOSE

1) Assure ABC's

2) Obtain history:
- type and amount of poison
- route (ingested, inhaled, injected or through skin surface contamination)
- time poisoned
- has patient vomited? When?
- history of drug or ETOH usage?
- PMH

3) In unresponsive or altered mental status, got to **ALTERED MENTAL STATUS PROTOCOL**

4) If seizing, got to **SEIZURE PROTOCOL**

5) If anaphylaxis or allergic reaction suspected, go to **ANAPHYLAXIS/ALLERGIC REACTION PROTOCOL**

6) If inhaled poison:
- expose to fresh air/remove from environment
- administer 100% O2 via NRB

7) If skin surface contaminated:

Dry Chemical
- brush off particles
- irrigate with H2O for 20 min

Liquid Chemical
- irrigate area with H2O for 20 min

8) Ingested poison (non acid, alkali, or other caustic substance):
- if acid, alkali or other caustic substance, proceed to step 9
- if < 30 min after poison ingestion, give 1 gram/kg Activated Charcoal PO (if tolerated)
- place NG tube if unable to tolerate PO
- if > 30 min since ingestion, monitor and proceed to step 9

9) Contact Poison Control Center or obtain MSDS sheets as needed

10) Continue to monitor, transport to clinic, contact MO ASAP for medical oversight

SEIZURE

1) Assure ABC's

2) Protect patient from injury

3) If respiratory failure is imminent, proceed to **ADVANCED AIRWAY PROTOCOL**

4) Obtain FSBS. If less than 60 mg/dl, go to **ALTERED MENTAL STATUS PROTOCOL**

5) If patient is actively seizing > 10 min:

- obtain vascular access
- *Diazepam* 2-10mg IVP (N) ** or *Lorazepam* 2-5 mg IVP (N) **

6) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

** If unable to obtain IV access, may administer Diazepam via rectum

GENERAL TRAUMA PROTOCOL

1) Assure scene safety

2) Perform primary assessment:

A
- ensure open airway with c-spine control
- if respiratory failure imminent, go to **ADVANCED AIRWAY PROTOCOL**

B
- IAPP and ensure adequate respiratory function
- provide supplemental O2 to keep SpO2 > 92%
- if S/S of tension pneumothorax evident, perform needle thoracentesis

C
- stop all life-threatening hemorrhage
- perform "blood sweep"

D
- AVPU or GCS
- ongoing mental status checks

E
- expose all suspected injury areas
- prevent hypothermia and shock from excessive exposure

F
- full set of vital signs (including SpO2 and pain assessment)
- EBL to determine blood loss

3) Secure airway using ADVANCED AIRWAY PROTOCOL if needed

4) Obtain venous access and infuse NS via bolus(s) to maintain SBP > 90 mmHg

5) Perform secondary assessment and treat all associated injuries

6) ***Morphine sulfate*** 2-5mg IM (C)/(N) or 2-5mg IV (N) PRN for pain (maximum 10mg) titrated to effect

7) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

CARDIAC ARREST PROTOCOL FOR NON-ACLS PROVIDERS

AUTOMATED EXTERNAL DEFIBRILLATION (AED) FOR NON-ACLS PERSONNEL

1) Establish pulselessness
2) Contact Delta Clinic or Detention Hospital and call "Code Blue"
3) Start CPR utilizing BVM and 100% O2.
4) Turn AED on
5) Attach electrodes
6) Analyze rhythm

If shock indicated:
- give (3) "stacked shocks"
- continue CPR for (1) minute
- maintain airway control utilizing **ADVANCED AIRWAY PROTOCOL** and establish IV access
- ***Epinephrine*** 1:10,000 1mg IVP (N) or 2.5 mg ETT (N) q 3-5 min
- analyze rhythm
- give (3) "stacked shocks" if needed
- continue CPR for (1) minute
- ***Lidocaine*** 1-1.5 mg/kg IVP (N) or 2-3 mg ETT (N) to a maximum of 3 mg/kg
- analyze rhythm
- give (3) "stacked shocks" if needed
- continue CPR, monitoring and delivering drug, shock, drug, shock, etc.

If no shock indicated:
- continue CPR
- maintain airway control and establish IV access
- ***Epinephrine*** 1:10,000 1mg IVP (N) or 2.5mg ETT (N) q 3-5 min
- continue CPR
- ***Atropine*** 1mg IVP (N) or 2mg ETT (N) q 5min (max of 3mg)

- continue CPR, monitoring with AED and proceed to "If shock indicated" if shock

7) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**

8) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight.

EMERGENCY CARDIAC CARE PROTCOLS FOR ACLS PROVIDERS

ASYSTOLE

1) Establish unresponsiveness

2) Begin CPR with BVM and 100% O2

3) 3-lead EKG monitor

4) Maintain airway utilizing **ADVANCED AIRWAY PROTOCOL**

5) Obtain vascular access

6) ***Epinephrine*** 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5min

7) Continue CPR

8) ***Atropine*** 1mg IVP or 2mg ETT (C)/(N) q 3-5 min (max 3 mg)

9) Continue CPR

10) If spontaneous return of pulse, go to **POST RESUSCITATION PROTOCOL**

11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

Possible Causes
- Myocardial Infarction
- Acidosis
- Tension Pneumothorax
- Hyperkalemia/Hypokalemia
- Hypothermia
- Hypoxia
- Cardiac Tamponade
- Emboli
- Drug Overdose

BRADYCARDIA

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) EKG monitor

4) If 2nd degree Type II or 3rd degree Heart Block present with signs of hypoperfusion, consider early transcutaneous pacing (TCP)

5) Obtain vascular access

6) *Atropine* 0.5-1mg IVP (N) titrated to effect (maximum 3mg)

7) If patient fails to respond to atropine, consider transcutaneous pacing (TCP)

8) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

PULSELESS ELECTRICAL ACTIVITY (PEA)

1) Establish pulselessness

2) Begin CPR with BVM and 100% O2

3) Maintain airway utilizing **ADVANCED AIRWAY PROTOCOL**

4) Obtain vascular access

5) ***Epinephrine*** 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5 min

6) Continue CPR

7) ***Atropine*** 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5 min (maximum 3mg) ••

8) Continue CPR

9) Rule out causes of PEA and treat according to appropriate protocol

10) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**

11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

•• Give atropine for electrical heart rate < 60 bpm

Possible Causes

- Myocardial Infarction
- Acidosis
- Tension Pneumothorax
- Hyperkalemia/Hypokalemia
- Hypothermia
- Hypoxia
- Cardiac Tamponade
- Emboli
- Drug Overdose

TACHYCARDIA- NARROW COMPLEX

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) 3-lead EKG monitor

4) If pulse > 150 bpm with signs of altered mental status or hypoperfusion:
   - synchronized cardioversion (100J, 200J, 300J, 360J) *
   - if pulseless go to appropriate protocol

5) Obtain vascular access

6) 12 Lead EKG

7) If pulse > 150 bpm and without signs of hypoperfusion, attempt vagal maneuver **

8) If signs of deteriorating mental status or hypoperfusion present
   - synchronized cardioversion (100J, 200J, 300J, 360J) ***
   - if pulseless go to appropriate protocol

9) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

* May start at 50J for Atrial Flutter

** Vagal maneuvers should not be attempted on the following:
   - history of transient ischemic attack (TIA)/ cerebral vascular accident (CVA)
   - previous neck surgery
   - neck cancer
   - history of aortic stenosis
   - known carotid artery blockage

*** If possible, provide sedation with analgesia:
   - *Versed* 1-2mg IVP (N)
   - *Morphine Sulfate* 2-4mg IVP (N)

TACHYCARDIA- WIDE COMPLEX

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) 3-lead EKG monitor

4) If pulse > 150 bpm with signs of altered mental status or hypoperfusion:
   - synchronized cardioversion (100J, 200J, 300J, 360J) *

5) Obtain vascular access

6) 12 Lead EKG

7) *Lidocaine* 1-1.5 mg/kg slow IVP (N) over 2 min **

8) If rhythm does not spontaneously convert to sinus within 10 min:

   - *Lidocaine* 0.5-0.75 mg/kg slow IVP (N) over 2 min **

9) If patient becomes pulseless, go to **VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA PROTCOL**

10) If patient develops sign of altered mental status or hypoperfusion:
   - synchronized cardioversion (100J, 200J, 300J, 360J) *

11) If patient converts to sinus rhythm, start *Lidocaine* drip 2-4 mg/min

☐ Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

* If possible, provide sedation with analgesia:
   - *Versed* 1-2mg IVP (N)
   - *Morphine Sulfate* 2-4mg IVP (N)

** Give ½ dose in patients with impaired liver function, left ventricular dysfunction or > 70 yo

VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA

1) Establish pulselessness

2) Contact Delta Clinic or Detention Hospital and call "Code Blue"

3) EKG monitor

4) Defibrillate at 200J, 300J, 360J

5) CPR with BVM and 100% O2

6) Maintain airway utilizing ADVANCED AIRWAY PROTOCOL

7) Obtain venous access

8) ***Epinephrine*** 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5min

9) Continue CPR

10) Defibrillate at 360J

11) ***Lidocaine*** 1-1.5mg/kg IVP (N) or 3mg/kg ETT (C)/(N) *

12) Continue CPR

13) Defibrillate at 360J

14) ***Lidocaine*** 1.5mg/kg IVP (N) or 3mg/kg ETT (C)/(N) * (maximum 3mg/kg)

15) Continue CPR

16) Defibrillate 360J

16) Continue "drug-shock" sequence with defibrillation every 30-60 seconds after drug administration

17) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**

18) Continue to monitor, transport to clinic, and call MO ASAP for medical oversight

* Give ½ dose in patients with impaired liver function, left ventricular dysfunction or > 70 yo

POST RESUSCITTATION

1) Assure ABC's

2) Assess heart rate:
   - if heart rate < 60 bpm, go to **BRADYCARDIA PROTOCOL**
   - if heart rate > 150, go to **NARROW or WIDE TACHYCARDIA PROTOCOL**

3) If patient is hypotensive and lung sounds are clear:
   - give 250ml NS bolus(s) to maintain SBP > 90 mmHg
   - consider *Dopamine* 5-10 mcg/kg/min to maintain SBP > 90 mmHg if unresponsive to fluid bolus(s)

4) If patient V-FIB or V-TACH during resuscitation:
   - give *Lidocaine* 1.5 mg/kg slow IVP (N) over 2 minutes (if not previously given) *
   - start *Lidocaine* drip at 2-4 mg/min

5) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

* Give ½ dose in patients with impaired liver function, left ventricular dysfunction or > 70 yo

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

_____ _____
Officer In Charge Date

IMPLEMENTED BY:

_____ _____
Director for Administration Date

_____ _____
Senior Enlisted Advisor Date

ANNUAL REVIEW LOG:

By:_____ Date:_____
By:_____ Date:_____
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By:_____ Date:_____

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ENTIRE SOP SUPERSEDED BY:

Title:_____
SOP NO:_____ Date:_____

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DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: JMG 006
Title: MORTUARY AFFAIRS	Page 1 of 4 Effective Date: 1 Jun 2005
SCOPE: JOINT MEDICAL GROUP (JMG)	

Ref: (a) Geneva Convention on Prisoners of War
(b) JTF GTMO/JDOG SOP for Mortuary Affairs
(c) NAVMEDCOMINST 5360.1

I. BACKGROUND:

As a consequence of disease, battle injury and non-battle injury it is assumed that some loss of life may occur among detainees.

II. POLICY:

JTF GTMO conducts mortuary affairs services in support of detainee operations. Mortuary services include the supervision and execution of matters pertaining to:

A. Search, recovery, identification, and evacuation of deceased U. S. Military, civilians, and detainees.

B. Recovery and disposition, including collection, receipt, recording, and storage of personal effects of deceased personnel.

C. The maintenance of pertinent records and reports in connection with graves registration services. A graves registration program will only be implemented at the direction of USSOUTHCOM.

III. PROCEDURE:

A. Mortuary services (current/concurrent death program) will remain in effect as long as the operational and logistical situation permits. Mortuary affairs will not be performed per reference (a), but "consistent with" the Geneva Convention.

B. JTF GTMO J4 Mortuary Affairs Officer serves as coordinating activity for all aspects of mortuary affairs at GTMO and coordinates directly with USSOUTHCOM Joint Mortuary Affairs Office (JMAO).

C. Limited mortuary services are available at Naval Hospital Guantanamo Bay.

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D. All U. S. remains will be handled per reference (b) and (c).

E. Detainee remains.

1. If a detainee dies while in the Detention Hospital or Delta Medical Clinic the JDOG Watch Officer, Detention Hospital Officer in Charge, Duty Medical Officer, Senior Medical Officer and JTF SG/JMG Commander will be notified immediately.

(a) Once a detainee's body is cleared for release (by NCIS), JDOG personnel will bag the body and place it in an ambulance. Care will be given to not remove any life sustaining, tubes or lines, these must be clipped and remain intact. Detention Hospital will provide the ambulance and driver to transport the body to the morgue.

2. Detainee remains will be cared for per reference (a) and as amplified by the following procedures:

(a) To the extent possible, detainee remains will be cared for in a matter consistent with their religious tradition.

(b) JTF GTMO JOC Watch Officer will notify USSOUTHCOM CAC and provide detainee personal data.

(c) JTF Surgeon will coordinate a post mortem medical evaluation.

(d) JTF GTMO Surgeon's Office will request a pathologist from the Armed Forces Institute of Pathology (AFIP). The AFIP/Armed Forces Medical Examiner (AFME) takes the request for action and a pathology team will be ready to fly within four (4) hours of notification. Military Air will need to be coordinated with the J4 Strategic Mobility Officer.

(1) As of May 2005, the point of contact i[redacted] at b(6)
the Office of Armed Forces Medical Examiner, Armed Forces Institute of Pathology,
[redacted] b(6)

(e) JTF GTMO Surgeon's Office will coordinate with the JTF Chaplain, and if necessary, request an Imam from Navy Mortuary Affairs (Great Lakes).

(1) As of May 2005, the Military Medical Support Office Mortuary
[redacted] b(6)
Normal office hours are 0700 to 1600 Central time. After hours, the duty mortician can be paged. Mortuary Affairs can be contacted at

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[redacted] b(7)

the prompts provided. and follow

(f) An autopsy will be conducted in every case to document the cause of death for all detainees. The autopsy will be conducted at the Naval Hospital morgue. Once complete and AFME has released the body, burial will occur as soon as practical.

(g) JTF GTMO Surgeon will send a copy of detainee death certificate to USSOUTHCOM CAC (surgeon).

(h) JTF GTMO J-4 Mortuary Affairs Officer will notify the Department of State, who will contact the embassy of the decedent's home of record and advise them of the death and for a determination of the detainee remains disposition as well as disposition of detainee personal effects.

(i) [redacted] b2

(j) Naval Hospital Patient Administration (mortuary services) will coordinate with the JTF GTMO J-4 Mortuary Affairs Officer to obtain cemetery access and purchase services from base contractor for burial ground preparation.

(k) Detainee personal effects will be handled by the J-4 in the same manner as those of U.S. decedents.

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STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge _____ Date

IMPLEMENTED BY:

Director for Administration _____ Date

Senior Enlisted Advisor _____ Date

ANNUAL REVIEW LOG:

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ENTIRE SOP SUPERSEDED BY:

Title:
SOP NO:

Date:_____

DETENTION HOSPITAL GUANTANAMO BAY, CUBA Title: ADVANCE DIRECTIVES	SOP NO: JMG 011 Page 1 of 3 Effective Date: 1 Apr 2005
SCOPE: JOINT MEDICAL GROUP	

I. BACKGROUND:

As a consequence of disease, battle injury and non-battle injury it is assumed that some loss of life may occur among detainees.

II. ADVANCED DIRECTIVES

A. Detainees have the right to self-determination and the opportunity to request advance directives or living wills.

B. Given the inherent difficulty in next of kin notification, no health care surrogates will be chosen. The JTF Commander will act as the health care surrogate for all detainees under advisement of the JTF Surgeon and JTF GTMO Staff Judge Advocate.

C. To the degree possible, cultural sensitivity will be maintained in executing these requests. For detainees wishing to execute an advance directive/living will, form NHGTMO 6320/24 will be completed and placed in the record. The medical officer will ensure the detainee understands this process and its implications prior to accepting the directive.

III. DO NOT RESUSCITATE

A. Detainees have the right to end-of-life medical care. They also have the right to refuse resuscitation in the event of cardiopulmonary arrest. Detainees requesting such orders will discuss them with a medical officer.

B. Only the medical officer can write a DNR order; it must be reviewed and approved by the Detention Hospital CO, the JTF Surgeon and Staff Judge Advocate. Documentation within the medical record must be clear and include the following at a minimum:

- Diagnosis and prognosis
- Description of the detainee's mental state

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- Express wishes of the detainee and evidence of informed consent
- Reference to an advanced directive/living will if one exists

IV. SUICIDE

A. The medical staff is trained to recognize signs of suicidal thinking and behavior. Detainees will be screened during in-processing and if identified as "at risk" referred for psychiatric evaluation.

B. Duty medical staff and security personnel will be informed of any detainees on a "suicide watch" and follow the instructions of the consulting psychiatrist. The JTF Surgeon via the Detention Hospital CO will be apprised of any such determinations.

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STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge _____ Date

IMPLEMENTED BY:

Director for Administration _____ Date

Senior Enlisted Advisor _____ Date

ANNUAL REVIEW LOG:

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ENTIRE SOP SUPERSEDED BY:

Title:
SOP NO: Date:_____

005155

DETAINEE HOSPITAL
EFFECTIVE DATE: 18 JAN 2004

SOP NO: 010

GUANTANAMO BAY, CUBA

Title: MEDICATION DISPENSING POLICY

SCOPE: Detention Hospital

I. PURPOSE:

To provide guidelines for the procedures to be followed in dispensing medications to the detainees located at Camp Delta Clinic and Detention Hospital.

II. BACKGROUND:

The pharmacy technician (NEC 8482) provides pharmacy support by dispensing medications pursuant to valid prescriptions written by credentialed providers.

III. RESPONSIBILITY:

The Director for Ancillary Services has overall responsibility for pharmaceuticals and reports directly to the Officer in Charge. The Leading Petty Officer (LPO) for the Pharmacy is responsible for the proper organization, efficient inventory management, and proper dispensing and issuance of all pharmaceuticals. Operational procedures shall be in compliance with all provisions of Chapter 21 of the Manual of the Medical Department.

Security of Pharmaceuticals: The Detention Hospital pharmacy technician will ensure the proper security of the pharmaceuticals transported to Camp Delta. The pharmacy LPO will ensure that adequate medication stock is kept available at the camp clinic. A satellite pharmacy will be run from the Delta Detention Hospital, which will provide most stock medication to the Camp Delta Clinic and to the Detention Hospital. At the camp, all pre-dispensed medications will be kept in a designated drug cabinet. All controlled substances will be kept in a locked cabinet and the clinic nurse will maintain

the narcotics log and locker key. A small stock of frequently used immunizations will be stored in the Detention Hospital Pharmacy reefer. Larger quantities of immunizations will be stored at the Naval Hospital GTMO Pharmacy and transferred to Delta Clinic on an as needed basis.

IV. DISPENSING OF MEDICATIONS:

1. The Camp Delta medication formulary will be determined by the Senior Medical Officer. The formulary will be reviewed on an annual basis.

2. The medical providers will enter all prescriptions into CHCS. A CHCS terminal and label printer will be available for the pharmacy technician to use in the dispensing of prescriptions. The pharmacy technician will fill all prescriptions and will apply CHCS generated prescription label and ancillary warning labels to the bottles as appropriate. Medications ordered beyond a one-time use and dispensed by the Hospital Corpsmen will be dispensed from the Detention Hospital pharmacy.

3. The controlled substances are dispensed to the custody of the nursing staff, which will be in charge of counting the drugs and securing them in the locker. All other dispensed medications will be kept a designated area within the clinic and will be stored according to type of drug and patient identification number.

4. Corpsman may pass medications on the blocks after they have completed the five-day Corpsman orientation to the camp and has had direct observation by the Team Leader.

V. WASTING OF NARCOTIC MEDICATIONS:

1. When a narcotic medication is returned for any reason, it will not be returned to the Narcotic Locker. The medication will be annotated as wasted on the Narcotic and Controlled Drug Account Record (NAVMED 7610/1) for that particular medication. An arrow will be drawn to the right of the Balance on Hand block pointing to the back of the form. On the back of the Narcotic and Controlled Drug Account Record, at the same level of the arrow, the waste will be annotated as to how much, time and date, and the names of the two people who wasted the narcotic. Two nurses or a nurse and a corpsman are authorized to annotate the waste of the narcotic.

VI. DOCUMENTATION OF MEDICATION ADMINISTRATION

1. When the nurse takes orders off the chart, the nurse will initial to the side of each order as it is taken off and transcribed to the Medication Administration Record (MAR). After all of the orders of that provider are transcribed appropriately, the nurse will sign, date and time when he or she completed the transcription of the orders.

2. When verifying the day's charts, the RN will compare the MAR with CHCS and will annotate: "Chart verified with MAR, CHCS (and, when appropriate, profile)" and then sign and time on the doctor's order sheet.

3. When medications are discontinued by a provider, nursing staff will ensure all discontinued medications are pulled from the patient's drawer at the time the order is transcribed.

4. Each evening, in the absence of a pharmacy technician, the RN and an HM will go through all the patient med drawers with the MARs to assure the correct medications are in the proper drawers and no drugs are past their expiration date.

5. When medications are given to a detainee, nursing staff will annotate by signing initials on the MAR to indicate medications were given.

6. Whenever a narcotic is given, annotation will be made in the nurses notes stating the reason why the narcotic was given, including a patient-perceived pain scale (1-10), and, 30 minutes or so later, the patient's reaction to the medication (e.g. less pain, patient asleep, etc).

7. Whenever possible, no detainee will have more than one MAR at any given time. When more than one MAR is necessary because of the space required by medications already discontinued, a new MAR is to be transcribed to reduce the number of MAR pages necessary.

8. When more than one MAR is necessary, each page will be numbered – "one of two, two of two . . ., and so forth.

9. When MARs are transcribed, either at the end of the month, or at points during the month, a nurse shall verify and initial the new MAR to indicate it accurately reflects the current provider orders for the detainee.

10. At change of shift, the oncoming RN will review the MAR with the off going RN to ensure all medications have been passed and to ask questions generated by the MAR documentation.

VII. REFUSAL OF MEDICATIONS BY DETAINEES

1. [redacted] (b)(2)

2. Any medication refusals in the hospital, and on the block need to be brought to the attention of the MP on duty. They have to log this information in to DIMS system for tracking purposes. On the blocks, a MP MUST be with you as you pass meds, taking note of any refusals. Let the Clinic Nurse know if this is not happening

3. Certain types of medication refusals must be brought to the M.O. 's attention immediately after the medication pass. List I contains important medications that need to be addressed as soon as possible with the Medical staff. List II consists of all others that do not severely impact the health of the detainee immediately.

List I:

a. Cardiac medications- Ex.- Verapamil, NTG, Isordil, etc.
b. High blood pressure medications- Ex.- Atenolol, Calan SR, etc.
c. Tuberculosis medication- INH
d. Diabetic medications– Ex. - Glucophage, Metformin, Glipizide, Avandia, etc.
e. Psychiatric medications- Ex.- Olanzipine, Klonopin, Prozac, Zoloft, etc.
f. Anti-seizure medications- Ex. – Tegretol, Dilantin, Depakote, etc.
g. Antibiotics – Ex.-Amoxicillin, Ancef, Dioxicillin, etc.
h. Endocrine medications- Synthroid
i. Asthma medications – Flovent, Azmacort, Advair, Serevent, Albuteral, Singular, etc.

List II:

a. All other medications, i.e. Surfak, Artificial tears, Zantac, Prilosec, Mom, Mylanta, Motrin, etc.

3. If the detainee refuses medication from List I, the corpsman, at the end of that medication pass, will annotate a note in the chart stating which med was refused and hand it DIRECTLY to the MO.

4. If the detainee refuses meds from List II more than three times in one week, the corpsman will annotate a note in the chart and place it in the "MO to Sign" bin. The corpsman shall inform the detainee that if he continues to refuse the medication, the MO will be notified and the decision to continue the medication will be made.

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STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge _____ Date

IMPLEMENTED BY:

Director for Administration _____ Date

Senior Enlisted Advisor _____ Date

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ENTIRE SOP SUPERSEDED BY:

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SOP NO: Date:_____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA Title: MENTAL HEALTH SERVICES TO DETAINEES	SOP NO: 015 Page 1 of 7 Effective Date: Revised 01 Feb 2004
SCOPE: Delta Block	

Ref: Psychiatric Services in Jails and Prisons. 2nd ed., American Psychiatric Association, 2000; Camp Delta Standard of Procedures, February 2004.

Encl: BHS Organizational chart

1. PURPOSE:

To specify the minimum requirements for the psychiatric evaluation and treatment of mentally ill detainees on Delta Block.

II. BACKGROUND:

1Delta Behavioral Healthcare Block

Overview

Delta Behavioral Health Block is comprised in two sections [redacted] (b)(2)

The next section, Delta Acute [redacted] (b)(2)

(b)(2)

(b)(2)

(b)(2)

(b)(2)

[redacted] (b)(2)

Staffing

a. Behavioral Healthcare Service Manager, in conjunction with the Delta Block NCOIC, will have overall responsibility for the daily operations of Delta Block. Accountability will be to CJDOG and to the Chief, Behavioral Healthcare Services. The Behavioral Healthcare Service Chief is a credentialed provider who is responsible for mental healthcare, operations and resource management.

b. D[redacted] Behavioral Healthcare Block staffing:

[redacted] (b)(2)

d. [redacted] (b)(2)

e. [redacted] (b)(2)

f. JDOG S3 will identify candidates for permanent NCO MP staff assignment to Delta Block; candidates will be interviewed and recommendations for assignment made by Behavioral Healthcare Staff to the JDOG S3.

g. [redacted] (b)(2)

Watch

[redacted] (b)(2)

[redacted] (b)(2)

[redacted]

(b)(2)

[redacted]

(b)(2)

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b(2)

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b(2)

Restraints and Seclusion

I. PURPOSE

To publish policy and guidelines for use of medical restraint and seclusion as a means of assisting a detainee in regaining control of his behavior to protect self, other detainees, guards and other staff.

II. BACKGROUND

a. It is the policy of Detention Hospital, JTF GTMO to deliver proper and humane patient care to all detainees while observing basic human rights. Use of restraint temporarily restricts these rights. Restraint is used only for detainees who are at imminent risk of harming themselves or others. Restraint is to be used only after other less restrictive interventions have proven unsuccessful in efforts to control behavior.

b. Restraint cannot be ordered PRN (as needed).

c. When healthcare staff notes what they consider to be improper use of restraints, jeopardizing the health of a detainee, they communicate their concerns as soon as possible to the Detention Hospital Officer in Charge and the Detention Operations Center.

d. The Chief of Behavioral Health Services is to be NOTIFIED/PAGED IMMEDIATELY ANY TIME A DETAINEE IS RESTRAINED, in order to obtain a formal order for restraints.

III. DEFINITIONS

a. *Restraint:* any method of physically restricting a person's movement, physical activity, or normal access to his or her body. *Restraint* is considered involuntary and is used as part of an approved protocol or as indicated by an individual's orders.

[redacted] (b)(7)

e. Licensed Independent Practitioner (LIP). For the purposes of this directive, a clinician that is permitted by law and by the hospital to provide detainee care services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

[redacted] (b)(2)

V. PRACTICE AUTHORITY

A licensed independent practitioner orders the use of medical restraints or seclusion. When the LIP is not immediately available, a psychiatric nurse, a registered nurse or a psychiatric technician *may initiate* the use of restraint or seclusion before an order is obtained from the LIP. As soon as possible, but no longer than one hour after the initiation of restraint or seclusion, a qualified registered nurse notifies and obtains an order (verbal or written) from the LIP and consults with the LIP about the patient's physical and psychological condition.

a. Attending Physician/Psychologist. The LIP who is primarily responsible for the patient's ongoing care, or another LIP when the primary LIP is not available, conducts an in-person evaluation of the patient within 4 hours of the initiation of restraint or seclusion for patients ages 16 and older and within 2 hours of initiation for adolescents ages 15 and under.

At the time of the in-person evaluation, the LIP:

(1) Works with the patient and staff to identify ways to help the patient regain control;

(2) Makes any necessary revisions to the patient's treatment plan; and

(3) If necessary, provides a new written order.

c. The LIP conducts an in-person evaluation of the patient within 24 hours of the initiation of restraint or seclusion, if the patient is no longer in restraint or seclusion when an original verbal order expires.

b. Registered Nurse. Responsible for ongoing observation of a restrained or secluded detainee, assessment of the physical and emotional needs of the detainee, re-evaluation of the need for continuation of restraint or seclusion, documentation, and supervision of hospital corps staff.

[redacted]

(b)(2)

b. Application of restraint is done in a humane manner that affords the detainee as much dignity and safety as possible. Guard staff applying the restraint will be knowledgeable in the use of this intervention, familiar with the equipment and trained in the application, monitoring and release protocols.

[redacted]

(b)(2)

[redacted]

c. Monitoring and Patient Care.

(1) The monitoring process addresses physical and emotional needs of the detainee. This monitoring includes simple observation, vital signs, circulation checks, observation of the extremities, range of motion, emotional and physical response to restraint, food, hydration, and toileting needs. Other monitoring will be done, as needed based on individual needs.

[redacted]

[redacted] (b)(7)

d. Documentation.

(1) The documentation requirement for a detainee requiring restraint must incorporate the critical elements of assessment, application and monitoring, and reflect concern for the detainee's human needs and preservation of dignity.

(2) Each time a restraint is applied or seclusion initiated the following will be documented by an RN or Corpsman:

(a) Time and date restraint is applied.

(b) The detainee's behavior, verbalization or actions that lead to the need for external control.

[redacted] (b)(7)

VII. DOCTOR'S ORDER

a. THE USE OF PRN ORDERS WHETHER INDIVIDUAL OR AS PART OF A PROTOCOL FOR DETAINEES WITH PRIMARY BEHAVIORAL HEALTH NEEDS IS PROHIBITED.

b. A doctor's order for restraint or seclusion must be written or verbally obtained from the LIP within one hour of initiating restraint, and if verbal, must be signed within 4 hours.

[redacted] (b)(2)

VIII. TRAINING

a. Initial and ongoing training on restraint and seclusion for block personnel will be conducted as needed by the Behavioral Healthcare Service and Block NCOIC.

IX. PERFORMANCE IMPROVEMENT.

Seclusion and Restraint is a difficult, high-risk patient care intervention. Review of policies and procedures should occur no less than annually. After each incident an After Action Review will take place. This is the ideal forum to address issues and resolve shortcomings.

[redacted] (b)(2)

[redacted]

(b)(2)

Detainee Behavioral Management Matrix

Detainees with mental illnesses often present with behaviors that are very difficult to manage. They often have poor impulse control, ineffective coping skills and may be at an increased risk for self-injurious behaviors. The Delta Behavioral Healthcare Block Behavior Management Matrix takes this into consideration. The matrix is intended to assist the detainee in maintaining appropriate behavior and to facilitate consistency between the MP's and Behavioral Healthcare Service staff.

[redacted]

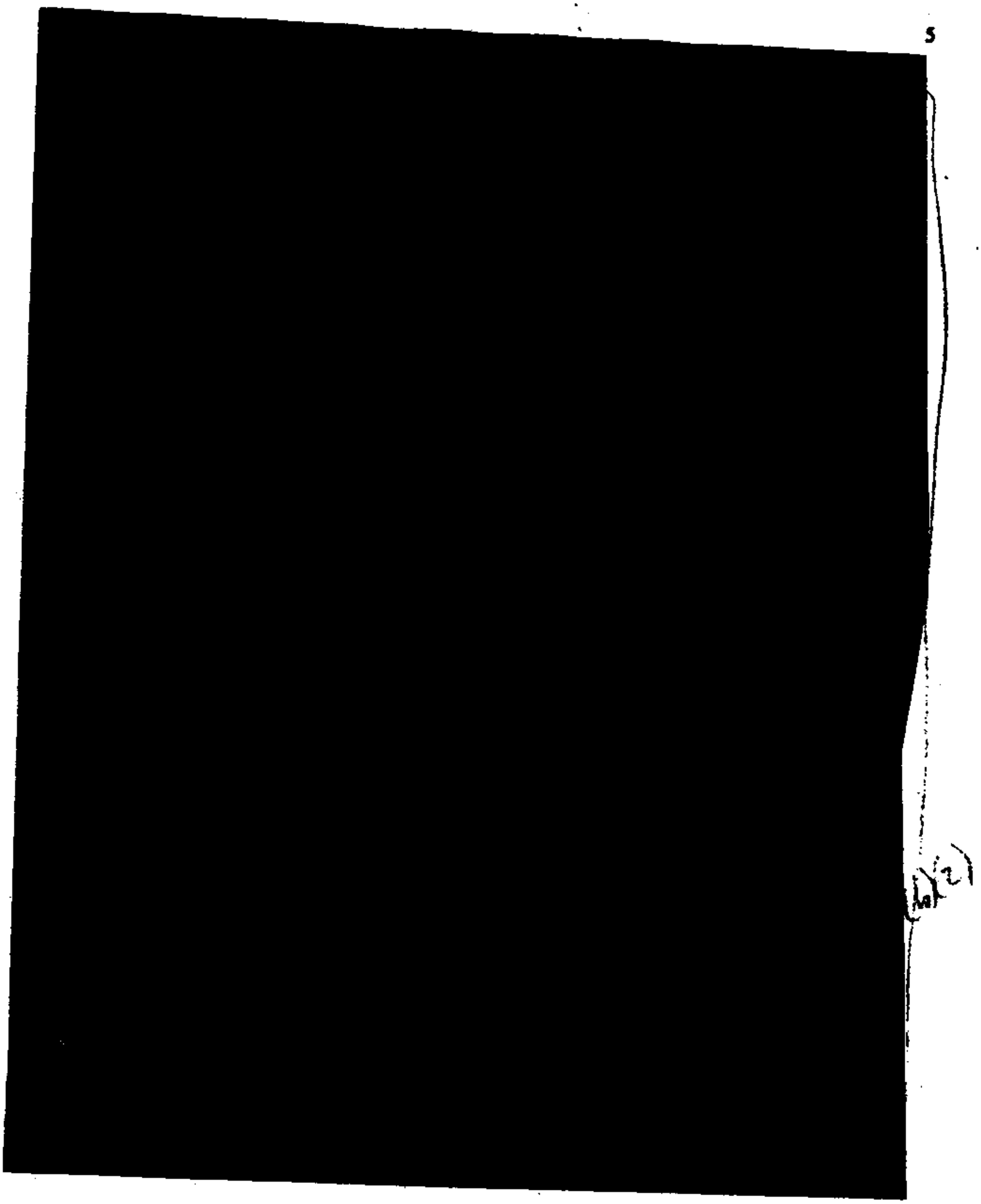
b(2)

Delta Block Behavior Management Matrix

[redacted]

[redacted]

b(2)



[redacted]

Dispensing of Prescribed Medication and Medical Sick call Procedure

a. Detainees on Delta Block who have prescribed medications will have those medications dispensed to them by Behavioral Healthcare Service staff certified in medication administration. BHS staff will ensure appropriate actions are taken to prevent cheeking of medications. All medication refusals will be documented and brought to the attention of the Unit Nurse. In the case of psychotropic medications the psychiatrist will be contacted within two days of the initial refusal; for non-psychiatric medications the unit nurse will contact the medical clinic nurse or physician for further guidance.

b. The Block NCO will ensure that all detainees with medical/physical complaints are placed on the Medical Sick call List in DIMS by 0600 each morning. Detainees may be evaluated/treated either in their cell or transported to the Delta Medical Clinic at the discretion of the Medical staff.

c. For medical issues of a non-routine nature the Unit Nurse may contact the psychiatrist.

d. For medical issues of an acute or potentially serious nature the Unit Nurse will coordinate transfer to the medical clinic where adequate medical triage can be performed.

e. Under no circumstances will GF personnel dispense any form of medication.

Medical Records

a. Medical Records for detainees housed on Delta Behavioral Healthcare Block will be kept in the Nurse's Station.

(1) If a particular detainee requires medical care at Delta Medical Clinic or Detention Hospital, the Medical Record will be delivered to the clinic by BHS staff.

(2) The Medical Record will be returned to Delta Block by BHS or Medical staff. The Behavioral Healthcare RN will transcribe any necessary doctor's orders.

b. Medical Records for detainees on Behavioral Healthcare Service, but not housed on Delta Block, will remain at the Delta Medical Clinic.

(1) All Behavioral Healthcare documentation will be kept in a convenience record on Delta Block.

(2) The Medical Record will be annotated, on the Summary of Care form, to indicate that a particular detainee is on Behavioral Healthcare Service and that a convenience record exists on Delta Block.

(3) Behavioral Healthcare Service staff will obtain the Medical Record from the Delta Medical Clinic if needed for Psychological evaluations or for Treatment Team meetings.

Combat Stress Reactions

Guard or behavioral healthcare staff exhibiting signs or symptoms of combat stress reactions will be referred to the Combat Stress Control team. DH behavioral healthcare staff will provide no treatment beyond normal unit leadership.

After a Serious Incident, leadership on the block should evaluate the circumstances surrounding the situation to determine if Combat Stress should be notified for soldier counseling.

Interpreters

Every effort will be made to consolidate visits by interpreters through coordination between guard and behavioral healthcare staff.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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Officer In Charge	Date
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ENTIRE SOP SUPERSEDED BY:

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Date:

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

Title: INFECTION CONTROL

SOP NO: 021

Page 1 of 4
Effective Date:

SCOPE: Detention Hospital

Reference: (a) NAVHOSPGTMO Infection Control Manual
\\nh-gtmo-sop\public\Fb20-Riots\Working SOPs\SOP Enclosures and Attachments\SOP 021 Encl A.doc
(b) NAVHOSPGTMOINST 6280.1

I. BACKGROUND:

As with other medical facilities, infection control practices exist to protect both the health care worker and the patient from contracting infectious disease. In that regard, infection control policies shall be no different than those outlined in reference (a). However, given the uniqueness of the mission, certain measures need be addressed. Detainees are native to a region plagued by a number of infectious diseases. It is estimated that a number of these detainees will carry one or more of these illnesses upon arrival.

II. POLICY:

Diagnosis, treatment, and prevention of these diseases will be conducted. Operating procedures outlined in reference (a) will be followed where applicable. Infectious waste will be handled in accordance with reference (b).

III. RESPONSIBILITY:

The medical officer-in-charge (MOIC) under the advisement of the public health officer and infectious disease consultant will coordinate this effort. Specifically, the MOIC is responsible for diagnosis and treatment as well as recommending measures for isolation of patients and force health protection. The public health officer is responsible for disease reporting, sanitation, and vector control as well as recommending methods of isolation and requirements for force health protection.

IV. PROCEDURE:

An immunization policy will exist and be continually evaluated. Td and TIG will be given when appropriate per the tetanus prophylaxis protocol. Empiric therapies will include: albendazole 400 mg, mefloquine 1250 mg.

Medical Event Reporting: Reportable medical events will be forwarded to the JTF GTMO Preventive Medicine Officer. Infectious waste, sharps, linens, and disinfecting procedures will be managed per references (a) and (b).

Infection Control Precautions: Standard precautions will be followed for all patients. In addition, until detainees are felt to be free of fecal contamination, skin infestation, and breaks in skin integrity, gloves will be worn. Transmission-based precautions will be used where appropriate.

Body Fluid Exposures

Exposure of JTF personnel to blood or body fluids of detainees should be handled as per reference (a)

[redacted]

(b)(2)

(b)(6)

(b)(6)

(b)(2)

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Exposure Control Program [redacted] (b)(2)

[redacted] All staff should be immunized against hepatitis B in addition to standard deployment immunizations.

Tuberculosis: Detainees will wear a surgical mask until cleared to remove it by the medical provider performing the in-processing examination. Detainees with highly suspicious chest x-rays or detainees exhibiting signs and symptoms suggestive of tuberculosis will be evaluated early and isolated from the remainder of the detainees. Multiple cases of pulmonary tuberculosis will be confined in one cellblock area and separated from other non-infected individuals. Outdoor air circulation and UV light will reduce communicability. Treatment will begin immediately with a 4-drug regimen if active disease is confirmed. All health care workers will have access to a N-95 respirator to be used when dealing with highly suspicious or confirmed cases when the patient is not masked. Security personnel will be fitted as needed. Masks need not be worn by staff unless coming into close, personal contact with the detainee FOLLOW THE TUBERCULOSIS CONTROL SOP IN THIS BINDER FOR SPECIFIC ALGORITHM PROTOCOLS.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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ENTIRE SOP SUPERSEDED BY:

Title:
SOP NO: **Date:**_____

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

Title: NURSING

SOP NO: 029

Page 1 of 14
Effective Date: 03 Oct 03

SCOPE: Detention Hospital

I. PURPOSE:
To provide Nursing staff with guidelines to assist with the nursing care provided at Camp Delta. The in-depth Nursing Procedures manual for Camp Delta is the Lippincott Manual of Nursing Practice (7th Edition) kept at the nurse's station at the Detention Hospital and Delta Clinic. Consult this resource for review of nursing procedures. Additional nursing resources are available at Naval Hospital, GTMO.

II. NURSING DUTIES AND RESPONSIBILITIES:

- Coordinate and administer patient care activities.
- Facilitate all steps in the medical in-processing of detainees including, CHCS registration, ordering of lab and radiological studies, set up of medical records.
- Ensure that all medical contacts (in-processing, follow up, sick call, and cell visits) are entered in the SITREP Log.
- Enter Walk-in Appointments, for every detainee clinic and cell visit (except medication rounds).
- Coordinate the movement of detainees into and out of the medical compound for evaluation, follow up and sick call visits with Escort Control at the Camp Delta Detainee Operations Center (DOC).
- Oversee the daily assignments of the Hospital Corpsmen; Provide nursing care oversight, ensure safety and accountability at all times.
- Update the pass down log for oncoming shifts to ensure that pertinent information is passed.
- Provide quality-nursing care to detainees admitted to the Detention Hospital.
- Perform triage, physical assessments, i.e. vital signs, neuro-vascular checks and assessment of pain and skin breakdown.
- Administer scheduled and PRN medication as ordered.
- Supervise the administration of medications by hospital corpsmen.
- Co-sign every Medication Administration Record transcribed by the corps staff.
- Administer treatments such as dressing changes, etc.
- Transcribe physician orders for all outpatients and in-patient.
- Verify order transcription via daily chart verification (q 24 hour chart review) after 2400 each day.
- Obtain a current detainee Alpha roster from DOC after 2400 each day.
- Ensure all procedures and findings are documented on appropriate forms.

- Co-sign all corps staff medical record entries.
- Supervise Hospital Corpsmen assigned to Camp Delta.
- Ensure monthly weights are completed on all detainees on the first of every month. Document monthly weights in the detainee's medical record. Additionally all detainees that are determined to be malnourished are weighed on the fifteenth of the month.
- Complete daily SITREP report and the 24-hour clinic report daily. Deliver one copy to the Detention Hospital Admin staff and second copy to DNS each morning before 0800.
- Complete Vulnerability Assessment for clinical area (DH, Delta Clinic and DACU) each shift.

The Following sections are designed to assist new personnel in performing nursing duties and responsibilities in a safe and effective manner.

DETAINEE IN-PROCESSING (Review In-processing Manual)

Prior to Detainee Arrival

- The Delta Clinic Division Officer (DO) is designated as the Point of Contact (POC) for all in processing issues at the Camp Delta Clinic. The Leading Petty Officer (LPO) is designated as the back up POC in the absence of the DO.
- Upon notification of incoming detainees, the DO will contact the S1 at the Joint Detainee Operations Group (JDOG). The DO will request a list or manifest with the names and ISN numbers for the new detainees. (Note: this information classified Secret).
- The DO or a designee will register each new detainee in the CHCS system following the step-by-step procedure found in the Nursing SOP for Camp Delta Medical Clinic. Each detainee will be registered using the ISN number as a social security number.
- After doing the mini registration in CHCS, enter the set of standing in-processing doctors order for each new detainee. The SMO will be entered as the ordering physician. The labs are ordered as part of an Order Set labeled 'Detainee Orders' which contains the following individual orders:

1. Hepatitis B Surface Antigen
2. Hepatitis C Virus
3. HIV
4. Hepatitis A Antibody
5. Hepatitis Core Antibody,
6. Hepatitis B Surface Antibody Titer
7. Radiograph, Chest PA
8. Mefloquine 250 mg PO, 3 tabs at in processing and 2 tabs at 0600 the next day
10. Albendazole 200 mg PO, 2 tabs at time of in processing

- The Detention Hospital Lab Tech will accession all lab orders and pre-print lab labels.
- A new medical record will be established for each new detainee at the in processing initial medical screening. See the In-processing Manual and Camp Delta Nursing SOP for medical chart organization.

- ☐ Place a tracking checklist on top of each chart.

Physical set up for the detainee in processing : Refer to In-processing manual

- ☐ Set up three to four phlebotomy stations.
- ☐ Set up three to four physical exam rooms.
- ☐ Place a small white board with the list of new detainee numbers in the admin office for tracking of chest films and medical issues (NAD means no active disease/TB).

Det #	Done	Read
8888	Yes	NAD

- ☐ Set up each exam room with a thermometer, BP cuff, stethoscope, reflex hammer, otoscope/opthalmoscope, unsterile gloves, surgi lube, dressing material, and bacitracin ointment.
- ☐ The Lab techs and Pharmacy techs will work in the pharmacy/lab room.
- ☐ The Pharmacy tech will ensure adequate supply of medications are on hand for in processing and will dispense Albendazole and the mefloquine for each detainee.
- ☐ The Lab tech will remain in the pharmacy/lab room to process collected specimens, assist with venipunctures and connect to the Portsmouth Naval Hospital lab via the Internet.
- ☐ In processing stations are:
  1) Check in , ID verification, Medical Record Issue
  2) Chest x-ray
  3) Phlebotomy, medication, immunizations & history taking station (include key mental health screening questions)
  4) Physical Exam room
  5) Height and weight
  6) Record and order review, Quality Assurance station.

The sequence of medical in processing flows as follows:

1. Detainee enters medical section of building from Army in-processing side accompanied by 2 MP's and a linguist. Detainee will continue to wear surgical face mask through out the medical processing stations (as TB protection for staff) until chest radiograph cleared by radiologist.
2. Verify detainee ID wristband and issue/ initiate medical record only after ID band verified.

IMPORTANT: To facilitate the final medical processing QA , each station will check off their section of the tracking sheet attached to the front of the medical record once the detainee has completed the station.

3. Chest radiograph.
4. Phlebotomy, 6 tubes of blood are required, 3 marble/red top (may substitute green, or yellow), 1 HIV, 1 lavender and 1 yellow serum tube.
5. A brief history of past and current illness, injuries, allergies, medications and mental health screening questionnaire is taken at the phlebotomy station.
6. Detainee is taken to an exam room for his physical exam.

7. Vitals are done & medications are given (Mefloquine, Albendazole) before the detainee leaves the exam room.
8. Tetanus and influenza vaccines are administered and PPD placed on forearm
9. Height and weight taken and recorded (BMI calculated later).
10. Radiologist reads chest x-ray before detainee leaves the building and if 'No Active Disease' (NAD) noted surgical face mask may be removed and disposed of. Also remove the scopolamine patch from behind ear (used to prevent airsickness during transit).
11. Perform quality assurance check on medical record. Verify that the detainee has stopped at each station, by checking the tracking sheet, before allowing the detainee's departure.
12. Detainee leaves the building through the medical side exit escorted by 2 MP's.

- **Personnel requirements:**
- 1 HM to check in detainee, verify ID band, and initiate/issue medical record
- 3-4 Physicians (for physical exams, this is the most time consuming section of medical processing)
- 1 Radiologist to review and read chest films (will be brought in TAD for event).
- 3-4 History takers /3-4 phlebotomists (not the lab techs)
- 2 lab techs (1 to process specimens, 1 for computer access to NMC Portsmouth)
- 2 Radiological techs (1 processes while the other shoots)
- 1 HM for Height and weight station
- 1-2 pharmacy techs to dispense the medications
- 1 HM to arrange for transport in the event of an admission to Detention Hospital
- 1 HM to perform medical record QA and compile consult list.

After detainee in-processing is completed:

- All new detainees will be added to the 0600 medication pass for their second dose of mefloquine.
- All new records are screened for active issues, follow-ups, additional labs, and consults.
- Any additional orders are taken and signed off by the nurse on duty.
- Verify all orders are entered in CHCS.
- All BMIs are calculated and entered into the medical record and in the weight management database.
- Any detainee with a BMI of less than 20 will be added to the Weight Program for weekly weight checks and will receive Ensure supplements TID.
- All detainees in processed will be added to the sitrep log as a new visit, entered in CHCS as a walk in appointment, the End of Day and the ADS completed.

DETAINEE OUT-PROCESSING

When a detainee is transferred off the island the Senior Medical Officer will ensure the completion of : a physical exam and medical summary, personal medical history sheet (in English & native language) and Southwest Asia Disease Information sheet (in English and Native language). These forms are forwarded in the medical package to the JTF Surgeon's office via the OIC. The original medical record is delivered to the DH Patient Admin for processing then forwarded to JTF Surgeon's office for archiving.

Cell Visits and Treatment (Emergent & Routine)

When Medical receives a call from the cell blocks or DOC that a detainee is acutely ill or has other sudden or emergent medical problem, a nurse, if available, or corpsman will take a "Jump Bag" (located in the supply room) and go to the detainee's unit and assess the need of medical treatment. This includes subjective and objective data analysis.

[redacted] b2

Routine sick call may be conducted in the cellblocks by the assigned corpsman. Each corpsmen will have with them the minimal sick call equipment and standard order medications when making rounds in their assigned blocks. They will document every patient encounter in the patient's chart on the Progress notes in SOAP format. The exception to this is when standard order medications are administered in the cellblocks, and then it is documented only in the patient's MAR.

In any case mentioned above, the SITREP Log and database must be filled out (Enclosures 6 and 7). A walk in appointment should be generated in CHCS per Enclosure 4 and a SOAP note must be written in the nursing note section of the patient's chart. This note will contain the chief complaint, subjective and objective data collected, analysis or problem identified, treatment given if any and plan of follow up care. All cell visits should be reported to the duty medical provider. Once the walk in appointment is completed, entering the ADS data per enclosure 5 will complete the visit.

The same documentation is required for scheduled cell visits for treatments such as wound care. Remember when in doubt chart it.

Tuberculosis Protocol and Documentation

All detainees will receive a chest x-ray and a PPD skin test during in-processing. The PPD will be administered in the left forearm. The documentation for detainees receiving a PPD is as follows: record the PPD on the second page of the Record of Immunization (SF 601). Ensure the date given and person who placed the PPD is charted. The PPD is read for results in 48 to 72 hours, it must be properly read by measuring area of redness and or induration. Documents results of the reading in millimeters on the SF 601.

All detainees presenting with a suspicious chest x-ray and/or other signs and symptoms of TB (persistent cough, bloody sputum, fevers, weight loss) will be placed in respiratory isolation in a laminar flow room at the Detention Hospital or if both respiratory isolation rooms at the Detention Hospital are occupied they will be admitted to the DACU or Respiratory Isolation Tent. All Respiratory isolation rooms will be tested by the Preventive Medicine Department (smoke test) prior to use and intermittently while in use. Detainees placed in respiratory isolation will have three consecutive morning sputum samples collected for AFB smears. Please note that in the collection of this sputum, the detainees must produce the sample by coughing. Production of saliva is not acceptable for this test (refer to sputum collection instructions posted in Detention Hospital, consult with assigned Respiratory Therapy tech if sputum induction in required).

SITREP Log

The SITREP log is the primary record of all patient interactions with medical staff. It is crucial that every patient interaction; sick call, follow-up, dressing change, or any other

interaction (other than passing scheduled medications) be recorded. This provides an accurate account of patient care and workload. Once the log is filled out (example in enclosure 6), the data must be entered into the SITREP database. This is used to permanently track the number of interactions and can be used to show trends in detainee interactions with medical staff. To fill out this database, utilize enclosure 7.

Corpsman Duties and Responsibilities

During the daily operations, corpsmen shall be responsible for passing detainee medications under the supervision of an RN, performing field assessments and relaying findings to the duty nurse and provider. The duty nurse and provider will determine care priorities and "triage" the sick call requests for the day.

Corpsmen assigned to work the day shift will have specific blocks assigned to them. Each HM will be responsible for all the medical issues within their assigned blocks including dressing changes, sick call, medication passes, & weights. All corps staff must be competent at passing medications as evidence by the successful completion of the Medication Administration Qualifications. No corpsmen will be allowed to pass medications until properly trained by the medication training RN. Remain cognizant of the seven rights of medication administration:
RIGHT PATIENT, RIGHT MEDICATION, RIGHT DOSE, RIGHT ROUTE, RIGHT TIME, RIGHT DOCUMENTATION AND RIGHT PERSON PASSING MEDICATIONS.

Corps staff must not pass any medication they are not familiar with. They should know what the medication is, what it is used for, the proper dosing, and be knowledgeable of possible interactions, incompatibilities, side effects and adverse reactions.

If at any time a corpsman is not familiar with an assigned procedure or task he or she is expected to request the appropriate training from the nurse or provider before attempting.

Proper documentation is required for any detainee interaction. Be sure to enter why the interaction occurred, the subjective and objective findings made, the name of the provider notified of the interaction, the treatment administered if any and the response to the treatment. This documentation should be made in a SOAP format on the detainee's Progress Notes (SF509). Ensure that a medical provider or RN co-signs all entries. DO NOT FORGET TO DOCUMENT PAIN ASSESSMENT. Log all patient visits into the SITREP Log and as well as the SITREP Database.

24-Hour Medical Record Review and Daily SITREP Report

In order to prevent the inadvertent omission of orders transcribed to the Patient MAR. The night nurse will conduct a medical record review of all detainees seen at Camp Delta Clinic in the preceding 24-hour period. For all new orders, pull the MAR and ensure that all orders were transcribed correctly. Once completed, the nurse will write "CHART VERIFIED" below the last order entry and draw a horizontal line below the entry with a highlighter. Also verify the detainee's current cell location on the front of the chart and MAR with the daily updated Alpha Roster obtained from DOC (do this in pencil). New Alpha rosters are picked up from DOC each am, place previous day's Alpha roster in a Burn Bag for proper disposal.

Once the night nurse has verified all records, complete the daily SITREP report. To do this, utilize enclosure 11 and provided hard copy to: Senior Nurse, the Admin Chief by 0700 each morning (needed to completed JTF SITREP to SOUTHCOM).

Appointments and Follow-ups

Each morning the night shift Charge Nurse will pass down in report a list of detainees scheduled for follow up for that day. The detainees requesting sick call will be identified by block NCOs on the block sick call list entered via DIMS. The DOC will provide the block sick call lists to Delta Clinic prior to AM clinic. The lists is triaged by the RN and/or Provider on duty to determine patient care priorities. To aid in this process, pull the charts for those detainees that will be seen. All medical clinic or in the cell visits will have walk-in appointments booked through CHCS. To do this follow enclosure 4 and in the Reason for appointment area write in what the detainee was being seen for. Again make sure these visits are logged in the SITREP Database and CHCS per enclosures 7 and 4 respectively. After the appointment complete CHCS entry showing the result of the appointment and diagnosis ICD9 data (utilize enclosure 5.)

Every detainee clinic visit should have a set of vital signs taken (blood pressure, pulse, respiratory rate, temperature, pain assessment, and a pulse oximetry reading when indicated). Document vital signs on the SF509 filed on the right side of the record.

Transfers to Detention Hospital

Delta Medial Officer's have admitting privileges at both Detention Hospital and to the DACU at Naval Hospital GTMO. [redacted] b(2)

Hunger / Thirst Strikes (refer to complete Hunger strike SOP)

In the event of a detainee hunger / thirst strike, DOC will notify medical when a detainee has refused hydration for [redacted] or has not eaten in [redacted] b(2) Otherwise, medical will be notified as detainees become symptomatic secondary to dehydration or starvation. (dizziness, lethargy, syncope or near-syncope episode, or inability to ambulate). In either case above, the detainee is brought to medical for medical screening. This screening includes a physical exam by a medical provider per Hunger and/or Thirst Strike Medical Evaluation Sheet (Enclosure 22). A Hunger / Thirst Strike Medical Flow Sheet (Enclosure 23) is also established. This form is used to document heart rate, mental status, status of detainee's eating / drinking, urinary output and weight. The detainee is educated on the risk of starvation / dehydration per enclosure 24. Note that this sheet is in English and a translator may be required. If after being educated on the risks of the hunger / thirst strike, the detainee still refuses to eat and/or drink, the detainee will be asked to sign the Refusal to Accept Food or Water/Fluids as Medical Treatment form (Enclosure 25) file in the SF 509 section of the detainee's medical record. Reassessment is performed every 24 hours.

Outpatient Medical Record

Medical record keeping and documentation of care delivered are important elements of the detainee medical mission.

Medical Records

It is recommended that forty pre-made records be kept readily available for processing new detainees.

To compile a new record (a go-by record is available in the file cabinet)
Obtain a new record jacket (located in the file cabinet)
The left side of the record shall have the following forms arranged from bottom to Top:

RECORD OF IMMUNIZATION (SF601 PAGE 2)
RECORD OF IMMUNIZATION (SF601 PAGE 1)
WEIGHT REGISTER (DD 2644)
STANDING ORDERS FOR DETAINEES
DOCTORS ORDERS (SF508)
PROBLEM SUMMARY LIST (NAVMED 6150/20)

c. The right side of the record shall have the following forms arranged from bottom to top:

REPORT OF MEDICAL EXAMINATION (SF88)
REPORT OF MEDICAL EXAMINATION (SF88 BACK PAGE)

*Note that this form has been altered with preprinted question for the TB protocol on the right side middle of the page.

REPORT OF MEDICAL EXAMINATION (SF88 PAGE 1)
INITIAL MEDICAL PROCESSING SCREENING
PROGRESS NOTES (SF509)

In addition to the basic record requirements, A MEDICATION ADMINISTRAION Record (MAR), and a DETAINEE CUSTODY FORM (DA4237 Page 2) shall be placed loosely in the center of the record. These forms will be completed during in-processing and filed in a separate location. The MAR will be filed in the MAR Book located by the medication lockers (The MARs are filed by cell block). The Detainee Custody Forms are collected after in-processing and turned in to the Army's in-processing office at the other end of the medical clinic.

Laboratory and Radiology Studies

Any printed out laboratory or radiological study results shall be filed behind the SF88 on the right hand side of the record. In the event a detainee has previously been admitted to the DACU, or Detention Hospital, copies of the detainee's inpatient record shall be filed on the right hand side of the detainee's outpatient record behind the laboratory results.

Transcribing Doctors Orders

Due to the high volume of detainees and the various treatment plans involved, accuracy in transcribing Doctors Orders is a critical element. Refer to Enclosures 9, 10A, and 10B for the transcribing of doctors orders onto the MAR (NAVMED 6550/8) and Enclosures 9. Please note that all orders should be initialed line for line on the Doctors order sheet (SF508) as noted to ensure no order is missed.

When taking off orders for medication, the order must be complete and include the medication name, dose, route, frequency and the period of treatment in number of days. Schedule any needed follow up appointments in the appointment book "To Be Done Book".

Physicians will place new orders in the 'New Orders' slot. The RN will read each order and carry it out before signing it off. All orders will be verified to be in CHCS when appropriate, i.e. labs, medications, radiological studies, etc. Any thing that goes in the 'To be done' book will be written in it by the nurse taking of the orders, i.e. follow up appointments, dental consults, optometry consults, labs to be drawn, etc.

A. Medication Administration Record (MAR)
The Medication Administration Record (MAR) is used to document the administration of all scheduled, PRN and one-time medications. To transcribe orders to this form from Doctors Orders (SF 508) utilize Enclosures 9, 10A, and 10B.
Enclosure 10A Section A is to be used to document scheduled medications. Ensure that the order date is filled out. This section should have the medication name, dose, route, frequency and treatment duration. If more than one medication is ordered, Draw a red line between each medication. When transcribing a MAR for the continuation of a medication, review the original order to verify transcription is correct. Never will a MAR be transcribed from another MAR without verifying the original order.

To ensure continuity of medication times the following frequency times are suggested to be used when transcribing orders to the Patient Profile and MAR:

TIMES TO BE GIVEN CAMP 4, Alpha block have specific times (see addendum)

QD	0600
BID	0600 AND 1800
TID	0600, 1400, 2200
QID	0600, 1200, 1800, 2200
Q4	0400, 0800, 1200, 1600, 2000, 2400
Q6	0600, 1200, 1800, 2400
Q8	0800, 1600, 2400
QAM	0600
QPM	1800
QHS	2200
QAC	0700, 1100, 1700

NOTE MEDICATIONS THAT ARE PRONE TO CAUSE GI UPSET SHOULD BE GIVEN WITH FOOD. SCHEDULE ACCORDINGLY. Meals are delivered to detainees at 0800, 1200, and 2000.

MAR section B is to be completed by each person who delivers any medication to the patient. If the signature is not legible, print the name to the right side of the block.

MAR section C is to have the detainee's name and pseudo social security number. (D,JTF0***** on top, 888-0*-**** on the bottom).

MAR section D is used to document one time medication. Be sure to date and time this section upon completion of administering medication. As with section A, place a red line between each order.

MAR section E is used to Document PRN medication. In addition to completing the appropriate boxes in this section, a nursing note should be written to document the effects of the medication such as pain level decrease.

MEDICATIONS GIVEN BY THE IM OR SQ ROUTE IS ALSO DOCUMENTED IN THE MEDICAL RECORD WITH LOCATION OF THE INJECTION, PATIENT RESPONSE AND ANY ADVERSE REACTIONS.

Note: If the patient is in the clinic and the provider orders a one-time dose of medication, it can be documented on the SF 600. This will alleviate transcribing the order to a MAR.

Narcotics

Narcotic inventory is completed at each shift change. Professional nurses will account for and sign that all narcotics are present on Narcotic and Controlled Drug Inventory – 24 hour (NAVMED 6710/4). Each time a narcotic is used it will be logged out on the appropriate Narcotic and Controlled Drug Record (NAVMED 6710/1). In cases where only a partial dose is needed, annotate the drug, amount given, the amount wasted and the detainee's identification number on the back of the 6710/1.

III. Administrative Notes

A. Supplies

Supplies are ordered through the designated supply Petty Officer. Each shift leader is responsible for ensuring that required supplies are ordered and picked up in a timely fashion. The Leading Petty Officer is responsible to train all personnel regarding the supply ordering and tracking process. Further information about supplies can be found in the Detention Hospital Supply SOP.

B. Labs

Procedure for Procuring and Submitting Lab Specimens

1. Verify orders are in CHCS *before* going out to cell blocks to collect specimens.
2. Collect all supplies, take out to cell, and collect specimen using proper technique.
3. While still at cell, label specimen with Det. # and date/time (time must be accurate).
4. Upon return to clinic spin down all yellow & tiger top tubes 10 minutes @ highest speed.
5. Label all specimens (save unused left over labels and take to lab @ FH with specimens).
6. Log in all specimens (complete all sections of log).
7. Notify Lab tech of specimens.
8. If after hours, place specimens in designated lab refrigerator. Inform lab tech of all specimens placed in the refrigerator page lab tech if specimen in a 'stat". Page duty driver to courier specimen to NH GTMO lab so that tech can perform needed test.

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LAB KEYS FLOW CHART

Use this sequence ONLY when the labs have not been ordered and ONLY if drawing the lab immediately, preferably in the clinic.

☐Do the ?? to get to the menu that allows you to choose LAB
☐LAB
☐shift ^OLG
☐Enter patient's name
☐Requesting Location (Enter Camp Delta, select #3 for Primary Care)
☐Action: (select N for new orders)
☐Select HCP: (enter doctor requesting the test)
☐Order origin: (select H for handwritten orders)
☐Order set: (default is NO just hit enter)
☐Date/time: (enter N for now or enter correct date & time)
☐Collection Method: (enter W for ward/clinic collection)
☐Collection Priority: (default is ROUTINE just hit enter)
☐Processing Priority: (default is ROUTINE just hit enter)
☐Order comment: (at this time enter any comments that you would like to add or just hit enter)
☐Select test: (enter test to be ordered, once done just hit enter to exit screen)
☐Action: (enter Q to quit and activate the orders)
☐Hit enter until you get to the printer prompt: Enter delta-lab and you are done.

When labs are ordered & you only want labels: (should be most common one used)

☐Lab
☐shift ^LGO
☐Enter Detainee number
☐(all lab orders will come up) select tests you want labels for
☐Enter
☐Type date & time of collection , example: 24May@1310 (important that the time be accurate)
☐Type comment if needed, if not, just enter
☐Type Delta-lab for printer selection

If you have to re-print labels:

☐Lab
☐shift ^PLI
☐Enter Detainee number
☐Enter (default for today)
☐type in an earlier date (ex. 22may2002)
☐Enter (highlight should be at 'go')
☐Find labs you want labels for & copy down Accession area (letters) & accession number
☐Move highlight to 'exit'
☐Move highlight to 'exit' a second time
☐Shift ^RSL
☐At 'Accession area- type in the 2 or 3 letter code
☐At "accession number' type in the number
☐Type in Delta-lab for printer

C. Pharmacy

When a provider writes an order for a medication they will simultaneously enter the order into CHCS. Nurses will verify CHCS order entered when transcribing orders. It can take up to 1600 the following day for routine medications to be delivered from Naval Hospital GTMO to the clinic, so if the order is to start immediately, or the order is STAT page the Detention Hospital Pharmacy Technician.

Note: Floor stock can be ordered by calling the Detention Hospital Pharmacy Tech. Also, a daily 'Not in Stock' (NIS) list is to be generated by clinic staff and given to the Pharmacy Tech for action and follow up.

Listing of Enclosures

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

_____ _____
Officer In Charge Date

IMPLEMENTED BY:

_____ _____
Director for Administration Date

_____ _____
Senior Enlisted Advisor Date

ANNUAL REVIEW LOG:

By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
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ENTIRE SOP SUPERSEDED BY:

Title: _____
SOP NO: _____ Date: _____

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 034

Page 1 of 3
Effective Date:

Title: Medical Department Training

SCOPE: Detention Hospital

Enclosure (1) – 2003 Detention Hospital Training Schedule

I. BACKGROUND:
Mission readiness is our priority and effective training remains central to that effort. The Detention Hospital provides medical treatment and healthcare services for detainees in support of Operation Enduring Freedom, as part of the JTF mission here in Guantanamo Bay. Safety and Security is the number one priority before any medical treatment is rendered to the detainee population. We work as a team with the MP's to accomplish our medical mission and constant training and vigilance is essential to ensure we remain mission focused, safe and effective as we conduct our daily operations in this maximum-security environment.

II. POLICY:
Our top priority is to maintain a trained and ready medical staff. Our training is focused on our mission essential tasks and are designed to prepare us for Mass Casualty, Emergency Response, and daily healthcare operations in the maximum-security environment of Camp Delta.

III. GENERAL PROCEDURES:

a. The Director for Administration is the designated Training Officer and is the primary point of contact for coordination of all training evolutions. The Director for Administration Leading Chief Petty Officer is the assistant Training Officer.

b. The Training Officer, in coordination with directorates and OIC is responsible for developing a formalized six-week required training schedule for all Detention Hospital personnel. Training will be conducted every Thursday from 0900-1100 for all Hands. Clinic schedules will be adjusted to ensure maximum participation in the weekly training. The training plan will include both command training (for all Hands) and clinical training for the emergency response team (ERT).

c. Training topics will be selected to maximize situational awareness, emergency response and readiness at Camp Delta realizing that constant effective training is the key to our mission success.

d. The Training Officer will maintain training files and training database to accurately reflect completion of scheduled training.

STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

_____ _____
Officer In Charge Date

IMPLEMENTED BY:

_____ _____
Director for Administration Date

_____ _____
Senior Enlisted Advisor Date

ANNUAL REVIEW LOG:

By: _____ Date: _____
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ENTIRE SOP SUPERSEDED BY:

Title: _____
SOP NO: _____ Date: _____

DETENTION HOSPITAL TRAINING SCHEDULE
2003

30JAN:
- HIV BLOOD DRAW

6FEB: COMMAND TRAINING
- Radio Communications training (frequency, channels, radio etiquette)

EMERGENCY RESPONSE TEAM TRAINING
- Airway Management
- Oxygen Delivery, Regulators, Tanks, Ambu usage/adjuncts

13FEB: COMMAND TRAINING
- Fire Plan / Bomb Threat Plan Review

EMERGENCY RESPONSE TEAM TRAINING
- AED Training

20FEB: COMMAND TRAINING
- OPSEC Update

EMERGENCY RESPONSE TEAM TRAINING
- Crash Carts/ Code Blue Drills/ BLS/ACLS

27FEB: COMMAND TRAINING
- Safety & Security Brief by JDOG

EMERGENCY RESPONSE TEAM TRAINING
- Litter Bearing/C-Spine Immobilization

6MAR: COMMAND TRAINING
- Infection Control Brief/ Performance Improvement Brief

EMERGENCY RESPONSE TEAM TRAINING
- Triage Principles

13MAR: COMMAND TRAINING
- CDO Training

EMERGENCY RESPONSE TEAM TRAINING
- Primary & Secondary Survey

Encl (1)

20MAR: COMMAND TRAINING
- Force Protection

EMERGENCY RESPONSE TEAM TRAINING
- MASS CAS

27MAR: COMMAND TRAINING
- Sexual Harassment Prevention/ Fraternization

EMERGENCY RESPONSE TEAM TRAINING
- Allergic Reactions/ Treatment of Anaphylaxis

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 035

Title: GUIDELINES FOR ROLE OF INDEPENDENT DUTY CORPSMEN

Effective Date: 04 Mar 03

SCOPE: Detention Hospital

Ref:
(a) OPNAVINST 6400.1B
(b) BUMEDINST 4651.3 Series

Encl:
(1) US Naval Hospital, Guantanamo Bay, IDC Physician Supervisor Handbook
(2) OPNAVINST 6400.1B, Appendix A
(3) Authorized Prescribing List for Independent Duty Hospital Corpsmen

I. PURPOSE:

To establish policy and assign responsibility for the re-certification, training and use of Independent Duty Hospital Corpsmen (IDCs) per reference (a).

II. BACKGROUND:

IDCs are integral and important components of the Navy Health Care Team whose mission is to care for Sailors and Marines independent of a Medical Officer. In addition, they also routinely fill leadership, training and administrative positions.

III. APPLICABILITY AND SCOPE:

This instruction applies to all Detention Hospital Guantanamo Bay IDCs IAW reference (a).

IV. POLICY:

IDCs will be assigned to clinical duties consistent with their skills, expertise, experience and needs of the command. Training must be ongoing and designed to prepare them to

fulfill this challenging role. Enclosure (1) outlines the periodic evaluations required for each IDC.

(a) Prior to assignment to clinical duties with indirect supervision, all IDCs will complete the initial evaluation period IAW reference (a). Upon satisfactory completion of clinical training and direct supervision, each IDC will be re-certified.

(b) The Physician Supervisor will document all training (CEU's, correspondence courses and college credits) on the quarterly report that is sent to the IDC Program Director. Additionally, the IDC Physician Supervisor will review enclosure (1) to determine what clinical competencies have been completed and the IDCs progress towards completing all clinical competencies prior to detaching the MTF for a PCS transfer.

(c) IDCs are required to complete 12 CEU's annually. Reference (b) provides guidance as to how this may be accomplished. The Command will make every effort to allocate sufficient funds to allow IDCs the opportunity to attend professional conferences. The Staff Education and Training Department will advise the IDC Program Director of training opportunities.

V. APPOINTMENTS:

The Commanding Officer will appoint in writing the IDC Program Director, IDC Program Manager, a Physician Supervisor and alternate Physician Supervisor. The qualification and responsibilities of these persons are itemized in reference (a). Additionally:

(a) The IDC Program Director will conduct quarterly review of the IDC program to ensure compliance with applicable directives.

(b) The IDC Program Manager will ensure IDCs have completed re-certification and appropriate letters and Page 13 entries are made.

(c) The IDC Physician Supervisor ensures quality care is provided by the IDC as per Ref.1.

VI. ACTION:

The following is a list of duties and responsibilities for all IDCs assigned to the MTF.

(a) After completing the initial evaluation period IDCs may attend to patients following the defined level of supervision.

(1) Active Duty: Indirect supervision.
(2) All others: Direct supervision.

(b) IDCs will prescribe medication authorized by the formulary in accordance with enclosure 1. A copy of the Authorized Prescription List will be placed in the IDC training record.

(c) For a non-active duty patient presenting at the Medical Liaison Office, the IDC will contact the Physician Supervisor before implementing or changing a regimen of care except in cases of dire emergencies.

(d) IDCs will not give over the phone consultation.

Authorized prescribing list for Independent Duty Hospital Corpsmen

You are authorized to prescribe medication from the hospital formulary except for the following general classes of medications:

Disease modifying anti-rheumatics
Intravenous antibiotics and intravenous antifungals
Anti-coagulants and other hematological agents excluding aspirin
General anesthetics, intravenous sedatives, and neuromuscular blocking agents
Antidotes
Systemic obstetrical and gynecologic agents excluding birth control
Androgens, pituitary hormone agonists and antagonists
Antineoplastics
Chapter 2 Cardiovascular Agents excluding antihypertensives and diuretics
Immunoglobulin
Chapter 3 Neurologic agents excluding migraine therapy
Chapter 4 Ophthalmic steroids and glaucoma agents
Psychiatric agents excluding nicotine, zolpidem, and disulfiram
Schedule II medications

You should not prescribe any medication clearly outside your clinical expertise or ethical practice.

STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge _____ Date

IMPLEMENTED BY:

Director for Administration _____ Date

Chapter 5 Senior Enlisted Advisor _____ Date

ANNUAL REVIEW LOG:

By: Date:_____
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ENTIRE SOP SUPERSEDED BY:

Title:
SOP NO: Date:_____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA Title: GUIDELINES FOR ROLE OF PHYSICIAN ASSISTANTS	SOP NO: 036 Page 1 of 100 Effective Date: 04 Mar 03
SCOPE: Detention Hospital	

Ref:

(a) SECNAVINST 1120.813
(b) SECNAVINST 1301.4
(c) MANMED Chapter 2
(d) MANMED Chapter 21
(e) BUMEDINST 6550.12
(f) BUMEDINST 6320.6613
(g) MANMED Chapter 15

Encl:

(1) Officer-in-Charge Ltr to Physician Assistant
(2) Authorized medication list
(3) Letter of Appointment, Primary Physician Supervisor
(4) Letter of Appointment, Secondary Physician Supervisor

I. PURPOSE:

Per references (a) through (g), this instruction establishes guidelines for the role of Physician Assistants (PAs) at Detention Hospital, Guantanamo Bay, Cuba.

II. BACKGROUND:

The selection and training of PAs for the purpose of improving primary care roles was undertaken as a result of a shortage of primary care medical officers. In July 1971, the decision was made to train a cadre of PAs for the purpose of improving patient access to the primary care system and lessening the use of highly trained specialists in primary care roles. Since that time, PAs have become an integral part of the Navy health care team, contributing a valuable admixture of comprehensive and relevent training, substantial experience with the military and the military health care delivery system, and a practical and highly effective approach to patients' problems. PAs are now a part of an entirely new level of health care providers. Although the status of PAs has changed, the fundamental objective of the PA community has not changed: to enhance the delivery of quality care to our beneficiaries in a cost-effective manner.

II. DEFINITIONS:

a. Physician Assistant (PA). Per reference (e), PAs are health care professionals who have successfully completed a physician assistant training program recognized by BUMED, and are certified by the National Commission on the Certification of Physician Assistants. PAs are credentialed and privileged to practice medicine with physician supervision. Common services provided by a PA include taking medical histories and performing physical examinations; ordering and interpreting laboratory tests; diagnosing and treating illnesses; assisting in surgery; prescribing and dispensing medication; and counseling patients. PAs are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs. Because of the close working relationship PAs have with physicians, they are educated in the medical model designed to complement physician training. Upon graduation, PAs take a national certification examination developed by the National Commission on Certification of Physician Assistants (NCCPA) in conjunction with the National Board of Medical Examiners.

b. Primary Care. Primary care is a type of health care delivery, which emphasizes first contact care and assumes ongoing responsibility for the patient in both health maintenance and therapy of illness. This personal care involves a unique interaction and communication between the patient and the health care provider. Primary care is comprehensive in scope and includes the overall coordination of the patient's health care, whether this is preventive or curative, and where the sphere of involvement is biologic, behavioral, or sociologic. Appropriate use of consultants and community resources is an important part of effective primary care.

IV. DUTIES AND RESPONSIBILITIES OF PAs:

a. General

(1) Although PAs exercise a substantial degree of independence in the performance of their duties, they must, by definition, function with the supervision of a doctor of medicine or osteopathy when performing medical services.

(2) PAs are qualified by training and experience to provide primary care and should be so assigned.

(3) In addition to the PA core privileges, the OIC may grant PAs specialty supplemental privileges when the need for the PA's services in that specialty exists, and when the credentials for that PA confirm current competency for supplemental privileges. A PA may obtain competencies by completing a post baccalaureate degree in that specialty or by completing a formalized training program within a medical treatment facility.

(4) PAs may be granted admitting privileges under reference (e). However, under the current setting of detainee care, there is currently no mechanism for PAs to admit or assist in the care of inpatients.

(5) PAs may perform physicals following reference (g).

(6) PA's will adhere to JTF GTMO uniform standards for Detainee Operations; woodland camouflage uniform with sewn on devices worn with sleeves rolled down and name tapes covered when working with detainees.

(7) PAs must sign the medical record of each patient examined, treated, or referred for treatment, and print or stamp his or her name, grade, title, and the last four numbers of the social security number, beneath the signature.

(8) Evaluation of the quality of care provided by every PA in a clinical billet should be included in every fitness report submitted.

(9) PAs must maintain close ties with the Medical Service Corps (MSC) community to remain competitive in their corps. This is best accomplished by participating in scheduled MSC meetings and functions.

b. Specific

(1) Each PA will be granted clinical privileges following the provisions of reference (f).

(2) PAs are authorized to write prescriptions under the provisions contained in reference (d). Enclosure (2) defines prescribing guidelines for this facility.

V. FACILITY PA PROGRAM RESPONSIBILITIES:

A program director (generally the senior PA) will be appointed to coordinate the PA program. Responsibilities include:

a. Ensure primary and alternate physician supervisors are assigned by the OIC and that letters of appointment are generated.

b. Review the newly arriving PA's duties and responsibilities with them to ensure clarity.

c. Provide a structured orientation for assigned physician supervisors.

d. Monitor compliance of the program with the pertinent instructions.

e. Monitor compliance with the required peer reviews.

f. Review pertinent instructions annually for currency.

VI. SUPERVISION OF PAs:

The PA should be fully integrated into the primary care team and should be expected to exercise a substantial degree of clinical judgment in ordering studies, requesting consultations, rendering diagnoses, and formulation and initiation of treatment plans: An open, informal exchange of information between PA and physicians is necessary. The formal requirement for supervision and review of the clinical work of a PA by a specific physician derives from many sources and is reaffirmed by reference (e).

a. A physician must be appointed in writing, utilizing enclosure (3), to supervise and formally review the patient care rendered by each PA. Continuity of supervision must be ensured. An alternate physician will be appointed, utilizing enclosure (4), to assume the supervisory responsibilities in the absence of the regularly appointed supervisor.

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b. When the PA is involved in watch standing duties (e.g., after hour acute care clinic) the physician in charge of the watch area will assume supervisor duties.

c. A physician will not be appointed responsibility for supervision of more than three nonphysician providers.

d. Physicians assigned supervisory responsibility must be fully credentialed and privileged and actively engaged in the same category of health care delivery as the PA to be supervised.

e. The supervising physician will conduct random record reviews and peer review the quality of care provided. A minimum of 10 records per month will be reviewed via established peer review processes and each record reviewed will be co-signed. A copy of all reviews will be forwarded to the PA Program Director who will ensure the PA receives a copy. Documentation of the record reviews will also be forwarded for retention by the Credentials Committee of the PAs home command.

f. Physicians appointed supervisory responsibility will be provided a structured orientation by the PA program Director. The orientation will describe the training, experience and background of Navy PAs as well as the general duties and responsibilities of PAs. It will also clearly define all related administrative and professional supervisory and review responsibilities of the supervisor.

g. The supervising physician must participate in the initial granting and subsequent reappraisal of clinical privileges. He or she must be advised of credentialing action taken in the case of the PAs being supervised and must communicate promptly through the chain of command to the Credentials Committee any concern that credentials granted may not be appropriate.

VII. CONTINUING MEDICAL EDUCATION (CME) AND PA CERTIFICATION:

Each PA must attain and maintain national certification through the NCCAP. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for recertification every six years. CME may be obtained through in-service training, correspondence course programs, and continuing education conferences in the command. Active membership in appropriate professional organizations is encouraged.

From: Officer in Charge, Detention Hospital, Guantanamo Bay, Cuba
To: (PA)

Subj: ASSIGNMENT OF PHYSICIAN ASSISTANT DUTIES AND SUPERVISOR

Ref (a) NAVAMBCARECENNPTINST 6322.3C
(b) BUMEDINST 6550.12
(c) BUMEDINST 6320.66B

1. You are being assigned to the Delta Clinic and will perform general primary care duties per reference (a).

2. During this assignment, (Primary Supervisor) has been designated to serve as your Primary Physician Supervisor per references (a) through (c). (Alternate Supervisor) has been designated as your Alternate Physician Supervisor per references (a) and (c) and will serve in the absence of your Primary Supervisor.

3. Your designated Physician Assistant Supervisor has been directed to provide ongoing review of, and assistance with, your delivery of health care to detainees at this facility. Your supervisor has been specifically directed to meet with you on a periodic basis and review your clinical practice and medical record documentation.

4. The Physician Assistant Program Director will meet with you and your assigned supervisors to review the Physician Assistant Program, provide a copy of reference (a) and review the authorized medication list from which you may prescribe.

5. You must be familiar with the provisions of reference (a) to ensure that all of the supervision and review requirements of this directive are fulfilled.

(OFFICER IN CHARGE)

Enclosure (1)

005207

MEMORANDUM

From: (PA Program Director)
To: Officer in Charge
Via: Chairman, Pharmacy and Therapeutics Committee

Subj: AUTHORIZED MEDICATION LIST FOR PHYSICIAN ASSISTANT (PA)

1. (PA) will have full access to the Detention Hospital formulary with the following recommended exceptions:

PROHIBITED DRUGS (MAY NOT BE PRESCRIBED)

ALCOHOL
BUSULFAN (MYLERAN)
CYCLOPHOSPHAMIDE (CYTOXAN)
FLUROURACIL (EFUDEX)
HYDROXYUREA (HYDREA)
MELPHALAN (ALKERAN)
VINCRISTINE
SUCCINYOCHOLINE CHLORIDE
BETHANECHOL
CLOMIPHENE (CLOMID)
FLUCYTOCINE (ANOCOBON)
HEPARIN SODIUM (HEPARIN)
LITHIUM (ESKALITH)
QUINACRINE
TUBOCURARINE CHLORIDE
PROTAMINE SULFATE

DRUGS WHICH MAY BE INITIATED WITH COUNTERSIGNATURE OF A LICENSED PHYSICIAN AND REFILLED WITHOUT COUNTERSIGNATURE

AMPHOTERICIN (FUNGIZONE)
DIGITALIS TYPES
ETHAMBUTOL (MYAMBUTOL)
THYROID
GUANETHIDIDE (ISMELIN)
PROPYLTHIOURACIL (PTU)
RESERPINE
ISOPROTERENOL (ISOPREL)
METHIMAZOLE (TAPAZOLE)
METHYSERGIDE MALEATE (SANSERT)
PHENOBARBITAL
STREPTOMYCIN
OPHTHALMIC STERIODS
BROMOCRIPTINE
CHLORAMEPHENOCOL (CHLOROMYCETIN)
PHENYTOIN (DILANTIN)
FUROSEMIDE (LASIX)
GENTAMICIN (EXCEPT OPHTHALMIC)
PROCAINAMIDE (PRONESTYL)
QUINIDINE
INSULIN
ISOSORBIDE DINITRATE (ISORDIL)
METHOTREXATE
NITROGLYCERIN
RIFAMPIN (RIMACTANE)
PREDNISONE •
ANDROGENS
WARFARIN SULFATE (COUMADIN)

Enclosure (2)

005268

Subj: AUTHORIZED MEDICATION LIST FOR PHYSICIAN ASSISTANT (PA)

*** Prednisone is limited to short term use but may be initiated without countersignature for control of inflammatory and allergic reactions**

All other drugs may be initiated and refilled

2. (PA) may also have access to non-formulary items in medication categories not otherwise excluded by paragraph 1.

3. Once approved, copies will be distributed in accordance with reference (a) by the Physician Assistant Program Director.

(PA PROGRAM DIRECTOR)

From: Officer in Charge, Detention Hospital, Guantanamo Bay, Cuba
To: (Physician)

Subj: ASSIGNMENT AS A PRIMARY PHYSICIAN ASSISTANT SUPERVISOR

Ref: (a) NAVAMBCARECENNPTINST 6322.3C
(b) BUMEDINST 6550.12
(c) BUMEDINST 6320.6613

1. Per references (a) through (c), you have been assigned as the Primary Physician Assistant Supervisor for (PA). The Alternate Physician Supervisor is (physician), who will assume your responsibilities in your absence.

2. As the Primary Physician Assistant Supervisor, you must supervise and formally review the patient care rendered by (PA) per reference (a) requirements,

3. The Physician Assistant Program Director will provide a formal orientation for you regarding your responsibilities. At that time, you will receive a copy of reference (a) that defines the Physician Assistant Program at this facility and a copy of (the assigned PA) clinical privileges and authorized medication list. You should become thoroughly familiar with these and keep them on file for ready reference.

4. In a separate letter of assignment, the Physician Assistant is notified of your assignment as the Primary Physician Supervisor.

(OFFICER IN CHARGE)

Enclosure (3)

005210

From: Officer in Charge, Detention Hospital, Guantanamo Bay, Cuba
To: (Physician)

Subj: ASSIGNMENT AS AN ALTERNATE PHYSICIAN ASSISTANT SUPERVISOR

Ref: (a) NAVAMBCARECENNPTINST 6322.3C
(b) BUMEDINST 6550.12
(c) BUMEDINST 6320.6613

1. Per references (a) through (c), you have been assigned as the Alternate Physician Assistant Supervisor for (PA).

2. As the assigned Alternate Physician Assistant Supervisor, you must supervise and formally review the patient care rendered by (PA) in the absence of (Physician), his/her Primary Supervisor.

3. The Physician Assistant Program Director will provide a formal orientation for you regarding your responsibilities. At that time, you will receive a copy of reference (a) that defines the Physician Assistant Program at this facility and a copy of (the assigned PA) clinical privileges and authorized medication list. You should become thoroughly familiar with these and keep them on file for ready reference.

4. In a separate letter of assignment, the Physician Assistant is notified of your assignment as the Alternate Physician Supervisor.

(OFFICER IN CHARGE)

Enclosure (4)

005211

STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

_____ _____
Officer In Charge Date

IMPLEMENTED BY:

_____ _____
Director for Administration Date

_____ _____
Senior Enlisted Advisor Date

ANNUAL REVIEW LOG:

By:_____ Date:_____
By:_____ Date:_____
By:_____ Date:_____
By:_____ Date:_____
By:_____ Date:_____
By:_____ Date:_____

SOP REVISION LOG:

Revision to Page:_____ Date:_____
Revision to Page:_____ Date:_____
Revision to Page:_____ Date:_____
Revision to Page:_____ Date:_____
Revision to Page:_____ Date:_____
Revision to Page:_____ Date:_____

ENTIRE SOP SUPERSEDED BY:

Title:_____
SOP NO:_____ Date:_____

005212

NOV00371

CARDIAC ARREST PROCEDURE(S)

DETENTION HOSPITAL GUANTANAMO BAY, CUBA Title: CARDIAC ARREST PROCEDURE(S) AT CAMP DELTA	SOP NO: 060 Page 1 of 21 Effective Date: April 2004
SCOPE: Detention Hospital, Delta Clinic, Block Area, Reservations	

I. REFERENCES:

a) Emergency Medical Response Standard Operating Procedure #059

II. PURPOSE:

To outline the standard operating procedure regarding emergency medical response to personnel and detainees at Camp Delta and to define the cardiac arrest (Code Blue) criteria for activating the Emergency Medical Response Team while identifying the personnel who will respond. This Standard Operating Procedure document is intended to deal with individual cases and not mass casualty situations although some of the same principles may apply.

III. POLICY:

The detainee outpatient clinic located at Camp Delta under the auspices of Fleet Hospital 20 will function at the Battalion Aid Station level. The Detention Hospital and Delta Clinic are intended for providing care to detainees only. However, emergency medical care may be rendered to U.S. personnel pending arrival of Emergency Medical Services from the Naval Hospital, Guantanamo Bay (GTMO). Otherwise, Joint Task Force personnel are to receive care in the Joint Aid Stations (JAS) set up for that purpose or the U.S. Naval Hospital. Definitive emergency medical care for detainees will be rendered in the Detention Hospital or the Detainee Acute Care Unit (DACU) located in the U.S. Naval Hospital based on clinical acquity and availability of necessary resources.

IV. CAMP DELTA PROCEDURES:

1. In the event of an emergency involving a member of the Joint Task Force, the following will apply:

- A medical "Code Blue" will be announced on the radio. [redacted] b(2)
- Medical personnel at Camp Delta will respond initially to the medical call to render immediate aid [redacted] b(2)
- [redacted] b(2)
- Medical personnel at Camp Delta will "package" patient on backboard or litter with all necessary precautions to prevent further injury as may be indicated by the clinical condition and mode of injury. [redacted] b(2)
- [redacted] b(2)

005213

2. **At Detention Hospital:**

- The Registered Nurse (RN) or designee will call Delta Clinic [redacted] to report cardiac arrest (Code Blue) and request activation of Emergency Medical Response team.
- Page Duty Medical Officer (refer to on Call schedule for numbers). If no answer from Medical Officer, call GTMO Naval Hospital ER Medical Officer at [redacted]
- Bring Crash Cart to scene to initiate CPR (ABCs, Airway, Breathing, Circulation).

The following list of personnel is available 24 hours/day, 7 days/week, and will respond to all cardiac arrest(s) in Detention Hospital, Delta Clinic, Blocks, Reservations, and Tribunal Hearing areas:

- **Duty Medical Officer, by pager. If no call returned, call GTMO Naval Hospital ER Medical Officer at [redacted]**
- **Detainee Operations Center (D.O.C) [redacted]**
- **Registered Nurse**
- **Emergency Response Teams #1 (Delta Clinic) and #2 (Detention Hospital) from Delta Clinic (4 assigned Corpsman):**

  a) ***Red Resuscitative Jump Bag***
  b) ***Automated External Defibrillator (AED)***
  c) ***Respiratory Bag***
  d) ***ACLS Medication Box***

- **Pharmacy Technician**
- **X-ray Technician**
- **Lab Technician**
- **Director of Nursing Services (DNS)**

*During normal duty hours the following will be notified. After hours they may be notified by pager or phone.

[redacted]

At Delta Clinic:

- **The Registered Nurse (RN) or designee will announce "Code Blue" over radio and request activation of**
- **Emergency Response Team (ERT #1 - 2 assigned Corpsman).**
- **Page Duty Medical Officer. If no call returned, call GTMO Naval Hospital ER Medical Officer at [redacted]**
- **Bring Crash Cart to scene to initiate CPR (ABCs, Airway, Breathing, Circulation).**

The following list of personnel is available 24 hours/day, 7 days/week, and will respond to all cardiac arrest(s) in Detention Hospital, Delta Clinic, Blocks, Reservations, and Tribunal Hearing areas:

- **Duty Medical Officer, by pager. If no call returned, call GTMO Naval Hospital ER Medical Officer at [redacted]**
- **Registered Nurse**
- **Pharmacy Technician**
- **X-ray Technician**
- **Lab Technician**
- **Director of Nursing Services (DNS)**

*During normal duty hours the following will be notified. After hours they may be notified by pager or phone.

In as specific Camp (1, 2, 3, 4) and/or in a specific Block area(s):

- **First responder on the the scene should call for help by using radio saying "Medical, Medical Code Blue block, over"** [redacted] b(2)
- **Notify Duty Medical Officer, by pager. If no call returned, call GTMO Naval Hospital ER Medical Officer at** [redacted] b(2)
- **A lockdown of all the units will be done and an accounting of all detainees will quickly be performed by Detainee Operation Center (DOC) and security staff.** [redacted] b(2)
- [redacted] b(2)
- **Emergency Medical Response Team #1 and #2** [redacted] **will respond to all cardiac arrests with:** b(2)

  a) ***Red Resuscitative Jump Bag***
  b) ***Automated External Defibrillator (AED)***
  c) ***Respiratory Bag***
  d) ***ACLS Medication Box***

- [redacted] b(2)
- **Assess for unresponsiveness and ABCs (Airway, Breathing, Circulation).**
- **If detainee is unresponsive without pulse, position on backboard and initiate CPR for 1 minute.**
- **Transport Detainee via backboard to the causeway STAT, apply AED, shock as advised.**
- **Reassess pulse, if no pulse, continue CPR and follow ACLS algorithm(s) as needed until Detainee is stabilized or pronounced 'dead' by Medical Officer.** [redacted] b(2)
- **Continue to communicate with Delta Clinic on detainee status via radio** [redacted] b(2)

Documentation of Cardiac Arrest shall be documented on the Advanced Cardiac Life Support Flow Sheet and shall include (at a minimum):

- **Condition of patient prior to code blue, if known**
- **Time onset of code blue**
- **Time onset of CPR**
- **Time and watts at which patient was defibrillated**
- **Continuous monitor strips**
- **Time medications are given**
- **Response to medications**
- **Time of resuscitation**
- **Names of personnel responding**
- **Time Emergency Medical Response was terminated or time of death**
- **Time the patient(body) was released to the morgue**
- **Any other important event**

***Immediately after the Emergency Response Team is called, the cart will be restocked. Pharmacy will be notified to restock any medications needed. Any supplies that need to be restocked will be obtained from the supply room and/or ISO container. All equipment will be cleaned or sterilized appropriately.**

CARDIAC ARREST PROCEDURE(S) SOP: 060

BLS/ACLS DRILLS:

Cardiac Arrest (Code Blue) Drills can be performed twice a month randomly at various locations by the Registered Nurse assigned to Delta Clinic, or Crash Cart Officer. Locations that drills can be performed:

Detention Hospital
Delta Clinic
Training Block
Reservations (yellow, brown, blue, orange, or gold buildings)

Code Blue Critiques of the Corps staff and other applicable staff will be completed by the RN and documented on the critique form(s). The RN will place the one copy of the completed critique in the Crash Cart book and one copy in the DNS folder.

SOP Issued: 2/2/04
Resubmitted: 3/9/04
4/9/04

[redacted] b(6)
CRASH CART OFFICER

AUTOMATED EXTERNAL DEFIBRILLATION (AED) FOR NON-ACLS PERSONNEL

1) Establish pulselessness
2) Contact Delta Clinic or Detention Hospital and call "Code Blue"
3) Start CPR utilizing BVM and 100% O2.
4) Turn AED on
5) Attach electrodes
6) Analyze rhythm

If shock indicated:
- give (3) "stacked shocks"
- continue CPR for (1) minute
- maintain airway control utilizing **ADVANCED AIRWAY PROTOCOL** and establish IV access
- ***Epinephrine*** 1:10,000 1mg IVP (N) or 2.5 mg ETT (N) q 3-5 min
- analyze rhythm
- give (3) "stacked shocks" if needed
- continue CPR for (1) minute
- ***Vasopressin*** 40 units IV x 1 dose (N) [wait 5-10 mins before starting Epinephrine]
- analyze rhythm
- give (3) "stacked shocks" if needed
- continue CPR for (1) minute
- ***Amiodarone*** 300 mg IVP (N) (may repeat once 150mg in 3-5 mins-max 2.2g IV/24 hrs)
(OR)
- ***Lidocaine*** 1-1.5 mg/kg IVP (N) or 2-3 mg ETT (N) to a maximum of 3 mg/kg
- analyze rhythm
- give (3) "stacked shocks" if needed
- continue CPR, monitoring and delivering drug, shock, drug, shock, etc.

If no shock indicated:
- continue CPR
- maintain airway control and establish IV access
- ***Epinephrine*** 1:10,000 1mg IVP (N) or 2.5mg ETT (N) q 3-5 min
- continue CPR
- ***Atropine*** 1mg IVP (N) or 2mg ETT (N) q 5min (max of 3mg)

- continue CPR, monitoring with AED and proceed to "If shock indicated" if shock

7) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**

8) Continue to monitor, transport to GTMO Naval Hospital ER, and contact MO ASAP for medical oversight.

POST RESUSCITATION

1) Assure ABC's

2) Assess heart rate:
   - if heart rate < 60 bpm, got to **BRADYCARDIA PROTOCOL**
   - if heart rate > 150, go to **NARROW or WIDE TACHYCARDIA PROTOCOL**

3) If patient is hypotensive and lung sounds are clear:
   - give 250ml NS bolus(s) to maintain SBP > 90 mmHg
   - consider *Dopamine* 5-10 mcg/kg/min to maintain SBP > 90 mmHg if unresponsive to fluid bolus(s)

4) If patient V-FIB or V-TACH during resuscitation:
   - give *Lidocaine* 1.5 mg/kg slow IVP (N) over 2 minutes (if not previously given) *
   - start *Lidocaine* drip at 2-4 mg/min

5) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

* Give ½ dose in patients with impaired liver function, left ventricular dysfunction or > 70 yo

EMERGENCY CARDIAC CARE PROTCOLS FOR ACLS PROVIDERS

Enclosure (3)

VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA

* Give ½ dose in patients with impaired liver function, left ventricular dysfunction or >70 yo

1) Establish pulselessness

2) Contact Delta Clinic or Detention Hospital and call "Code Blue"

3) EKG monitor

4) Defibrillate at 200J, 300J, 360J

5) CPR with BVM and 100% O2

6) Maintain airway utilizing ADVANCED AIRWAY PROTOCOL

7) Obtain venous access

8) *Epinephrine* 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5min

9) Continue CPR

10) Defibrillate at 360J

11) *Vasopressin* 40 units IV x 1 dose (N) [wait 5-10 mins before starting epinephrine]

12) Continue CPR

13) Defibrillate at 360J

14) *Amiodarone* 300 mg IVP (N) [may repeat once 150 mg in 3-5 mins] (maximum 2.2g IV/24 hrs)

(OR)

15) *Lidocaine* 1-1.5mg/kg IVP (N) or 3mg/kg ETT (C)/(N) *

16) Continue CPR

17) Defibrillate at 360J

18) *Lidocaine* 1.5mg/kg IVP (N) or 3mg/kg ETT (C)/(N) * (maximum 3mg/kg)

19) Continue CPR

20) Defibrillate 360J

21) Continue "drug-shock" sequence with defibrillation every 30-60 seconds after drug administration

22) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**

23) Continue to monitor, transport to clinic, and call MO ASAP for medical oversight

TACHYCARDIA- WIDE COMPLEX

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) 3-lead EKG monitor

4) If pulse > 150 bpm with signs of altered mental status or hypoperfusion:
   - synchronized cardioversion (100J, 200J, 300J, 360J) *

5) Obtain vascular access

6) 12 Lead EKG

7) Amiodarone 150mg IV over 10 mins (15 mg/min)
   (may repeat rapid infusion 150mg q 10 mins as needed)

8) *Lidocaine* 1-1.5 mg/kg slow IVP (N) over 2 min **
   OR

9) If rhythm does not spontaneously convert to sinus within 10 min:

   - *Lidocaine* 0.5-0.75 mg/kg slow IVP (N) over 2 min **

10) If patient becomes pulseless, go to **VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA PROTCOL**

11) If patient develops sign of altered mental status or hypoperfusion:
   - synchronized cardioversion (100J, 200J, 300J, 360J) *

12) If patient converts to sinus rhythm, start *Lidocaine* drip 2-4 mg/min

☐ Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

* If possible, provide sedation with analgesia:
   - *Versed* 1-2mg IVP (N)
   - *Morphine Sulfate* 2-4mg IVP (N)

** Give ½ dose in patients with impaired liver function, left ventricular dysfunction or > 70 yo

TACHYCARDIA- NARROW COMPLEX

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) 3-lead EKG monitor

4) If pulse > 150 bpm with signs of altered mental status or hypoperfusion:
   - synchronized cardioversion (100J, 200J, 300J, 360J) *
   - if pulseless got to appropriate protocol

5) Obtain vascular access

6) 12 Lead EKG

7) If pulse > 150 bpm and without signs of hypoperfusion, attempt vagal maneuver **

8) If signs of deteriorating mental status or hypoperfusion present
   - synchronized cardioversion (100J, 200J, 300J, 360J) ***
   - if pulseless go to appropriate protocol

9) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

* May start at 50J for Atrial Flutter

** Vagal maneuvers should not be attempted on the following:
   - history of transient ischemic attack (TIA)/ cerebral vascular accident (CVA)
   - previous neck surgery
   - neck cancer
   - history of aortic stenosis
   - known carotid artery blockage

*** If possible, provide sedation with analgesia:
   - *Versed* 1-2mg IVP (N)
   - *Morphine Sulfate* 2-4mg IVP (N)

BRADYCARDIA

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) EKG monitor

4) If 2nd degree Type II or 3rd degree Heart Block present with signs of hypoperfusion, consider early transcutaneous pacing (TCP)

5) Obtain vascular access

6) *Atropine* 0.5-1mg IVP (N) titrated to effect (maximum 3mg)

7) If patient fails to respond to atropine, consider transcutaneous pacing (TCP)

8) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

PULSELESS ELECTRICAL ACTIVITY (PEA)

1) Establish pulselessness

2) Begin CPR with BVM and 100% O2

3) Maintain airway utilizing **ADVANCED AIRWAY PROTOCOL**

4) Obtain vascular access

5) ***Epinephrine*** 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5 min

6) Continue CPR

7) ***Atropine*** 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5 min (maximum 3mg) **

8) Continue CPR

9) Rule out causes of PEA and treat according to appropriate protocol

10) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**

11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

Possible Causes

- Myocardial Infarction
- Acidosis
- Tension Pneumothorax
- Hyperkalemia/Hypokalemia
- Hyothermia
- Hypoxia
- Cardiac Tamponade
- Emboli
- Drug Overdose

** Give atropine for electrical heart rate < 60 bpm

ASYSTOLE

Possible Causes

- Myocardial Infarction
- Acidosis
- Tension Pneumothorax
- Hyperkalemia/Hypokalemia
- Hyothermia
- Hypoxia
- Cardiac Tamponade
- Emboli
- Drug Overdose

1) Establish unresponsiveness

2) Begin CPR with BVM and 100% O2

3) 3-lead EKG monitor

4) Maintain airway utilizing **ADVANCED AIRWAY PROTOCOL**

5) Obtain vascular access

6) ***Epinephrine*** 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5min

7) Continue CPR

8) ***Atropine*** 1mg IVP or 2mg ETT (C)/(N) q 3-5 min (max 3 mg)

9) Continue CPR

10) If spontaneous return of pulse, go to **POST RESUSCITATION PROTOCOL**

11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

ADVANCED CARDIAC LIFE SUPPORT SHEET

Date: ________________ Start Time: ____________ Recorder: ______________________________________

Time	Epi	Lido	Atropine	Other Drugs or IV Drips	Electricity Mode/Joules	Cardiac Rhythm	Nursing Notes (cont. on back)

Page ______ of ______

Enclosure (4)
Front

005226

NOV00385

Time	Nursing Notes

Page _____ of _____

CODE BLUE CRITIQUE

Area of Drill: ☐ **Hospital** ☐ **Delta Clinic**

Medical notified of Code Blue by: _____ **@** _____ ☐ **Radio** ☐ **Lan Line**

Brief description of scene:

_____

_____

TIME	ACTIVITY	Comments	Met	Not Met
	a. Establish unresponsiveness			
	1. Absence of breathing			
	2. Absence of pulse			
	b. Call for help			
	c. Initiate Code Procedures			
	1. Pager systems activated			
	2. Personnel assigned			
	d. Begin Basic Life Support			
	1. Patient Positioned for CPR			
	2. Airway			
	3. Chest Compressions			
	e. Crash Cart Setup			
	1. Airway equipment			
	2. Oxygen			
	3. Medications			
	4. IV equipment			
	f. Defibrillator/Monitor setup			
	1. Rhythm established/recognized			
	g. IV established			
	h. Airway Maintenance			
	1. Adequate mask ventilation			
	2. Endotracheal intubation			
	3. Auscultation of both lungs fields			
	i. Palpable pulse during compressions			
	j. Detection of pulse without compressions			
	k. Treatment modality			
	1. Follows algorithm for scenario			
	2. Used ACLS cards from Crash Cart			
	l. Post-resuscitation management			

Enclosure (6)

005228

TIME	ACTIVITY	Comments	Met	Not Met

Comments: _____

CARDIAC ARREST PROCEDURE(S)

SOP: 060

CODE BLUE CRITIQUE

Area of Drill: ☐ Camp ____ Block ____ ☐ Reservations _____
(brown, yellow, orange, blue, gold)

Medical notified of Code Blue by: _____ @ _____ ☐ Radio ☐ Lan Line

Brief description of scene:

_____

_____

Algorithm(s): _____

_____

TIME	ACTIVITY	Comments	Met	Not Met
	Medical Officer paged			
	CDO paged			
	DOC notified			
	ERT Team #1 and #2 responded			
	Red Bag with ERT team			
	AED with ERT team			
	ERT Teams arrived at Sally Port #			
	Sally Port # opened			
	Arrived on scene (with gator)			
	a. Established unresponsiveness			
	1. Absence of breathing			
	2. Absence of pulse			
	b. Begin Basic Life Support			
	1. Detainee positioned for CPR (supine position on back board)			
	2. Airway opened with			
	3. Adequate mask ventilations initiated			
	3. Rhythm identified by AED			
	4. Shock delivered by AED *(3 stacked shocks delivered by AED)			
	5. Shock delivered by AED			
	6. Shock delivered by AED			
	Detainee leaving block on back board to Sally Port #			
	Sally Port # opened			
	Detainee transported to gator STAT			
	Reassess for pulselessness			
	Chest compressions initiated			
	Arrived to Sally Port #			
	Sally Port # opened			
	Detainee arrives at Delta Clinic			
	Detainee's secondary assessment			

TIME	ACTIVITY	Comments	Met	Not Met

Comments: _____

STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge _____ Date _____

IMPLEMENTED BY:

Director for Administration _____ Date _____

Senior Enlisted Advisor _____ Date _____

ANNUAL REVIEW LOG:

b(6)

By: [redacted] Date: April 2004
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____

SOP REVISION LOG:

Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____
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Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____

ENTIRE SOP SUPERSEDED BY:

Title: Emergency Medical Response
SOP NO: 059 Date: _____

Enclosure (7)

MEDICAL PLANS/OPERATIONS GUANTANAMO BAY, CUBA Title: REQUEST FOR MEDICAL/DENTAL INFORMATION	SOP NO: 001 Page 1 of 2 Effective Date: 1 Mar 2005
SCOPE: JOINT MEDICAL GROUP (JMG)	

I. PURPOSE:

To outline the Standard Operating Procedure (SOP) regarding requests for detainee medical/dental information. This SOP document is intended to describe the process the Joint Medical Group will use to correctly task and track outside agencies (governmental and non-governmental) requests for detainee medical information.

II. POLICY:

The Joint Task Force Surgeon (SG) will serve as the approving authority for requests for detainee medical/dental information. The Officer in Charge (OIC), Medical Plans/Operations (MPO) will serve as the entry point for all outside agency requests for detainee medical/dental information as well as track, using a spreadsheet, the JMG response. The Senior Medical Officer (SMO)/Detention Hospital will be the primary point of contact for medical information requests. The Senior Dental Officer (SDO)/Detention Hospital will be the primary point of contact for dental information requests. The JTF Staff Judge Advocate (SJA) will act as legal consultant as needed to assist the SG to determine if/when medical/dental information can be released and the correct format for the release. Original medical records will remain in the custody of the JMG. If records are cleared for release, certified copies will be provided. Documentation of the appropriate authorization will be kept on file by the MPO office.

III. PROCEDURES:

1. **Requests for medical/dental information:**

   a. Requests for medical/dental information are common from the J-1, in the form of a Freedom of Information Act (FOIA); Behavioral Science Consultation Team (BSCT); Public Affairs Office (PAO); Federal Bureau of Investigation (FBI); Detainee Assessment Branch (DAB); the Office for the Administrative Review of Detainee Enemy Combatants (OARDEC) and detainee counsel.

   b. Medical/dental information requests will be sent through the SG, as identified below, or to the OIC MPO via the JMG organizational e-mail (SIPR). The OIC or NCOIC will enter the request into an excel spreadsheet. The MPO office will task the request for information to the SMO or SDO.

c. Requests from the FBI, OARDEC, and the DAB will come through the JMG organizational email (SIPR) on official letterhead and be signed by the respective director with an explanation of what information is required, how the information will be used, and date information needed. An accurate and current letter from these agencies/sections on file with the SG and MPO may be used to satisfy the above requirement (i.e. a letter is not required to be submitted for each request).

d. Requests from the J-1 regarding a FOIA will be accompanied by the complete FOIA package and be suspensed to the JMG organizational e-mail box.

e. Requests from the PAO and BSCT will be sent to the JMG organizational e-mail box.

f. Requests from detainee counsel, if received by the JMG, will be forwarded to the SJA office. The JMG will not provide any medical/dental information until the SJA has reviewed the request and determined the legal nature of the request and what, if any, information can be provided.

g. Requests for medical/dental information made directly to the Detention Hospital (DH) will be returned to the sender with an explanation of how to correctly request medical/dental information as described in this SOP.

h. The SDO/DH or SMO/DH will complete a medical/dental summary or complete the Medical RFI e-form submitted by the MPO, as appropriate, and respond directly to the MPO via SIPR e-mail, while courtesy copying the SG and Deputy SG. The SG will approve or deny the release of medical information and forward to the MPO. The MPO will track responses to ensure task completion. The MPO will forward the information, with the SG's approval noted, to the requestor.

2. **Release of medical/dental information:**

a. When detainee medical/dental information is released using names or ISNs, the information is considered SECRET. When the medical/dental information does not reveal names or ISNs, the information is considered For Official Use Only (FOUO).

b. No medical/dental information is to be used for the purposes of furthering intelligence gathering.

c. All release of medical/dental information must have written approval (email or hard-copy memo) of the SG or Deputy SG.

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DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 012

Page 1 of 3
Effective Date:

Title: CAMP 4 MEDICATION DISPENSING POLICY

SCOPE: Detention Hospital

I. BACKGROUND:

1. The pharmacy representative on the Camp Delta Medical Team provides pharmacy support to the team by dispensing medications pursuant to valid prescriptions written by designated providers and issuing medications needed for the direct administration to patients.

II. RESPONSIBILITY:

1. The designated pharmacy representative at the camp is responsible for the proper organization, efficient inventory management, and proper dispensing and issuance of all pharmaceuticals. Operational procedures shall be in compliance with all provisions of Chapter 21 of the Manual of the Medical Department.

2. Security of Pharmaceuticals: The Detention Hospital pharmacist will ensure the proper security of the pharmaceuticals transported to Camp Delta Clinic. The pharmacy representative will ensure that adequate medication stock is kept available at the camp.

3. All pre-dispensed medications will be kept in a lockable drug cabinet and all dispensed medications will be kept in separate designated lockers. The pharmacy representative and the medical staff administering the dispensed medications to the patients will hold custody of the keys to the locker. The narcotics log and locker key will (b)(2) be maintained by [redacted] All immunizations stored at the camp will be kept in a lockable refrigerator within the Camp Delta Clinic.

III. POLICY:

1. The Senior Medical Officer (SMO) shall determine which medications are to be stocked at the Camp Delta Clinic.

2. The designated camp medical providers will enter all prescriptions into CHCS. A CHCS terminal and label printer will be available for the pharmacy technician to use in the dispensing of prescriptions. The pharmacy technician will fill all prescriptions following the provider's entry and will apply CHCS generated prescription

label and auxiliary warning labels to the bottles as appropriate. It is preferred that medications ordered beyond a one-time use will be dispensed from the Detention Hospital pharmacy with the first dose dispensed from the Camp Delta Clinic pharmacy locker.

3. The prescriptions are dispensed to the custody of the nursing staff who will be in charge of administering the medications to the patient. All dispensed medications will be kept in designated lockers within the camp clinic and will be stored in alphabetical order.

IV. PROCEDURE:

1. Dispensing of medications to detainees.

a. The assigned hospital corpsman shall review NAVMED 6550/8 Medication Administration Record (MAR) and compare detainee ISN number and location against current alpha roster. If necessary make appropriate changes in individual MAR folders and move medications to appropriate place in medicinal locker.

b. Gather appropriate medicinals from Camp Delta Clinic and report to security personnel at Camp 4. Notify security personnel which detainees require meds. [redacted] b(2)

c. The hospital corpsman with [redacted] b(2) will dispense all medications from the bean port at each compound. Camp 4 security will be responsible for bringing the appropriate detainees to the bean port. The hospital corpsman will verify the following prior to dispensing any medications.

1). Have orders and MAR been verified by nursing staff?
2). Are you authorized to give this medication?
3). Is it the correct patient? Verify against ISN wrist band.
4). Is it the correct medication?
5). Is it the correct dose?
6). Is it the correct route of administration?
7). Is it the correct time to give the medication?

d. Document the administration of all medications and or refusals on the MAR and notify nursing staff of any concerns.

e. Transcribe any changes to medications on MAR. The nursing staff will verify accuracy on a regular basis.

f. In the event of inclement weather an ambulance will be brought onto the compound for shelter.

STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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Director for Administration Date

Senior Enlisted Advisor Date

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Title:
SOP NO: Date:

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 018

Title: DATA COLLECTION AND REPORTING

Effective Date: 17 Jun 03

SCOPE: Detention Hospital

I. BACKGROUND:

The Detention Hospital has been tasked with complete and accurate reporting of the medical conditions affecting each of the detainees.

II. POLICY:

The data collection procedures described below must be maintained until discontinued or modified by the command element or higher authority.

III. PROCEDURES:

- CHCS registration of all detainees will be completed during in-processing. All ancillary studies and pharmaceutical needs will be ordered through the CHCS system.

- KG-ADS recording of diagnostic ICD-9 codes will be completed on all patient visits. A superbill has been designed to aid with the most common diagnoses.

- A daily situation report will be completed by the Senior Medical Officer at Camp Delta and will be forwarded to the Officer in Charge via the Detention Hospital administrative personnel on disc for compilation into the Detention Hospital situation report.

- The night duty nurse will complete a daily workload summary for Camp Delta. This report allows for further breakdown of data to include cell versus clinic visits as well as wound care and physical therapy.

- The following spreadsheets will be maintained on various programs occurring within Camp Delta:
  - Weight Monitoring Program
  - Hunger/Thirst Strike Program
  - Malaria Control Program
  - Latent Tuberculosis Control Program
  - Hepatitis/Other Infectious Disease Monitoring Program

- Immunization Program
- In-processing Chest X-ray Follow-Up Program

- The individual program managers are responsible for updating these spreadsheets and checking them for accuracy and pursuing further actions indicated clinically on the results contained therein.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

Title: PROVIDER CREDENTIALS

SOP NO: 019

Effective Date: 27 Jun 03
Updated Date: 04 NOV 04

SCOPE: Detention Hospital

I. Purpose: To ensure that all clinical providers practicing at the Detention Hospital are properly privileged, and all credentials are current and verified prior to practicing medical care.

II. RESPONSIBILITIES:

Patient Administration Officer will receive ITCB from provider's parent command. Ensure credentials are signed by the privileging authority (Joint Task Force Surgeon) prior to provider performing any procedure at Detention Hospital.

III. PROCEDURES:

a. The information contained on the ITCB will be checked by the Professional Affairs Coordinator, Performance Improvement Offfice, U.S. Naval Hospital, Guantanamo Bay to ensure that the provider's credential information is current and in good standing.

b. Ensure that ITCB is designated to, "Joint Task Force Surgeon, U.S. Naval Hospital, Guantanamo Bay, Cuba / Detention Hospital."

c. Forward ITCB to Detention Hospital Officer in Charge for verification of skills Needed to perform the assigned procedure.

d. Upon receipt of approved ITCB, from Detention Hospital OIC, place in "Credentials" folder.

e. POC for credentials at NH-GTMO is (b)(6) She can be reached At extension (b)(6)

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA Title: CDO WATCHSTANDER GUIDE	SOP NO: 028 Page 1 of 3 Effective Date: 15 Oct 03 Updated: 04 Nov 04
SCOPE: Detention Hospital	

I. SCOPE AND GUIDELINES

- The CDO is the direct representative and responsible to the OIC of Detention Hospital.
- Ensure Safety and Security of all medical personnel at Camp Delta at all times.
- Communication is the key. Establish positive communication with clinical staff and be ready to support medical mission. Make rounds and introduce yourself to duty delta officers at DH and Delta Medical Clinic.
- CDO Hours: [redacted] After hours, take the pager home. The CDO will carry a pager at all times while on watch.
- [redacted] (b)(2)
- [redacted] schedule is included in the CDO watch schedule. All rounds should be documented in the logbook.
- The CDO should be familiar with emergency procedures, fire plan, Bomb threat, Mass Casualty plan and all other pertinent SOPs. The CDO is responsible to ensure that an updated staff recall is available.
- All changes of Duty (i.e. swaps) will only be approved with a special request chit. Both members performing swap and the CDO coordinator (bottom-line approval) must sign the special request chit. [redacted] (b)(2)

II. JOB SUMMARY:

1. Duty as the Detention Hospital Command Duty Officer (CDO) commences at [redacted] unless otherwise arranged by current and relieving CDO. The CDO must keep the pager with them at all times.

2. The CDO will make [redacted] rounds of Detention Hospital buildings and assets when on Camp Delta. At a minimum, this includes Detention Hospital and Delta Clinic at [redacted]. Check for the following:

A) [redacted]
B) [redacted]
C) [redacted]
D) [redacted]

(b)(2)

3. Log any event out of the ordinary in the CDO Logbook
   A) Visits from VIP's, SECDEF, and Commanding General.
   B) Power outages.
   C) Staff admitted to Hospital (notify OIC and Department Head or SEA if enlisted)
   D) Security called to housing.

4. CDO will be notified of any Public Works issues if they arise. (Generator out, toilet stopped up, etc). CDO will notify R&U for utilities problems and Burns & Roe for power outage to the Detention Hospital.

5. CDO has access to a vehicle in case he/she is needed at Detention Hospital.

6. [redacted]

(b)(2)

7. Mass Casualty recalls. If the CDO is contacted by the Delta Clinic Duty Nurse to activate the Mass casualty recall roster the following procedures in SOP 073 apply.

III. SAMPLE LOG ENTRY OVER A DUTY PERIOD

(b)(2)

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

Title: Medical Department Training

SOP NO: 034

Page 1 of 3
Effective Date: 05 Feb 03
Reviewed: 22 Apr 04
Updated: 04 NOV 04

SCOPE: Detention Hospital

I. BACKGROUND:

Mission readiness is our priority and effective training remains central to that effort. The Detention Hospital provides medical treatment and healthcare services for detainees in support of Operation Enduring Freedom, as part of the JTF mission here in Guantanamo Bay. Safety and Security is the number one priority before any medical treatment is rendered to the detainee population. We work as a team with the MP's to accomplish our medical mission and constant training and vigilance is essential to ensure we remain mission focused, safe and effective as we conduct our daily operations in this maximum-security environment.

II. POLICY:

Our top priority is to maintain a trained and ready medical staff. Our training is focused on our mission essential tasks and are designed to prepare us for Mass Casualty, Emergency Response, and daily healthcare operations in the maximum-security environment of Camp Delta.

III. GENERAL PROCEDURES:

a. The DNs will assign one Med/Surg nurse and one corpsmen to be the Training Officer and Petty Officer and are the primary points of contact for coordination of all training evolutions.

b. The Training Officer, in coordination with directorates and OIC is responsible for developing a formalized six-week required training schedule for all Detention Hospital personnel. Training will be conducted every [redacted] for all Hands. Clinic schedules will be adjusted to ensure maximum participation in the weekly training. The training plan will include command training (for all Hands) which will include General Military Training (GMT), and tactical/operational training to better prepare the corpsman for field activities.

c. Training topics will be selected to maximize situational awareness, emergency response and readiness at Camp Delta realizing that constant effective training is the key to our mission success.

d. The Training Officer will maintain training files and training database to accurately reflect completion of scheduled training.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 045

Title: RESTERALIZING AND CLEANING STRAIGHT CATHETERS

Page 1 of 2
Effective Date: 18 JUN 03

SCOPE: Detention Hospital

I. PURPOSE:

This SOP outlines the technique of cleaning and resterilizing straight catheters.

II. PROCEDURE:

A. Cleaning:
   1. Place straight catheters in the ultra sonic for 20min.
   2. When finished take out and squirt water through the end with a syringe.

B. Wrapping

   1. Place the well moisten straight catheters in the basin.
      a. Squirt four drops of water in basin.
      b. Make sure the inside and outside of the catheter is well moistened.

   2. Use blue muslin to wrap
      c. You must immediately wrap the catheter after moisten it and place it immediately in sterilizer.
      d. If catheter is not placed in sterilizer directly after moistened, remoisten and rewrap.

C. Checks before giving catheter to Detainee

   1. Make sure catheter is not hot
   2. Check catheter for cracks or holes, or any type of rubber breakdown.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 054

Title: KOH (POTASSIUM HYDROXIDE) PREPARATION

Effective Date: 23 SEP 03

SCOPE: Detention Hospital

I. BACKGROUND: The KOH prep is used to aid in the detection of fungal elements in thick mucoid material or in specimens containing keratinous material, such as skin scales, nails or hair. The KOH solution dissolves the background keratin, unmasking the fungus elements to make them apparent. Hyphae and yeast cells, that resist digestion by the KOH, can then be seen clearly against a homogenous background.

II. SPECIMEN: Skin scales, nail scrapings, hairs, or other materials that are thick in consistency or opaque are appropriate for KOH preps.

III. MATERIALS REQUIRED

A. Spot test Potassium Hydroxide (KOH) – 10%, storage at room temperature.
B. Glass slide
C. Cover slip
D. Microscope

IV. QUALITY CONTROL

A. Ensure that quality control is within normal range prior to testing patient samples.
B. Negative – Uninoculated KOH
C. Positive – Candida albicans
D. Record results, lot number and date in the quality control log each day of use.

V. SAFETY. Gloves and resistant lab coats must be worn at all times when working with blood and body fluids or body tissues. Protective face shields must be worn when working with biological specimens that may be aerosolized such as opening blood tubes.

VI. PROCEDURE

A. On a clean glass slide, suspend fragments of skin scales, nails or hair in a drop of 10% KOH.

B. Add a cover slip over the drop and let the slide sit for 10 to 15 minutes at room temperature.

C. Examine the slide under the microscope at low and high power for the presence of fungal elements of hyphae.

VII. RESULTING RESULTS

A. If no fungal elements aS seen, report as follows, "No fungal elements present – KOH negative."

B. If fungal elements are present on the slide, report as follows, "Fungal elements present – KOH positive."

C. Ensure the result is entered accurately in CHCS.

VIII. REFERENCE RANGE. No fungal elements seen.

IX. LIMITATIONS. Care must be taken to differentiate fungal elements from other artifacts such as cotton, wool, or other fabrics as well as mosaic cholesterol crystals.

X. REFERENCES

A. Naval Hospital GTMO reference SOP.

B. Color atlas and Textbook [redacted]

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

PREPARED AND WRITTEN BY:

(b)(6) | Date

REVIEWED AND APPROVED BY:

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Exposure Control Program [redacted] (1,2)

[redacted] All ERT should be immunized against hepatitis B in addition to standard deployment immunizations.

Tuberculosis: Detainees will wear a surgical mask until cleared to remove it by the medical provider performing the in-processing examination. Detainees with highly suspicious chest x-rays or detainees exhibiting signs and symptoms suggestive of tuberculosis will be evaluated early and isolated from the remainder of the detainees. Multiple cases of pulmonary tuberculosis will be confined in one cellblock area and separated from other non-infected individuals. Outdoor air circulation and UV light will reduce communicability. Treatment will begin immediately with a 4-drug regimen if active disease is confirmed. All health care workers will have access to a N-95 respirator to be used when dealing with highly suspicious or confirmed cases when the patient is not masked. Security personnel will be fitted as needed. Masks need not be worn by staff unless coming into close, personal contact with the detainee FOLLOW THE TUBERCULOSIS CONTROL SOP IN THIS BINDER FOR SPECIFIC ALGORITHM PROTOCOLS.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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005179

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

Title: NURSING

SCOPE: Detention Hospital

SOP NO: 029

Page 1 of 14
Effective Date: 03 Oct 03

I. PURPOSE:
To provide Nursing staff with guidelines to assist with the nursing care provided at Camp Delta. The in-depth Nursing Procedures manual for Camp Delta is the Lippincott Manual of Nursing Practice (7th Edition) kept at the nurse's station at the Detention Hospital and Delta Clinic. Consult this resource for review of nursing procedures. Additional nursing resources are available at Naval Hospital, GTMO.

II. NURSING DUTIES AND RESPONSIBILITIES:

- Coordinate and administer patient care activities.
- Facilitate all steps in the medical in-processing of detainees including, CHCS registration, ordering of lab and radiological studies, set up of medical records.
- Ensure that all medical contacts (in-processing, follow up, sick call, and cell visits) are entered in the SITREP Log.
- Enter Walk-in Appointments, for every detainee clinic and cell visit (except medication rounds).
- Coordinate the movement of detainees into and out of the medical compound for evaluation, follow up and sick call visits with Escort Control at the Camp Delta Detainee Operations Center (DOC).
- Oversee the daily assignments of the Hospital Corpsmen; Provide nursing care oversight, ensure safety and accountability at all times.
- Update the pass down log for oncoming shifts to ensure that pertinent information is passed.
- Provide quality-nursing care to detainees admitted to the Detention Hospital.
- Perform triage, physical assessments, i.e. vital signs, neuro-vascular checks and assessment of pain and skin breakdown.
- Administer scheduled and PRN medication as ordered.
- Supervise the administration of medications by hospital corpsmen.
- Co-sign every Medication Administration Record transcribed by the corps staff.
- Administer treatments such as dressing changes, etc.
- Transcribe physician orders for all outpatients and in-patient.
- Verify order transcription via daily chart verification (q 24 hour chart review) after 2400 each day.
- Obtain a current detainee Alpha roster from DOC after 2400 each day.
- Ensure all procedures and findings are documented on appropriate forms.

- Co-sign all corps staff medical record entries.
- Supervise Hospital Corpsmen assigned to Camp Delta.
- Ensure monthly weights are completed on all detainees on the first of every month. Document monthly weights in the detainee's medical record. Additionally all detainees that are determined to be malnourished are weighed on the fifteenth of the month.
- Complete daily SITREP report and the 24-hour clinic report daily. Deliver one copy to the Detention Hospital Admin staff and second copy to DNS each morning before 0800.
- Complete Vulnerability Assessment for clinical area (DH, Delta Clinic and DACU) each shift.

The Following sections are designed to assist new personnel in performing nursing duties and responsibilities in a safe and effective manner.

DETAINEE IN-PROCESSING (Review In-processing Manual)

Prior to Detainee Arrival

- The Delta Clinic Division Officer (DO) is designated as the Point of Contact (POC) for all in processing issues at the Camp Delta Clinic. The Leading Petty Officer (LPO) is designated as the back up POC in the absence of the DO.
- Upon notification of incoming detainees, the DO will contact the S1 at the Joint Detainee Operations Group (JDOG). The DO will request a list or manifest with the names and ISN numbers for the new detainees. (Note: this information classified Secret).
- The DO or a designee will register each new detainee in the CHCS system following the step-by-step procedure found in the Nursing SOP for Camp Delta Medical Clinic. Each detainee will be registered using the ISN number as a social security number.
- After doing the mini registration in CHCS, enter the set of standing in-processing doctors order for each new detainee. The SMO will be entered as the ordering physician. The labs are ordered as part of an Order Set labeled 'Detainee Orders' which contains the following individual orders:

1. Hepatitis B Surface Antigen
2. Hepatitis C Virus
3. HIV
4. Hepatitis A Antibody
5. Hepatitis Core Antibody,
6. Hepatitis B Surface Antibody Titer
7. Radiograph, Chest PA
8. Mefloquine 250 mg PO, 3 tabs at in processing and 2 tabs at 0600 the next day
10. Albendazole 200 mg PO, 2 tabs at time of in processing

- The Detention Hospital Lab Tech will accession all lab orders and pre-print lab labels.
- A new medical record will be established for each new detainee at the in processing initial medical screening. See the In-processing Manual and Camp Delta Nursing SOP for medical chart organization.

- ❑ Place a tracking checklist on top of each chart.

Physical set up for the detainee in processing : Refer to In-processing manual

- ❑ Set up three to four phlebotomy stations.
- ❑ Set up three to four physical exam rooms.
- ❑ Place a small white board with the list of new detainee numbers in the admin office for tracking of chest films and medical issues (NAD means no active disease/TB).

Det #	Done	Read
8888	Yes	NAD

- ❑ Set up each exam room with a thermometer, BP cuff, stethoscope, reflex hammer, otoscope/opthalmoscope, unsterile gloves, surgi lube, dressing material, and bacitracin ointment.
- ❑ The Lab techs and Pharmacy techs will work in the pharmacy/lab room.
- ❑ The Pharmacy tech will ensure adequate supply of medications are on hand for in processing and will dispense Albendazole and the mefloquine for each detainee.
- ❑ The Lab tech will remain in the pharmacy/lab room to process collected specimens, assist with venipunctures and connect to the Portsmouth Naval Hospital lab via the Internet.
- ❑ In processing stations are:
    1) Check in , ID verification, Medical Record Issue
    2) Chest x-ray
    3) Phlebotomy, medication, immunizations & history taking station (include key mental health screening questions)
    4) Physical Exam room
    5) Height and weight
    6) Record and order review, Quality Assurance station.

The sequence of medical in processing flows as follows:

1. Detainee enters medical section of building from Army in-processing side accompanied by 2 MP's and a linguist. Detainee will continue to wear surgical face mask through out the medical processing stations (as TB protection for staff) until chest radiograph cleared by radiologist.
2. Verify detainee ID wristband and issue/ initiate medical record only after ID band verified.

IMPORTANT: To facilitate the final medical processing QA , each station will check off their section of the tracking sheet attached to the front of the medical record once the detainee has completed the station.

3. Chest radiograph.
4. Phlebotomy, 6 tubes of blood are required, 3 marble/red top (may substitute green, or yellow), 1 HIV, 1 lavender and 1 yellow serum tube.
5. A brief history of past and current illness, injuries, allergies, medications and mental health screening questionnaire is taken at the phlebotomy station.
6. Detainee is taken to an exam room for his physical exam.

7. Vitals are done & medications are given (Mefloquine, Albendazole) before the detainee leaves the exam room.
8. Tetanus and influenza vaccines are administered and PPD placed on forearm
9. Height and weight taken and recorded (BMI calculated later).
10. Radiologist reads chest x-ray before detainee leaves the building and if 'No Active Disease' (NAD) noted surgical face mask may be removed and disposed of. Also remove the scopolamine patch from behind ear (used to prevent airsickness during transit).
11. Perform quality assurance check on medical record. Verify that the detainee has stopped at each station, by checking the tracking sheet, before allowing the detainee's departure.
12. Detainee leaves the building through the medical side exit escorted by 2 MP's.

- **Personnel requirements:**
- 1 HM to check in detainee, verify ID band, and initiate/issue medical record
- 3-4 Physicians (for physical exams, this is the most time consuming section of medical processing)
- 1 Radiologist to review and read chest films (will be brought in TAD for event).
- 3-4 History takers /3-4 phlebotomists (not the lab techs)
- 2 lab techs (1 to process specimens, 1 for computer access to NMC Portsmouth)
- 2 Radiological techs (1 processes while the other shoots)
- 1 HM for Height and weight station
- 1-2 pharmacy techs to dispense the medications
- 1 HM to arrange for transport in the event of an admission to Detention Hospital
- 1 HM to perform medical record QA and compile consult list.

After detainee in-processing is completed:

- All new detainees will be added to the 0600 medication pass for their second dose of mefloquine.
- All new records are screened for active issues, follow-ups, additional labs, and consults.
- Any additional orders are taken and signed off by the nurse on duty.
- Verify all orders are entered in CHCS.
- All BMIs are calculated and entered into the medical record and in the weight management database.
- Any detainee with a BMI of less than 20 will be added to the Weight Program for weekly weight checks and will receive Ensure supplements TID.
- All detainees in processed will be added to the sitrep log as a new visit, entered in CHCS as a walk in appointment, the End of Day and the ADS completed.

DETAINEE OUT-PROCESSING

When a detainee is transferred off the island the Senior Medical Officer will ensure the completion of : a physical exam and medical summary, personal medical history sheet (in English & native language) and Southwest Asia Disease Information sheet (in English and Native language). These forms are forwarded in the medical package to the JTF Surgeon's office via the OIC. The original medical record is delivered to the DH Patient Admin for processing then forwarded to JTF Surgeon's office for archiving.

Cell Visits and Treatment (Emergent & Routine)

When Medical receives a call from the cell blocks or DOC that a detainee is acutely ill or has other sudden or emergent medical problem, a nurse, if available, or corpsman will take a "Jump Bag" (located in the supply room) and go to the detainee's unit and assess the need of medical treatment. This includes subjective and objective data analysis.

[redacted] b2

Routine sick call may be conducted in the cellblocks by the assigned corpsman. Each corpsmen will have with them the minimal sick call equipment and standard order medications when making rounds in their assigned blocks. They will document every patient encounter in the patient's chart on the Progress notes in SOAP format. The exception to this is when standard order medications are administered in the cellblocks, and then it is documented only in the patient's MAR.

In any case mentioned above, the SITREP Log and database must be filled out (Enclosures 6 and 7). A walk in appointment should be generated in CHCS per Enclosure 4 and a SOAP note must be written in the nursing note section of the patient's chart. This note will contain the chief complaint, subjective and objective data collected, analysis or problem identified, treatment given if any and plan of follow up care. All cell visits should be reported to the duty medical provider. Once the walk in appointment is completed, entering the ADS data per enclosure 5 will complete the visit.

The same documentation is required for scheduled cell visits for treatments such as wound care. Remember when in doubt chart it.

Tuberculosis Protocol and Documentation

All detainees will receive a chest x-ray and a PPD skin test during in-processing. The PPD will be administered in the left forearm. The documentation for detainees receiving a PPD is as follows: record the PPD on the second page of the Record of Immunization (SF 601). Ensure the date given and person who placed the PPD is charted. The PPD is read for results in 48 to 72 hours, it must be properly read by measuring area of redness and or induration. Documents results of the reading in millimeters on the SF 601.

All detainees presenting with a suspicious chest x-ray and/or other signs and symptoms of TB (persistent cough, bloody sputum, fevers, weight loss) will be placed in respiratory isolation in a laminar flow room at the Detention Hospital or if both respiratory isolation rooms at the Detention Hospital are occupied they will be admitted to the DACU or Respiratory Isolation Tent. All Respiratory isolation rooms will be tested by the Preventive Medicine Department (smoke test) prior to use and intermittently while in use.

Detainees placed in respiratory isolation will have three consecutive morning sputum samples collected for AFB smears. Please note that in the collection of this sputum, the detainees must produce the sample by coughing. Production of saliva is not acceptable for this test (refer to sputum collection instructions posted in Detention Hospital, consult with assigned Respiratory Therapy tech if sputum induction in required).

SITREP Log

The SITREP log is the primary record of all patient interactions with medical staff. It is crucial that every patient interaction; sick call, follow-up, dressing change, or any other

interaction (other than passing scheduled medications) be recorded. This provides an accurate account of patient care and workload. Once the log is filled out (example in enclosure 6), the data must be entered into the SITREP database. This is used to permanently track the number of interactions and can be used to show trends in detainee interactions with medical staff. To fill out this database, utilize enclosure 7.

Corpsman Duties and Responsibilities

During the daily operations, corpsmen shall be responsible for passing detainee medications under the supervision of an RN, performing field assessments and relaying findings to the duty nurse and provider. The duty nurse and provider will determine care priorities and "triage" the sick call requests for the day.

Corpsmen assigned to work the day shift will have specific blocks assigned to them. Each HM will be responsible for all the medical issues within their assigned blocks including dressing changes, sick call, medication passes, & weights. All corps staff must be competent at passing medications as evidence by the successful completion of the Medication Administration Qualifications. No corpsmen will be allowed to pass medications until properly trained by the medication training RN. Remain cognizant of the seven rights of medication administration:
RIGHT PATIENT, RIGHT MEDICATION, RIGHT DOSE, RIGHT ROUTE, RIGHT TIME, RIGHT DOCUMENTATION AND RIGHT PERSON PASSING MEDICATIONS.

Corps staff must not pass any medication they are not familiar with. They should know what the medication is, what it is used for, the proper dosing, and be knowledgeable of possible interactions, incompatibilities, side effects and adverse reactions.

If at any time a corpsman is not familiar with an assigned procedure or task he or she is expected to request the appropriate training from the nurse or provider before attempting.

Proper documentation is required for any detainee interaction. Be sure to enter why the interaction occurred, the subjective and objective findings made, the name of the provider notified of the interaction, the treatment administered if any and the response to the treatment. This documentation should be made in a SOAP format on the detainee's Progress Notes (SF509). Ensure that a medical provider or RN co-signs all entries. DO NOT FORGET TO DOCUMENT PAIN ASSESSMENT. Log all patient visits into the SITREP Log and as well as the SITREP Database.

24-Hour Medical Record Review and Daily SITREP Report

In order to prevent the inadvertent omission of orders transcribed to the Patient MAR. The night nurse will conduct a medical record review of all detainees seen at Camp Delta Clinic in the preceding 24-hour period. For all new orders, pull the MAR and ensure that all orders were transcribed correctly. Once completed, the nurse will write "CHART VERIFIED" below the last order entry and draw a horizontal line below the entry with a highlighter. Also verify the detainee's current cell location on the front of the chart and MAR with the daily updated Alpha Roster obtained from DOC (do this in pencil). New Alpha rosters are picked up from DOC each am, place previous day's Alpha roster in a Burn Bag for proper disposal.

Once the night nurse has verified all records, complete the daily SITREP report. To do this, utilize enclosure 11 and provided hard copy to: Senior Nurse, the Admin Chief by 0700 each morning (needed to completed JTF SITREP to SOUTHCOM).

Appointments and Follow-ups

Each morning the night shift Charge Nurse will pass down in report a list of detainees scheduled for follow up for that day. The detainees requesting sick call will be identified by block NCOs on the block sick call list entered via DIMS. The DOC will provide the block sick call lists to Delta Clinic prior to AM clinic. The lists is triaged by the RN and/or Provider on duty to determine patient care priorities. To aid in this process, pull the charts for those detainees that will be seen. All medical clinic or in the cell visits will have walk-in appointments booked through CHCS. To do this follow enclosure 4 and in the Reason for appointment area write in what the detainee was being seen for. Again make sure these visits are logged in the SITREP Database and CHCS per enclosures 7 and 4 respectively. After the appointment complete CHCS entry showing the result of the appointment and diagnosis ICD9 data (utilize enclosure 5.)

Every detainee clinic visit should have a set of vital signs taken (blood pressure, pulse, respiratory rate, temperature, pain assessment, and a pulse oximetry reading when indicated). Document vital signs on the SF509 filed on the right side of the record.

Transfers to Detention Hospital

Delta Medial Officer's have admitting privileges at both Detention Hospital and to the DACU at Naval Hospital GTMO.

[redacted] b(2)

Hunger / Thirst Strikes (refer to complete Hunger strike SOP)

In the event of a detainee hunger / thirst strike, DOC will notify medical when a detainee has refused hydration for [redacted] or has not eaten in [redacted] b(2) Otherwise, medical will be notified as detainees become symptomatic secondary to dehydration or starvation. (dizziness, lethargy, syncope or near-syncope episode, or inability to ambulate). In either case above, the detainee is brought to medical for medical screening. This screening includes a physical exam by a medical provider per Hunger and/or Thirst Strike Medical Evaluation Sheet (Enclosure 22). A Hunger / Thirst Strike Medical Flow Sheet (Enclosure 23) is also established. This form is used to document heart rate, mental status, status of detainee's eating / drinking, urinary output and weight. The detainee is educated on the risk of starvation / dehydration per enclosure 24. Note that this sheet is in English and a translator may be required. If after being educated on the risks of the hunger / thirst strike, the detainee still refuses to eat and/or drink, the detainee will be asked to sign the Refusal to Accept Food or Water/Fluids as Medical Treatment form (Enclosure 25) file in the SF 509 section of the detainee's medical record. Reassessment is performed every 24 hours.

Outpatient Medical Record

Medical record keeping and documentation of care delivered are important elements of the detainee medical mission.

Medical Records

It is recommended that forty pre-made records be kept readily available for processing new detainees.

To compile a new record (a go-by record is available in the file cabinet)
Obtain a new record jacket (located in the file cabinet)
The left side of the record shall have the following forms arranged from bottom to Top:

RECORD OF IMMUNIZATION (SF601 PAGE 2)
RECORD OF IMMUNIZATION (SF601 PAGE 1)
WEIGHT REGISTER (DD 2644)
STANDING ORDERS FOR DETAINEES
DOCTORS ORDERS (SF508)
PROBLEM SUMMARY LIST (NAVMED 6150/20)

c. The right side of the record shall have the following forms arranged from bottom to top:

REPORT OF MEDICAL EXAMINATION (SF88)
REPORT OF MEDICAL EXAMINATION (SF88 BACK PAGE)

*Note that this form has been altered with preprinted question for the TB protocol on the right side middle of the page.

REPORT OF MEDICAL EXAMINATION (SF93 PAGE 1)
INITIAL MEDICAL PROCESSING SCREENING
PROGRESS NOTES (SF509)

In addition to the basic record requirements, A MEDICATION ADMINISTRAION Record (MAR), and a DETAINEE CUSTODY FORM (DA4237 Page 2) shall be placed loosely in the center of the record. These forms will be completed during in-processing and filed in a separate location. The MAR will be filed in the MAR Book located by the medication lockers (The MARs are filed by cell block). The Detainee Custody Forms are collected after in-processing and turned in to the Army's in-processing office at the other end of the medical clinic.

Laboratory and Radiology Studies

Any printed out laboratory or radiological study results shall be filed behind the SF88 on the right hand side of the record. In the event a detainee has previously been admitted to the DACU, or Detention Hospital, copies of the detainee's inpatient record shall be filed on the right hand side of the detainee's outpatient record behind the laboratory results.

Transcribing Doctors Orders

Due to the high volume of detainees and the various treatment plans involved, accuracy in transcribing Doctors Orders is a critical element. Refer to Enclosures 9, 10A, and 10B for the transcribing of doctors orders onto the MAR (NAVMED 6550/8) and Enclosures 9. Please note that all orders should be initialed line for line on the Doctors order sheet (SF508) as noted to ensure no order is missed.

When taking off orders for medication, the order must be complete and include the medication name, dose, route, frequency and the period of treatment in number of days. Schedule any needed follow up appointments in the appointment book "To Be Done Book".

Physicians will place new orders in the 'New Orders' slot. The RN will read each order and carry it out before signing it off. All orders will be verified to be in CHCS when appropriate, i.e. labs, medications, radiological studies, etc. Any thing that goes in the 'To be done' book will be written in it by the nurse taking of the orders, i.e. follow up appointments, dental consults, optometry consults, labs to be drawn, etc.

A. Medication Administration Record (MAR)
The Medication Administration Record (MAR) is used to document the administration of all scheduled, PRN and one-time medications. To transcribe orders to this form from Doctors Orders (SF 508) utilize Enclosures 9, 10A, and 10B.
Enclosure 10A Section A is to be used to document scheduled medications. Ensure that the order date is filled out. This section should have the medication name, dose, route, frequency and treatment duration. If more than one medication is ordered, Draw a red line between each medication. When transcribing a MAR for the continuation of a medication, review the original order to verify transcription is correct. Never will a MAR be transcribed from another MAR without verifying the original order.

To ensure continuity of medication times the following frequency times are suggested to be used when transcribing orders to the Patient Profile and MAR:

TIMES TO BE GIVEN CAMP 4, Alpha block have specific times (see addendum)	
QD	0600
BID	0600 AND 1800
TID	0600, 1400, 2200
QID	0600, 1200, 1800, 2200
Q4	0400, 0800, 1200, 1600, 2000, 2400
Q6	0600, 1200, 1800, 2400
Q8	0800, 1600, 2400
QAM	0600
QPM	1800
QHS	2200
QAC	0700, 1100, 1700

NOTE MEDICATIONS THAT ARE PRONE TO CAUSE GI UPSET SHOULD BE GIVEN WITH FOOD. SCHEDULE ACCORDINGLY. Meals are delivered to detainees at 0800, 1200, and 2000.

MAR section B is to be completed by each person who delivers any medication to the patient. If the signature is not legible, print the name to the right side of the block.

MAR section C is to have the detainee's name and pseudo social security number. (D,JTF0***** on top, 888-0*-**** on the bottom).

MAR section D is used to document one time medication. Be sure to date and time this section upon completion of administering medication. As with section A, place a red line between each order.

MAR section E is used to Document PRN medication. In addition to completing the appropriate boxes in this section, a nursing note should be written to document the effects of the medication such as pain level decrease.

MEDICATIONS GIVEN BY THE IM OR SQ ROUTE IS ALSO DOCUMENTED IN THE MEDICAL RECORD WITH LOCATION OF THE INJECTION, PATIENT RESPONSE AND ANY ADVERSE REACTIONS.

Note: If the patient is in the clinic and the provider orders a one-time dose of medication, it can be documented on the SF 600. This will alleviate transcribing the order to a MAR.

Narcotics

Narcotic inventory is completed at each shift change. Professional nurses will account for and sign that all narcotics are present on Narcotic and Controlled Drug Inventory – 24 hour (NAVMED 6710/4). Each time a narcotic is used it will be logged out on the appropriate Narcotic and Controlled Drug Record (NAVMED 6710/1). In cases where only a partial dose is needed, annotate the drug, amount given, the amount wasted and the detainee's identification number on the back of the 6710/1.

III. Administrative Notes

A. Supplies

Supplies are ordered through the designated supply Petty Officer. Each shift leader is responsible for ensuring that required supplies are ordered and picked up in a timely fashion. The Leading Petty Officer is responsible to train all personnel regarding the supply ordering and tracking process. Further information about supplies can be found in the Detention Hospital Supply SOP.

B. Labs

Procedure for Procuring and Submitting Lab Specimens

1. Verify orders are in CHCS *before* going out to cell blocks to collect specimens.
2. Collect all supplies, take out to cell, and collect specimen using proper technique.
3. While still at cell, label specimen with Det. # and date/time (time must be accurate).
4. Upon return to clinic spin down all yellow & tiger top tubes 10 minutes @ highest speed.
5. Label all specimens (save unused left over labels and take to lab @ FH with specimens).
6. Log in all specimens (complete all sections of log).
7. Notify Lab tech of specimens.
8. If after hours, place specimens in designated lab refrigerator. Inform lab tech of all specimens placed in the refrigerator page lab tech if specimen in a 'stat". Page duty driver to courier specimen to NH GTMO lab so that tech can perform needed test.

005189

LAB KEYS FLOW CHART

Use this sequence ONLY when the labs have not been ordered and ONLY if drawing the lab immediately, preferably in the clinic.

☐Do the ?? to get to the menu that allows you to choose LAB
☐LAB
☐shift ^OLG
☐Enter patient's name
☐Requesting Location (Enter Camp Delta, select #3 for Primary Care)
☐Action: (select N for new orders)
☐Select HCP: (enter doctor requesting the test)
☐Order origin: (select H for handwritten orders)
☐Order set: (default is NO just hit enter)
☐Date/time: (enter N for now or enter correct date & time)
☐Collection Method: (enter W for ward/clinic collection)
☐Collection Priority: (default is ROUTINE just hit enter)
☐Processing Priority: (default is ROUTINE just hit enter)
☐Order comment: (at this time enter any comments that you would like to add or just hit enter)
☐Select test: (enter test to be ordered, once done just hit enter to exit screen)
☐Action: (enter Q to quit and activate the orders)
☐Hit enter until you get to the printer prompt: Enter delta-lab and you are done.

When labs are ordered & you only want labels: (should be most common one used)

☐Lab
☐shift ^LGO
☐Enter Detainee number
☐(all lab orders will come up) select tests you want labels for
☐Enter
☐Type date & time of collection , example: 24May@1310 (important that the time be accurate)
☐Type comment if needed, if not, just enter
☐Type Delta-lab for printer selection

If you have to re-print labels:

☐Lab
☐shift ^PLI
☐Enter Detainee number
☐Enter (default for today)
☐type in an earlier date (ex. 22may2002)
☐Enter (highlight should be at 'go')
☐Find labs you want labels for & copy down Accession area (letters) & accession number
☐Move highlight to 'exit'
☐Move highlight to 'exit' a second time
☐Shift ^RSL
☐At 'Accession area- type in the 2 or 3 letter code
☐At "accession number' type in the number
☐Type in Delta-lab for printer

C. Pharmacy

When a provider writes an order for a medication they will simultaneously enter the order into CHCS. Nurses will verify CHCS order entered when transcribing orders. It can take up to 1600 the following day for routine medications to be delivered from Naval Hospital GTMO to the clinic, so if the order is to start immediately, or the order is STAT page the Detention Hospital Pharmacy Technician.

Note: Floor stock can be ordered by calling the Detention Hospital Pharmacy Tech. Also, a daily 'Not in Stock' (NIS) list is to be generated by clinic staff and given to the Pharmacy Tech for action and follow up.

Listing of Enclosures

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

_____ _____
Officer In Charge Date

IMPLEMENTED BY:

_____ _____
Director for Administration Date

_____ _____
Senior Enlisted Advisor Date

ANNUAL REVIEW LOG:

By:_____ Date:_____
By:_____ Date:_____
By:_____ Date:_____
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SOP REVISION LOG:

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ENTIRE SOP SUPERSEDED BY:

Title:_____
SOP NO:_____ Date:_____

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 034

Page 1 of 3
Effective Date:

Title: Medical Department Training

SCOPE: Detention Hospital

Enclosure (1) – 2003 Detention Hospital Training Schedule

I. BACKGROUND:
Mission readiness is our priority and effective training remains central to that effort. The Detention Hospital provides medical treatment and healthcare services for detainees in support of Operation Enduring Freedom, as part of the JTF mission here in Guantanamo Bay. Safety and Security is the number one priority before any medical treatment is rendered to the detainee population. We work as a team with the MP's to accomplish our medical mission and constant training and vigilance is essential to ensure we remain mission focused, safe and effective as we conduct our daily operations in this maximum-security environment.

II. POLICY:
Our top priority is to maintain a trained and ready medical staff. Our training is focused on our mission essential tasks and are designed to prepare us for Mass Casualty, Emergency Response, and daily healthcare operations in the maximum-security environment of Camp Delta.

III. GENERAL PROCEDURES:

a. The Director for Administration is the designated Training Officer and is the primary point of contact for coordination of all training evolutions. The Director for Administration Leading Chief Petty Officer is the assistant Training Officer.

b. The Training Officer, in coordination with directorates and OIC is responsible for developing a formalized six-week required training schedule for all Detention Hospital personnel. Training will be conducted every Thursday from 0900-1100 for all Hands. Clinic schedules will be adjusted to ensure maximum participation in the weekly training. The training plan will include both command training (for all Hands) and clinical training for the emergency response team (ERT).

c. Training topics will be selected to maximize situational awareness, emergency response and readiness at Camp Delta realizing that constant effective training is the key to our mission success.

d. The Training Officer will maintain training files and training database to accurately reflect completion of scheduled training.

STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge _____ Date _____

IMPLEMENTED BY:

Director for Administration _____ Date _____

Senior Enlisted Advisor _____ Date _____

ANNUAL REVIEW LOG:

By: _____ Date: _____
By: _____ Date: _____
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ENTIRE SOP SUPERSEDED BY:

Title: _____
SOP NO: _____ Date: _____

DETENTION HOSPITAL TRAINING SCHEDULE
2003

30JAN:
- HIV BLOOD DRAW

6FEB: COMMAND TRAINING
- Radio Communications training (frequency, channels, radio etiquette)

EMERGENCY RESPONSE TEAM TRAINING
- Airway Management
- Oxygen Delivery, Regulators, Tanks, Ambu usage/adjuncts

13FEB: COMMAND TRAINING
- Fire Plan / Bomb Threat Plan Review

EMERGENCY RESPONSE TEAM TRAINING
- AED Training

20FEB: COMMAND TRAINING
- OPSEC Update

EMERGENCY RESPONSE TEAM TRAINING
- Crash Carts/ Code Blue Drills/ BLS/ACLS

27FEB: COMMAND TRAINING
- Safety & Security Brief by JDOG

EMERGENCY RESPONSE TEAM TRAINING
- Litter Bearing/C-Spine Immobilization

6MAR: COMMAND TRAINING
- Infection Control Brief/ Performance Improvement Brief

EMERGENCY RESPONSE TEAM TRAINING
- Triage Principles

13MAR: COMMAND TRAINING
- CDO Training

EMERGENCY RESPONSE TEAM TRAINING
- Primary & Secondary Survey

Encl (1)

20MAR: COMMAND TRAINING
- Force Protection

EMERGENCY RESPONSE TEAM TRAINING
- MASS CAS

27MAR: COMMAND TRAINING
- Sexual Harassment Prevention/ Fraternization

EMERGENCY RESPONSE TEAM TRAINING
- Allergic Reactions/ Treatment of Anaphylaxis

DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA

SOP NO: 035

Title: GUIDELINES FOR ROLE OF INDEPENDENT DUTY CORPSMEN

Effective Date: 04 Mar 03

SCOPE: Detention Hospital

Ref:
(a) OPNAVINST 6400.1B
(b) BUMEDINST 4651.3 Series

Encl:
(1) US Naval Hospital, Guantanamo Bay, IDC Physician Supervisor Handbook
(2) OPNAVINST 6400.1B, Appendix A
(3) Authorized Prescribing List for Independent Duty Hospital Corpsmen

I. PURPOSE:

To establish policy and assign responsibility for the re-certification, training and use of Independent Duty Hospital Corpsmen (IDCs) per reference (a).

II. BACKGROUND:

IDCs are integral and important components of the Navy Health Care Team whose mission is to care for Sailors and Marines independent of a Medical Officer. In addition, they also routinely fill leadership, training and administrative positions.

III. APPLICABILITY AND SCOPE:

This instruction applies to all Detention Hospital Guantanamo Bay IDCs IAW reference (a).

IV. POLICY:

IDCs will be assigned to clinical duties consistent with their skills, expertise, experience and needs of the command. Training must be ongoing and designed to prepare them to

fulfill this challenging role. Enclosure (1) outlines the periodic evaluations required for each IDC.

(a) Prior to assignment to clinical duties with indirect supervision, all IDCs will complete the initial evaluation period IAW reference (a). Upon satisfactory completion of clinical training and direct supervision, each IDC will be re-certified.

(b) The Physician Supervisor will document all training (CEU's, correspondence courses and college credits) on the quarterly report that is sent to the IDC Program Director. Additionally, the IDC Physician Supervisor will review enclosure (1) to determine what clinical competencies have been completed and the IDCs progress towards completing all clinical competencies prior to detaching the MTF for a PCS transfer.

(c) IDCs are required to complete 12 CEU's annually. Reference (b) provides guidance as to how this may be accomplished. The Command will make every effort to allocate sufficient funds to allow IDCs the opportunity to attend professional conferences. The Staff Education and Training Department will advise the IDC Program Director of training opportunities.

V. APPOINTMENTS:

The Commanding Officer will appoint in writing the IDC Program Director, IDC Program Manager, a Physician Supervisor and alternate Physician Supervisor. The qualification and responsibilities of these persons are itemized in reference (a). Additionally:

(a) The IDC Program Director will conduct quarterly review of the IDC program to ensure compliance with applicable directives.

(b) The IDC Program Manager will ensure IDCs have completed re-certification and appropriate letters and Page 13 entries are made.

(c) The IDC Physician Supervisor ensures quality care is provided by the IDC as per Ref.1.

VI. ACTION:

The following is a list of duties and responsibilities for all IDCs assigned to the MTF.

(a) After completing the initial evaluation period IDCs may attend to patients following the defined level of supervision.

(1) Active Duty: Indirect supervision.
(2) All others: Direct supervision.

(b) IDCs will prescribe medication authorized by the formulary in accordance with enclosure 1. A copy of the Authorized Prescription List will be placed in the IDC training record.

(c) For a non-active duty patient presenting at the Medical Liaison Office, the IDC will contact the Physician Supervisor before implementing or changing a regimen of care except in cases of dire emergencies.

(d) IDCs will not give over the phone consultation.

Authorized prescribing list for Independent Duty Hospital Corpsmen

You are authorized to prescribe medication from the hospital formulary except for the following general classes of medications:

Disease modifying anti-rheumatics
Intravenous antibiotics and intravenous antifungals
Anti-coagulants and other hematological agents excluding aspirin
General anesthetics, intravenous sedatives, and neuromuscular blocking agents
Antidotes
Systemic obstetrical and gynecologic agents excluding birth control
Androgens, pituitary hormone agonists and antagonists
Antineoplastics
Chapter 2 Cardiovascular Agents excluding antihypertensives and diuretics
Immunoglobulin
Chapter 3 Neurologic agents excluding migraine therapy
Chapter 4 Ophthalmic steroids and glaucoma agents
Psychiatric agents excluding nicotine, zolpidem, and disulfiram
Schedule II medications

You should not prescribe any medication clearly outside your clinical expertise or ethical practice.

STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer in Charge _____ Date

IMPLEMENTED BY:

Director for Administration _____ Date

Chapter 5 Senior Enlisted Advisor _____ Date

ANNUAL REVIEW LOG:

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ENTIRE SOP SUPERSEDED BY:

Title:
SOP NO: Date:_____

005202

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA Title: GUIDELINES FOR ROLE OF PHYSICIAN ASSISTANTS	SOP NO: 036 Page 1 of 100 Effective Date: 04 Mar 03
SCOPE: Detention Hospital	

Ref:

(a) SECNAVINST 1120.813
(b) SECNAVINST 1301.4
(c) MANMED Chapter 2
(d) MANMED Chapter 21
(e) BUMEDINST 6550.12
(f) BUMEDINST 6320.6613
(g) MANMED Chapter 15

Encl:

(1) Officer-in-Charge Ltr to Physician Assistant
(2) Authorized medication list
(3) Letter of Appointment, Primary Physician Supervisor
(4) Letter of Appointment, Secondary Physician Supervisor

I. PURPOSE:

Per references (a) through (g), this instruction establishes guidelines for the role of Physician Assistants (PAs) at Detention Hospital, Guantanamo Bay, Cuba.

II. BACKGROUND:

The selection and training of PAs for the purpose of improving primary care roles was undertaken as a result of a shortage of primary care medical officers. In July 1971, the decision was made to train a cadre of PAs for the purpose of improving patient access to the primary care system and lessening the use of highly trained specialists in primary care roles. Since that time, PAs have become an integral part of the Navy health care team, contributing a valuable admixture of comprehensive and relevant training, substantial experience with the military and the military health care delivery system, and a practical and highly effective approach to patients' problems. PAs are now a part of an entirely new level of health care providers. Although the status of PAs has changed, the fundamental objective of the PA community has not changed: to enhance the delivery of quality care to our beneficiaries in a cost-effective manner.

II. DEFINITIONS:

a. Physician Assistant (PA). Per reference (e), PAs are health care professionals who have successfully completed a physician assistant training program recognized by BUMED, and are certified by the National Commission on the Certification of Physician Assistants. PAs are credentialed and privileged to practice medicine with physician supervision. Common services provided by a PA include taking medical histories and performing physical examinations; ordering and interpreting laboratory tests; diagnosing and treating illnesses; assisting in surgery; prescribing and dispensing medication; and counseling patients. PAs are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs. Because of the close working relationship PAs have with physicians, they are educated in the medical model designed to complement physician training. Upon graduation, PAs take a national certification examination developed by the National Commission on Certification of Physician Assistants (NCCPA) in conjunction with the National Board of Medical Examiners.

b. Primary Care. Primary care is a type of health care delivery, which emphasizes first contact care and assumes ongoing responsibility for the patient in both health maintenance and therapy of illness. This personal care involves a unique interaction and communication between the patient and the health care provider. Primary care is comprehensive in scope and includes the overall coordination of the patient's health care, whether this is preventive or curative, and where the sphere of involvement is biologic, behavioral, or sociologic. Appropriate use of consultants and community resources is an important part of effective primary care.

IV. DUTIES AND RESPONSIBILITIES OF PAs:

a. General

(1) Although PAs exercise a substantial degree of independence in the performance of their duties, they must, by definition, function with the supervision of a doctor of medicine or osteopathy when performing medical services.

(2) PAs are qualified by training and experience to provide primary care and should be so assigned.

(3) In addition to the PA core privileges, the OIC may grant PAs specialty supplemental privileges when the need for the PA's services in that specialty exists, and when the credentials for that PA confirm current competency for supplemental privileges. A PA may obtain competencies by completing a post baccalaureate degree in that specialty or by completing a formalized training program within a medical treatment facility.

(4) PAs may be granted admitting privileges under reference (e). However, under the current setting of detainee care, there is currently no mechanism for PAs to admit or assist in the care of inpatients.

(5) PAs may perform physicals following reference (g).

(6) PA's will adhere to JTF GTMO uniform standards for Detainee Operations; woodland camouflage uniform with sewn on devices worn with sleeves rolled down and name tapes covered when working with detainees.

(7) PAs must sign the medical record of each patient examined, treated, or referred for treatment, and print or stamp his or her name, grade, title, and the last four numbers of the social security number, beneath the signature.

(8) Evaluation of the quality of care provided by every PA in a clinical billet should be included in every fitness report submitted.

(9) PAs must maintain close ties with the Medical Service Corps (MSC) community to remain competitive in their corps. This is best accomplished by participating in scheduled MSC meetings and functions.

b. Specific

(1) Each PA will be granted clinical privileges following the provisions of reference (f).

(2) PAs are authorized to write prescriptions under the provisions contained in reference (d). Enclosure (2) defines prescribing guidelines for this facility.

V. FACILITY PA PROGRAM RESPONSIBILITIES:

A program director (generally the senior PA) will be appointed to coordinate the PA program. Responsibilities include:

a. Ensure primary and alternate physician supervisors are assigned by the OIC and that letters of appointment are generated.

b. Review the newly arriving PA's duties and responsibilities with them to ensure clarity.

c. Provide a structured orientation for assigned physician supervisors.

d. Monitor compliance of the program with the pertinent instructions.

e. Monitor compliance with the required peer reviews.

f. Review pertinent instructions annually for currency.

VI. SUPERVISION OF PAs:

The PA should be fully integrated into the primary care team and should be expected to exercise a substantial degree of clinical judgment in ordering studies, requesting consultations, rendering diagnoses, and formulation and initiation of treatment plans: An open, informal exchange of information between PA and physicians is necessary. The formal requirement for supervision and review of the clinical work of a PA by a specific physician derives from many sources and is reaffirmed by reference (e).

a. A physician must be appointed in writing, utilizing enclosure (3), to supervise and formally review the patient care rendered by each PA. Continuity of supervision must be ensured. An alternate physician will be appointed, utilizing enclosure (4), to assume the supervisory responsibilities in the absence of the regularly appointed supervisor.

b. When the PA is involved in watch standing duties (e.g., after hour acute care clinic) the physician in charge of the watch area will assume supervisor duties.

c. A physician will not be appointed responsibility for supervision of more than three nonphysician providers.

d. Physicians assigned supervisory responsibility must be fully credentialed and privileged and actively engaged in the same category of health care delivery as the PA to be supervised.

e. The supervising physician will conduct random record reviews and peer review the quality of care provided. A minimum of 10 records per month will be reviewed via established peer review processes and each record reviewed will be co-signed. A copy of all reviews will be forwarded to the PA Program Director who will ensure the PA receives a copy. Documentation of the record reviews will also be forwarded for retention by the Credentials Committee of the PAs home command.

f. Physicians appointed supervisory responsibility will be provided a structured orientation by the PA program Director. The orientation will describe the training, experience and background of Navy PAs as well as the general duties and responsibilities of PAs. It will also clearly define all related administrative and professional supervisory and review responsibilities of the supervisor.

g. The supervising physician must participate in the initial granting and subsequent reappraisal of clinical privileges. He or she must be advised of credentialing action taken in the case of the PAs being supervised and must communicate promptly through the chain of command to the Credentials Committee any concern that credentials granted may not be appropriate.

VII. CONTINUING MEDICAL EDUCATION (CME) AND PA CERTIFICATION:

Each PA must attain and maintain national certification through the NCCAP. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for recertification every six years. CME may be obtained through in-service training, correspondence course programs, and continuing education conferences in the command. Active membership in appropriate professional organizations is encouraged.

005206

From: Officer in Charge, Detention Hospital, Guantanamo Bay, Cuba
To: (PA)

Subj: ASSIGNMENT OF PHYSICIAN ASSISTANT DUTIES AND SUPERVISOR

Ref (a) NAVAMBCARECENNPTINST 6322.3C
(b) BUMEDINST 6550.12
(c) BUMEDINST 6320.66B

1. You are being assigned to the Delta Clinic and will perform general primary care duties per reference (a).

2. During this assignment, (Primary Supervisor) has been designated to serve as your Primary Physician Supervisor per references (a) through (c). (Alternate Supervisor) has been designated as your Alternate Physician Supervisor per references (a) and (c) and will serve in the absence of your Primary Supervisor.

3. Your designated Physician Assistant Supervisor has been directed to provide ongoing review of, and assistance with, your delivery of health care to detainees at this facility. Your supervisor has been specifically directed to meet with you on a periodic basis and review your clinical practice and medical record documentation.

4. The Physician Assistant Program Director will meet with you and your assigned supervisors to review the Physician Assistant Program, provide a copy of reference (a) and review the authorized medication list from which you may prescribe.

5. You must be familiar with the provisions of reference (a) to ensure that all of the supervision and review requirements of this directive are fulfilled.

(OFFICER IN CHARGE)

Enclosure (1)

005207

MEMORANDUM

From: (PA Program Director)
To: Officer in Charge
Via: Chairman, Pharmacy and Therapeutics Committee

Subj: AUTHORIZED MEDICATION LIST FOR PHYSICIAN ASSISTANT (PA)

1. (PA) will have full access to the Detention Hospital formulary with the following recommended exceptions:

PROHIBITED DRUGS (MAY NOT BE PRESCRIBED)

ALCOHOL
BUSULFAN (MYLERAN)
CYCLOPHOSPHAMIDE (CYTOXAN)
FLUROURACIL (EFUDEX)
HYDROXYUREA (HYDREA)
MELPHALAN (ALKERAN)
VINCRISTINE
SUCCINYOCHOLINE CHLORIDE
BETHANECHOL
CLOMIPHENE (CLOMID)
FLUCYTOCINE (ANOCOBON)
HEPARIN SODIUM (HEPARIN)
LITHIUM (ESKALITH)
QUINACRINE
TUBOCURARINE CHLORIDE
PROTAMINE SULFATE

DRUGS WHICH MAY BE INITIATED WITH COUNTERSIGNATURE OF A LICENSED PHYSICIAN AND REFILLED WITHOUT COUNTERSIGNATURE

AMPHOTERICIN (FUNGIZONE)
DIGITALIS TYPES
ETHAMBUTOL (MYAMBUTOL)
THYROID
GUANETHIDIDE (ISMELIN)
PROPYLTHIOURACIL (PTU)
RESERPINE
ISOPROTERENOL (ISOPREL)
METHIMAZOLE (TAPAZOLE)
METHYSERGIDE MALEATE (SANSERT)
PHENOBARBITAL
STREPTOMYCIN
OPHTHALMIC STERIODS
BROMOCRIPTINE
CHLORAMEPHENOCOL (CHLOROMYCETIN)
PHENYTOIN (DILANTIN)
FUROSEMIDE (LASIX)
GENTAMICIN (EXCEPT OPHTHALMIC)
PROCAINAMIDE (PRONESTYL)
QUINIDINE
INSULIN
ISOSORBIDE DINITRATE (ISORDIL)
METHOTREXATE
NITROGLYCERIN
RIFAMPIN (RIMACTANE)
PREDNISONE *
ANDROGENS
WARFARIN SULFATE (COUMADIN)

Enclosure (2)

005268

Subj: AUTHORIZED MEDICATION LIST FOR PHYSICIAN ASSISTANT (PA)

*** Prednisone is limited to short term use but may be initiated without countersignature for control of inflammatory and allergic reactions**

All other drugs may be initiated and refilled

2. (PA) may also have access to non-formulary items in medication categories not otherwise excluded by paragraph 1.

3. Once approved, copies will be distributed in accordance with reference (a) by the Physician Assistant Program Director.

(PA PROGRAM DIRECTOR)

005269

From: Officer in Charge, Detention Hospital, Guantanamo Bay, Cuba
To: (Physician)

Subj: ASSIGNMENT AS A PRIMARY PHYSICIAN ASSISTANT SUPERVISOR

Ref: (a) NAVAMBCARECENNPTINST 6322.3C
(b) BUMEDINST 6550.12
(c) BUMEDINST 6320.6613

1. Per references (a) through (c), you have been assigned as the Primary Physician Assistant Supervisor for (PA). The Alternate Physician Supervisor is (physician), who will assume your responsibilities in your absence.

2. As the Primary Physician Assistant Supervisor, you must supervise and formally review the patient care rendered by (PA) per reference (a) requirements.

3. The Physician Assistant Program Director will provide a formal orientation for you regarding your responsibilities. At that time, you will receive a copy of reference (a) that defines the Physician Assistant Program at this facility and a copy of (the assigned PA) clinical privileges and authorized medication list. You should become thoroughly familiar with these and keep them on file for ready reference.

4. In a separate letter of assignment, the Physician Assistant is notified of your assignment as the Primary Physician Supervisor.

(OFFICER IN CHARGE)

Enclosure (3)

005210

From: Officer in Charge, Detention Hospital, Guantanamo Bay, Cuba
To: (Physician)

Subj: ASSIGNMENT AS AN ALTERNATE PHYSICIAN ASSISTANT SUPERVISOR

Ref: (a) NAVAMEDCARECENNPTINST 6322.3C
(b) BUMEDINST 6550.12
(c) BUMEDINST 6320.6613

1. Per references (a) through (c), you have been assigned as the Alternate Physician Assistant Supervisor for (PA).

2. As the assigned Alternate Physician Assistant Supervisor, you must supervise and formally review the patient care rendered by (PA) in the absence of (Physician), his/her Primary Supervisor.

3. The Physician Assistant Program Director will provide a formal orientation for you regarding your responsibilities. At that time, you will receive a copy of reference (a) that defines the Physician Assistant Program at this facility and a copy of (the assigned PA) clinical privileges and authorized medication list. You should become thoroughly familiar with these and keep them on file for ready reference.

4. In a separate letter of assignment, the Physician Assistant is notified of your assignment as the Alternate Physician Supervisor.

(OFFICER IN CHARGE)

Enclosure (4)

005211

STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

_____ _____
Officer In Charge Date

IMPLEMENTED BY:

_____ _____
Director for Administration Date

_____ _____
Senior Enlisted Advisor Date

ANNUAL REVIEW LOG:

By:_____ Date:_____
By:_____ Date:_____
By:_____ Date:_____
By:_____ Date:_____
By:_____ Date:_____
By:_____ Date:_____

SOP REVISION LOG:

Revision to Page:_____ Date:_____
Revision to Page:_____ Date:_____
Revision to Page:_____ Date:_____
Revision to Page:_____ Date:_____
Revision to Page:_____ Date:_____
Revision to Page:_____ Date:_____

ENTIRE SOP SUPERSEDED BY:

Title:_____
SOP NO:_____ Date:_____

005212

CARDIAC ARREST PROCEDURE(S)

DETENTION HOSPITAL
GUANTANAMO BAY, CUBA

Title: CARDIAC ARREST PROCEDURE(S) AT CAMP DELTA

SOP NO: 060

Page 1 of 21
Effective Date: April 2004

SCOPE: Detention Hospital, Delta Clinic, Block Area, Reservations

I. REFERENCES:

a) Emergency Medical Response Standard Operating Procedure #059

II. PURPOSE:

To outline the standard operating procedure regarding emergency medical response to personnel and detainees at Camp Delta and to define the cardiac arrest (Code Blue) criteria for activating the Emergency Medical Response Team while identifying the personnel who will respond. This Standard Operating Procedure document is intended to deal with individual cases and not mass casualty situations although some of the same principles may apply.

III. POLICY:

The detainee outpatient clinic located at Camp Delta under the auspices of Fleet Hospital 20 will function at the Battalion Aid Station level. The Detention Hospital and Delta Clinic are intended for providing care to detainees only. However, emergency medical care may be rendered to U.S. personnel pending arrival of Emergency Medical Services from the Naval Hospital, Guantanamo Bay (GTMO). Otherwise, Joint Task Force personnel are to receive care in the Joint Aid Stations (JAS) set up for that purpose or the U.S. Naval Hospital. Definitive emergency medical care for detainees will be rendered in the Detention Hospital or the Detainee Acute Care Unit (DACU) located in the U.S. Naval Hospital based on clinical acquity and availability of necessary resources.

IV. CAMP DELTA PROCEDURES:

1. In the event of an emergency involving a member of the Joint Task Force, the following will apply:

- A medical "Code Blue" will be announced on the radio. [redacted] b(2)
- Medical personnel at Camp Delta will respond initially to the medical call to render immediate aid [redacted] b(2) b(2)
- [redacted] b(2)
- Medical personnel at Camp Delta will "package" patient on backboard or litter with all necessary precautions to prevent further injury as may be indicated by the clinical condition and mode of injury. [redacted] b(2) b(2)

005213

2. **At Detention Hospital:**

- The Registered Nurse (RN) or designee will call Delta Clinic [redacted] to report cardiac arrest (Code Blue) and request activation of Emergency Medical Response team.
- Page Duty Medical Officer (refer to on Call schedule for numbers). If no answer from Medical Officer, call GTMO Naval Hospital ER Medical Officer at [redacted]
- Bring Crash Cart to scene to initiate CPR (ABCs, Airway, Breathing, Circulation).

The following list of personnel is available 24 hours/day, 7 days/week, and will respond to all cardiac arrest(s) in Detention Hospital, Delta Clinic, Blocks, Reservations, and Tribunal Hearing areas:

- Duty Medical Officer, by pager. If no call returned, call GTMO Naval Hospital ER Medical Officer at [redacted]
- Detainee Operations Center (D.O.C) [redacted]
- Registered Nurse
- Emergency Response Teams #1 (Delta Clinic) and #2 (Detention Hospital) from Delta Clinic (4 assigned Corpsman):

  a) *Red Resuscitative Jump Bag*
  b) *Automated External Defibrillator (AED)*
  c) *Respiratory Bag*
  d) *ACLS Medication Box*

- [redacted]
- [redacted]
- [redacted]
- Director of Nursing Services (DNS)

*During normal duty hours the following will be notified. After hours they may be notified by pager or phone.

[redacted]

At Delta Clinic:

- The Registered Nurse (RN) or designee will announce "Code Blue" over radio and request activation of
- Emergency Response Team (ERT #1 - 2 assigned Corpsman).
- Page Duty Medical Officer. If no call returned, call GTMO Naval Hospital ER Medical Officer [redacted]
- Bring Crash Cart to scene to initiate CPR (ABCs, Airway, Breathing, Circulation).

The following list of personnel is available 24 hours/day, 7 days/week, and will respond to all cardiac arrest(s) in Detention Hospital, Delta Clinic, Blocks, Reservations, and Tribunal Hearing areas:

- Duty Medical Officer, by pager. If no call returned, call GTMO Naval Hospital ER Medical Officer at [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- Director of Nursing Services (DNS)

*During normal duty hours the following will be notified. After hours they may be notified by pager or phone.

In as specific Camp (1, 2, 3, 4) and/or in a specific Block area(s):

- **First responder on the the scene should call for help by using radio saying "Medical, Medical Code Blue [redacted] b(2)**
- **Notify Duty Medical Officer, by pager. If no call returned, call GTMO Naval Hospital ER Medical Officer at [redacted] b(2)**
- **A lockdown of all the units will be done and an accounting of all detainees will quickly be performed by Detainee Operation Center (DOC) and security staff.**
- **[redacted] b(2)**
- **Emergency Medical Response Team #1 and #2 [redacted] will respond to all cardiac arrests with:**

  a) ***Red Resuscitative Jump Bag***
  b) ***Automated External Defibrillator (AED)***
  c) ***Respiratory Bag***
  d) ***ACLS Medication Box***

- **[redacted] b(2)**
- **Assess for unresponsiveness and ABCs (Airway, Breathing, Circulation).**
- **If detainee is unresponsive without pulse, position on backboard and initiate CPR for 1 minute.**
- **Transport Detainee via backboard to the causeway STAT, apply AED, shock as advised.**
- **Reassess pulse, if no pulse, continue CPR and follow ACLS algorithm(s) as needed until Detainee is stabilized or pronounced 'dead' by Medical Officer.**
- **Continue to communicate with Delta Clinic on detainee status via radio [redacted] b(2)**

Documentation of Cardiac Arrest shall be documented on the Advanced Cardiac Life Support Flow Sheet and shall include (at a minimum):

- **Condition of patient prior to code blue, if known**
- **Time onset of code blue**
- **Time onset of CPR**
- **Time and watts at which patient was defibrillated**
- **Continuous monitor strips**
- **Time medications are given**
- **Response to medications**
- **Time of resuscitation**
- **Names of personnel responding**
- **Time Emergency Medical Response was terminated or time of death**
- **Time the patient(body) was released to the morgue**
- **Any other important event**

***Immediately after the Emergency Response Team is called, the cart will be restocked. Pharmacy will be notified to restock any medications needed. Any supplies that need to be restocked will be obtained from the supply room and/or ISO container. All equipment will be cleaned or sterilized appropriately.**

CARDIAC ARREST PROCEDURE(S) SOP: 060

BLS/ACLS DRILLS:

Cardiac Arrest (Code Blue) Drills can be performed twice a month randomly at various locations by the Registered Nurse assigned to Delta Clinic, or Crash Cart Officer. Locations that drills can be performed:

Detention Hospital
Delta Clinic
Training Block
Reservations (yellow, brown, blue, orange, or gold buildings)

Code Blue Critiques of the Corps staff and other applicable staff will be completed by the RN and documented on the critique form(s). The RN will place the one copy of the completed critique in the Crash Cart book and one copy in the DNS folder.

SOP Issued: 2/2/04
Resubmitted: 3/9/04
4/9/04

[redacted] b(6)
CRASH CART OFFICER

AUTOMATED EXTERNAL DEFIBRILLATION (AED) FOR NON-ACLS PERSONNEL

1) Establish pulselessness
2) Contact Delta Clinic or Detention Hospital and call "Code Blue"
3) Start CPR utilizing BVM and 100% O2.
4) Turn AED on
5) Attach electrodes
6) Analyze rhythm

If shock indicated:
- give (3) "stacked shocks"
- continue CPR for (1) minute
- maintain airway control utilizing **ADVANCED AIRWAY PROTOCOL** and establish IV access
- ***Epinephrine*** 1:10,000 1mg IVP (N) or 2.5 mg ETT (N) q 3-5 min
- analyze rhythm
- give (3) "stacked shocks" if needed
- continue CPR for (1) minute
- ***Vasopressin*** 40 units IV x 1 dose (N) [wait 5-10 mins before starting Epinephrine]
- analyze rhythm
- give (3) "stacked shocks" if needed
- continue CPR for (1) minute
- ***Amiodarone*** 300 mg IVP (N) (may repeat once 150mg in 3-5 mins-max 2.2g IV/24 hrs)
(OR)
- ***Lidocaine*** 1-1.5 mg/kg IVP (N) or 2-3 mg ETT (N) to a maximum of 3 mg/kg
- analyze rhythm
- give (3) "stacked shocks" if needed
- continue CPR, monitoring and delivering drug, shock, drug, shock, etc.

If no shock indicated:
- continue CPR
- maintain airway control and establish IV access
- ***Epinephrine*** 1:10,000 1mg IVP (N) or 2.5mg ETT (N) q 3-5 min
- continue CPR
- ***Atropine*** 1mg IVP (N) or 2mg ETT (N) q 5min (max of 3mg)

- continue CPR, monitoring with AED and proceed to "If shock indicated" if shock

7) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**

8) Continue to monitor, transport to GTMO Naval Hospital ER, and contact MO ASAP for medical oversight.

Enclosure (1)

005217

POST RESUSCITATION

1) Assure ABC's

2) Assess heart rate:
   - if heart rate < 60 bpm, got to **BRADYCARDIA PROTOCOL**
   - if heart rate > 150, go to **NARROW or WIDE TACHYCARDIA PROTOCOL**

3) If patient is hypotensive and lung sounds are clear:
   - give 250ml NS bolus(s) to maintain SBP > 90 mmHg
   - consider *Dopamine* 5-10 mcg/kg/min to maintain SBP > 90 mmHg if unresponsive to fluid bolus(s)

4) If patient V-FIB or V-TACH during resuscitation:
   - give *Lidocaine* 1.5 mg/kg slow IVP (N) over 2 minutes (if not previously given) •
   - start *Lidocaine* drip at 2-4 mg/min

5) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

• Give ½ dose in patients with impaired liver function, left ventricular dysfunction or > 70 yo

EMERGENCY CARDIAC CARE PROTCOLS FOR ACLS PROVIDERS

VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA

* Give ½ dose in patients with impaired liver function, left ventricular dysfunction or >70 yo

1) Establish pulselessness

2) Contact Delta Clinic or Detention Hospital and call "Code Blue"

3) EKG monitor

4) Defibrillate at 200J, 300J, 360J

5) CPR with BVM and 100% O2

6) Maintain airway utilizing ADVANCED AIRWAY PROTOCOL

7) Obtain venous access

8) *Epinephrine* 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5min

9) Continue CPR

10) Defibrillate at 360J

11) *Vasopressin* 40 units IV x 1 dose (N) [wait 5-10 mins before starting epinephrine]

12) Continue CPR

13) Defibrillate at 360J

14) *Amiodarone* 300 mg IVP (N) [may repeat once 150 mg in 3-5 mins] (maximum 2.2g IV/24 hrs)

(OR)

15) *Lidocaine* 1-1.5mg/kg IVP (N) or 3mg/kg ETT (C)/(N) *

16) Continue CPR

17) Defibrillate at 360J

18) *Lidocaine* 1.5mg/kg IVP (N) or 3mg/kg ETT (C)/(N) * (maximum 3mg/kg)

19) Continue CPR

20) Defibrillate 360J

21) Continue "drug-shock" sequence with defibrillation every 30-60 seconds after drug administration

22) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**

23) Continue to monitor, transport to clinic, and call MO ASAP for medical oversight

TACHYCARDIA- WIDE COMPLEX

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) 3-lead EKG monitor

4) If pulse > 150 bpm with signs of altered mental status or hypoperfusion:
   - synchronized cardioversion (100J, 200J, 300J, 360J) *

5) Obtain vascular access

6) 12 Lead EKG

7) Amiodarone 150mg IV over 10 mins (15 mg/min)
   (may repeat rapid infusion 150mg q 10 mins as needed)

8) *Lidocaine* 1-1.5 mg/kg slow IVP (N) over 2 min **
   OR

9) If rhythm does not spontaneously convert to sinus within 10 min:

   - *Lidocaine* 0.5-0.75 mg/kg slow IVP (N) over 2 min **

10) If patient becomes pulseless, go to **VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA PROTCOL**

11) If patient develops sign of altered mental status or hypoperfusion:
   - synchronized cardioversion (100J, 200J, 300J, 360J) *

12) If patient converts to sinus rhythm, start *Lidocaine* drip 2-4 mg/min

☐ Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

* If possible, provide sedation with analgesia:
   - *Versed* 1-2mg IVP (N)
   - *Morphine Sulfate* 2-4mg IVP (N)

** Give ½ dose in patients with impaired liver function, left ventricular dysfunction or > 70 yo

TACHYCARDIA- NARROW COMPLEX

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) 3-lead EKG monitor

4) If pulse > 150 bpm with signs of altered mental status or hypoperfusion:
   - synchronized cardioversion (100J, 200J, 300J, 360J) *
   - if pulseless got to appropriate protocol

5) Obtain vascular access

6) 12 Lead EKG

7) If pulse > 150 bpm and without signs of hypoperfusion, attempt vagal maneuver **

8) If signs of deteriorating mental status or hypoperfusion present
   - synchronized cardioversion (100J, 200J, 300J, 360J) ***
   - if pulseless go to appropriate protocol

9) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

* May start at 50J for Atrial Flutter

** Vagal maneuvers should not be attempted on the following:
   - history of transient ischemic attack (TIA)/ cerebral vascular accident (CVA)
   - previous neck surgery
   - neck cancer
   - history of aortic stenosis
   - known carotid artery blockage

*** If possible, provide sedation with analgesia:
   - *Versed* 1-2mg IVP (N)
   - *Morphine Sulfate* 2-4mg IVP (N)

BRADYCARDIA

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) EKG monitor

4) If 2nd degree Type II or 3rd degree Heart Block present with signs of hypoperfusion, consider early transcutaneous pacing (TCP)

5) Obtain vascular access

6) *Atropine* 0.5-1mg IVP (N) titrated to effect (maximum 3mg)

7) If patient fails to respond to atropine, consider transcutaneous pacing (TCP)

8) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

PULSELESS ELECTRICAL ACTIVITY (PEA)

1) Establish pulselessness

2) Begin CPR with BVM and 100% O2

3) Maintain airway utilizing **ADVANCED AIRWAY PROTOCOL**

4) Obtain vascular access

5) ***Epinephrine*** 1:10,000 1mg IVP (N) or 2mg ETT (C)(N) q 3-5 min

6) Continue CPR

7) ***Atropine*** 1mg IVP (N) or 2mg ETT (C)(N) q 3-5 min (maximum 3mg) **

8) Continue CPR

9) Rule out causes of PEA and treat according to appropriate protocol

10) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**

11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

** Give atropine for electrical heart rate < 60 bpm

Possible Causes

- Myocardial Infarction
- Acidosis
- Tension Pneumothorax
- Hyperkalemia/Hypokalemia
- Hypothermia
- Hypoxia
- Cardiac Tamponade
- Emboli
- Drug Overdose

ASYSTOLE

1) Establish unresponsiveness

2) Begin CPR with BVM and 100% O2

3) 3-lead EKG monitor

4) Maintain airway utilizing **ADVANCED AIRWAY PROTOCOL**

5) Obtain vascular access

6) *Epinephrine* 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5min

7) Continue CPR

8) *Atropine* 1mg IVP or 2mg ETT (C)/(N) q 3-5 min (max 3 mg)

9) Continue CPR

10) If spontaneous return of pulse, go to **POST RESUSCITATION PROTOCOL**

11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

Possible Causes

- Myocardial Infarction
- Acidosis
- Tension Pneumothorax
- Hyperkalemia/Hypokalemia
- Hyothermia
- Hypoxia
- Cardiac Tamponade
- Emboli
- Drug Overdose

ADVANCED CARDIAC LIFE SUPPORT SHEET

Date: ______________ Start Time: __________ Recorder: ______________________________

Time	Epi	Lido	Atropine	Other Drugs or IV Drips	Electricity Mode/Joules	Cardiac Rhythm	Nursing Notes (cont. on back)

Page _____ of _____

Enclosure (4)
Front

Time	Nursing Notes

Page _____ of _____

Enclosure (5)
Back

005??7

NOV00386

CODE BLUE CRITIQUE

Area of Drill: ☐ Hospital ☐ Delta Clinic

Medical notified of Code Blue by: _____ @ _____ ☐ Radio ☐ Lan Line

Brief description of scene:

_____

_____

TIME	ACTIVITY	Comments	Met	Not Met
	a. Establish unresponsiveness			
	1. Absence of breathing			
	2. Absence of pulse			
	b. Call for help			
	c. Initiate Code Procedures			
	1. Pager systems activated			
	2. Personnel assigned			
	d. Begin Basic Life Support			
	1. Patient Positioned for CPR			
	2. Airway			
	3. Chest Compressions			
	e. Crash Cart Setup			
	1. Airway equipment			
	2. Oxygen			
	3. Medications			
	4. IV equipment			
	f. Defibrillator/Monitor setup			
	1. Rhythm established/recognized			
	g. IV established			
	h. Airway Maintenance			
	1. Adequate mask ventilation			
	2. Endotracheal intubation			
	3. Auscultation of both lungs fields			
	i. Palpable pulse during compressions			
	j. Detection of pulse without compressions			
	k. Treatment modality			
	1. Follows algorithm for scenario			
	2. Used ACLS cards from Crash Cart			
	l. Post-resuscitation management			

Enclosure (6)

005228

TIME	ACTIVITY	Comments	Met	Not Met

Comments: _____

CARDIAC ARREST PROCEDURE(S)

SOP: 060

CODE BLUE CRITIQUE

Area of Drill: ☐ Camp ____ Block ____ ☐ Reservations _____
(brown, yellow, orange, blue, gold)

Medical notified of Code Blue by: _____ @ _____ ☐ Radio ☐ Lan Line

Brief description of scene:

_____

_____

Algorithm(s): _____

TIME	ACTIVITY	Comments	Met	Not Met
	Medical Officer paged			
	CDO paged			
	DOC notified			
	ERT Team #1 and #2 responded			
	Red Bag with ERT team			
	AED with ERT team			
	ERT Teams arrived at Sally Port #			
	Sally Port # opened			
	Arrived on scene (with gator)			
	a. Established unresponsiveness			
	1. Absence of breathing			
	2. Absence of pulse			
	b. Begin Basic Life Support			
	1. Detainee positioned for CPR (supine position on back board)			
	2. Airway opened with			
	3. Adequate mask ventilations initiated			
	3. Rhythm identified by AED			
	4. Shock delivered by AED *(3 stacked shocks delivered by AED)			
	5. Shock delivered by AED			
	6. Shock delivered by AED			
	Detainee leaving block on back board to Sally Port #			
	Sally Port # opened			
	Detainee transported to gator STAT			
	Reassess for pulselessness			
	Chest compressions initiated			
	Arrived to Sally Port #			
	Sally Port # opened			
	Detainee arrives at Delta Clinic			
	Detainee's secondary assessment			

TIME	ACTIVITY	Comments	Met	Not Met

Comments: _____

STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge _____ Date

IMPLEMENTED BY:

Director for Administration _____ Date

Senior Enlisted Advisor _____ Date

ANNUAL REVIEW LOG:

b(6)

By: [redacted] Date: April 2004
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____

SOP REVISION LOG:

Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____

ENTIRE SOP SUPERSEDED BY:

Title: Emergency Medical Response
SOP NO: 059 Date: _____

Enclosure (7)

MEDICAL PLANS/OPERATIONS GUANTANAMO BAY, CUBA Title: REQUEST FOR MEDICAL/DENTAL INFORMATION	SOP NO: 001 Page 1 of 2 Effective Date: 1 Mar 2005
SCOPE: JOINT MEDICAL GROUP (JMG)	

I. PURPOSE:

To outline the Standard Operating Procedure (SOP) regarding requests for detainee medical/dental information. This SOP document is intended to describe the process the Joint Medical Group will use to correctly task and track outside agencies (governmental and non-governmental) requests for detainee medical information.

II. POLICY:

The Joint Task Force Surgeon (SG) will serve as the approving authority for requests for detainee medical/dental information. The Officer in Charge (OIC), Medical Plans/Operations (MPO) will serve as the entry point for all outside agency requests for detainee medical/dental information as well as track, using a spreadsheet, the JMG response. The Senior Medical Officer (SMO)/Detention Hospital will be the primary point of contact for medical information requests. The Senior Dental Officer (SDO)/Detention Hospital will be the primary point of contact for dental information requests. The JTF Staff Judge Advocate (SJA) will act as legal consultant as needed to assist the SG to determine if/when medical/dental information can be released and the correct format for the release. Original medical records will remain in the custody of the JMG. If records are cleared for release, certified copies will be provided. Documentation of the appropriate authorization will be kept on file by the MPO office.

III. PROCEDURES:

1. **Requests for medical/dental information:**

   a. Requests for medical/dental information are common from the J-1, in the form of a Freedom of Information Act (FOIA); Behavioral Science Consultation Team (BSCT); Public Affairs Office (PAO); Federal Bureau of Investigation (FBI); Detainee Assessment Branch (DAB); the Office for the Administrative Review of Detainee Enemy Combatants (OARDEC) and detainee counsel.

   b. Medical/dental information requests will be sent through the SG, as identified below, or to the OIC MPO via the JMG organizational e-mail (SIPR). The OIC or NCOIC will enter the request into an excel spreadsheet. The MPO office will task the request for information to the SMO or SDO.

c. Requests from the FBI, OARDEC, and the DAB will come through the JMG organizational email (SIPR) on official letterhead and be signed by the respective director with an explanation of what information is required, how the information will be used, and date information needed. An accurate and current letter from these agencies/sections on file with the SG and MPO may be used to satisfy the above requirement (i.e. a letter is not required to be submitted for each request).

d. Requests from the J-1 regarding a FOIA will be accompanied by the complete FOIA package and be suspensed to the JMG organizational e-mail box.

e. Requests from the PAO and BSCT will be sent to the JMG organizational e-mail box.

f. Requests from detainee counsel, if received by the JMG, will be forwarded to the SJA office. The JMG will not provide any medical/dental information until the SJA has reviewed the request and determined the legal nature of the request and what, if any, information can be provided.

g. Requests for medical/dental information made directly to the Detention Hospital (DH) will be returned to the sender with an explanation of how to correctly request medical/dental information as described in this SOP.

h. The SDO/DH or SMO/DH will complete a medical/dental summary or complete the Medical RFI e-form submitted by the MPO, as appropriate, and respond directly to the MPO via SIPR e-mail, while courtesy copying the SG and Deputy SG. The SG will approve or deny the release of medical information and forward to the MPO. The MPO will track responses to ensure task completion. The MPO will forward the information, with the SG's approval noted, to the requestor.

2. Release of medical/dental information:

a. When detainee medical/dental information is released using names or ISNs, the information is considered SECRET. When the medical/dental information does not reveal names or ISNs, the information is considered For Official Use Only (FOUO).

b. No medical/dental information is to be used for the purposes of furthering intelligence gathering.

c. All release of medical/dental information must have written approval (email or hard-copy memo) of the SG or Deputy SG.

005234

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA Title: CAMP 4 MEDICATION DISPENSING POLICY	SOP NO: 012 Page 1 of 3 Effective Date:
SCOPE: Detention Hospital	

I. BACKGROUND:

1. The pharmacy representative on the Camp Delta Medical Team provides pharmacy support to the team by dispensing medications pursuant to valid prescriptions written by designated providers and issuing medications needed for the direct administration to patients.

II. RESPONSIBILITY:

1. The designated pharmacy representative at the camp is responsible for the proper organization, efficient inventory management, and proper dispensing and issuance of all pharmaceuticals. Operational procedures shall be in compliance with all provisions of Chapter 21 of the Manual of the Medical Department.

2. Security of Pharmaceuticals: The Detention Hospital pharmacist will ensure the proper security of the pharmaceuticals transported to Camp Delta Clinic. The pharmacy representative will ensure that adequate medication stock is kept available at the camp.

3. All pre-dispensed medications will be kept in a lockable drug cabinet and all dispensed medications will be kept in separate designated lockers. The pharmacy representative and the medical staff administering the dispensed medications to the patients will hold custody of the keys to the locker. The narcotics log and locker key will (b)(2) be maintained by [redacted] All immunizations stored at the camp will be kept in a lockable refrigerator within the Camp Delta Clinic.

III. POLICY:

1. The Senior Medical Officer (SMO) shall determine which medications are to be stocked at the Camp Delta Clinic.

2. The designated camp medical providers will enter all prescriptions into CHCS. A CHCS terminal and label printer will be available for the pharmacy technician to use in the dispensing of prescriptions. The pharmacy technician will fill all prescriptions following the provider's entry and will apply CHCS generated prescription