

	<b>DEPARTMENT OF PUBLIC SAFETY</b> <b>CORRECTIONS ADMINISTRATION</b> <b>POLICY AND PROCEDURES</b>	<b>EFFECTIVE DATE:</b> <b>10/03/2014</b>	<b>POLICY NO.:</b> <b>COR.10.1A.08</b>
		<b>SUPERSEDES (Policy No. &amp; Date):</b> <b>COR.10.1A.08 10/08/07</b>	
	<b>SUBJECT:</b> <b>COMMUNICATION ON SPECIAL NEEDS PATIENTS</b>		<b>Page 1 of 4</b>

PSD 2007-2895

## 1.0 PURPOSE

The purpose of this policy is to establish communication guidelines between the facility administrator and the treating clinicians, or their designees, regarding inmates' significant medical and mental health needs prior to transfers or programming in order to preserve the health and safety of the inmate and others.

## 2.0 REFERENCES AND DEFINITIONS

### .1 References

- a. Hawaii Revised Statutes, Section 26-14.6, Department of Public Safety; and Section 353C-2, Director of Public Safety, Powers and Duties.
- b. National Commission on Correctional Health Care, Standards for Health Services in Prisons and Jails, (2003).
- c. Department of Public Safety, Policy and Procedures, Chapter 10:  
COR.10.1E.02, Receiving Screening;  
COR.10.1E.09, Segregated Inmates;  
COR.10.1G.01, Special Needs Treatment Plans;  
COR.10.1G.02, Management of Chronic Diseases;  
COR.10.1G.04, Mental Health Services.

### .2 Definitions

Special Needs Inmates: Inmates with medical or mental health disabilities or disorders that interfere with the ability to carry out normal activities.

## 3.0 POLICY

Correctional staff shall be advised of inmates' special needs that may affect housing, work and program assignments, disciplinary sanctions, and admissions and transfers to and from institutions. The communication shall be documented.

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<b>COR</b>  <b>P &amp; PM</b>	<b>SUBJECT:</b>  <b>COMMUNICATION ON SPECIAL NEEDS PATIENTS</b>	<b>POLICY NO.:</b> <b>COR.10.1A.08</b>
		<b>EFFECTIVE DATE:</b> <b>10/03/2014</b>
		<b>Page 2 of 4</b>

#### **4.0 PROCEDURES**

- .1 The facility Clinical (CSA) and Mental Health (MHSA) Section Administrators shall be responsible for ensuring the communication between clinical, mental health and correctional staff, including Correctional Officers in therapeutic units and facility counselors and social workers on a need to know basis, regarding inmates with special needs (e.g. inmates requiring therapeutic housing, terminal inmates requiring hospice care, inmates with acute injuries, pregnant inmates, inmates with environmental or developmental disabilities that require housing assistance, adolescents in adult facilities, and the frail or the elderly). Substance abuse treatment, mental health treatment and HIV/AIDs information requires a patient's consent or a court order before the information can be shared with a third party. Communication about inmates with special needs shall include:
  - a. Infirmity admissions and discharges;
  - b. Patients who require therapeutic housing;
  - c. Admission to and discharges from therapeutic housing units or segregation;
  - d. Special housing requirements or living assistance;
  - e. Special diets;
  - f. Inmates requiring transport to community or inpatient hospital service providers;
  - g. Inmates requiring special needs or equipment during transport;
  - h. Inmates who are potentially suicidal;
  - i. Behavior patterns that treatment providers recognize and set to modify or reinforce through treatment planning and implementation.
  
- .2 Health care staff shall use the Inmate Medical Injury Report template; Special Needs Form; the Transfer Authorization And Information Form For Evaluation, Treatment, Suicide/Safety Watch, Restraint, Seclusion and General Transfer Form, DOC 0457; and the Health Status Classification Report (HSCR), Form DOC 0497 to communicate special needs to correctional staff. Medical and mental health restrictions and applicable medical needs will be described on the form. The patient's actual diagnosis shall be protected as much a possible. Documentation should be in general terms of the patient's physical limitations secondary to the diagnosis rather than using a specific diagnosis.
  
- .3 Nurses or psychiatric social workers shall evaluate the medical and mental health of an inmate prior to an Interfacility transfer or job placement. Referrals to the physician, psychiatrist or clinical psychologist shall be made when necessary.

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<b>COR</b>  <b>P &amp; PM</b>	<b>SUBJECT:</b>  <b>COMMUNICATION ON SPECIAL NEEDS PATIENTS</b>	<b>POLICY NO.:</b> <b>COR.10.1A.08</b>
		<b>EFFECTIVE DATE:</b> <b>10/03/2014</b>
		<b>Page 3 of 4</b>

- .4 There are four categories of work or transfer clearances:
- cleared,
  - cleared with restrictions,
  - hold,
  - denied,
- Cleared with restrictions shall identify what the inmate is physically or mentally able or not able to do.
- .5 Mental Health staff shall ensure that the information on Form 0497 is transferred to the Mental Health Treatment Plan. Health care staff shall not determine what facility the inmate may transfer to but may indicate the type of facility required (e.g. facility must have twenty-four (24) hour nursing services, or facility must have twenty-four (24) hour infirmary services, or facility must have a therapeutic unit, etc.)
- .6 Holds are for acute conditions that are expected to be resolved or chronic conditions that are expected to stabilize within two (2) months. Holds require a review and a HSCR update at the end of the two-month period. Initial Mental Health (MH) treatment plans based on information from the initial HSCR shall be reviewed at the end of the two (2) month period to update changes in health status.
- .7 Inmates with conditions that are expected to take longer than two (2) months to resolve shall be denied job or transfer clearance until the condition is resolved. At that time a new HSCR and a revision to the MH treatment plan is generated to reflect the inmate's change in health status.
- .8 The designated MH clinician shall address the treatment recommended to maintain optimal functioning including behavioral changes required to reduce risk, to monitor risk, and to implement action when the treatment plan is in need of revision or modification.
- .9 As part of the HSCR evaluation, the nurse shall complete the HSCR indicating the inmate's job and transfer status. Notations on the "Comment" section of the HSCR shall be general and shall not violate patient confidentiality. A copy of the HSCR will be forwarded to the facility Classification Officer for action.
- .10 As part of the MH treatment Plan, the designated MH clinician shall address the treatment actions recommended to maintain optimal functioning for the patient including behavioral actions required to reduce risk, to monitor risk and to implement action when the treatment plan is in need of revision or modification.

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COR  P & PM	<b>SUBJECT:</b>  <b>COMMUNICATION ON SPECIAL NEEDS PATIENTS</b>	<b>POLICY NO.:</b> COR.10.1A.08
		<b>EFFECTIVE DATE:</b> <b>OCT 08 2014</b>
		Page 4 of 4

- .11 Based on staff recommendations, the Physician, Psychiatrist or Psychologist, may request the removal of an inmate from segregation if the inmate's physical and/or mental health begins to deteriorate. The Clinical or MH Section Administrator or a designee shall ensure that the Watch Commander is informed of the request by completing a Medical Needs Memo. A copy of the memo will be filed in the inmate's medical record and in the MH case management file.
- .12 The Watch Commander will be responsible for reporting any housing changes to his supervisors. Inmates removed from segregation for medical or mental health reasons shall be placed in an infirmary or in a therapeutic unit.

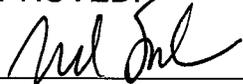
**5.0 SCOPE**

This policy and procedure applies to all correctional facilities and their personnel.

APPROVAL RECOMMENDED:

 _____ Medical Director	7/28/14 _____ Date
 _____ Health Care Division Administrator	7/29/14 _____ Date
 _____ Deputy Director for Corrections	10/1/14 _____ Date

APPROVED:

 _____ Director
10/3/14 _____ Date

Patient: T, TEMPLATES  
DOB: 01/01/1970 Age: 31 Y Sex: Male

Provider:  
Date: 01/01/2001

**Reason for Appointment**

1. INMATE MEDICAL INJURY REPORT

**History of Present Illness**

Description of Events Leading to Injury:

Place Injury Occurred: \_\_\_\_\_. Injury Classification \_\_\_\_\_. Description of Injurious Event: \_\_\_\_\_. Witnesses \_\_\_\_\_.

Injury:

Historian: \_\_\_\_\_. Injury Occured: \_\_\_\_\_. Location of Injuries: \_\_\_\_\_. Pain Scale: \_\_\_\_\_. Associated Symptoms: \_\_\_\_\_.

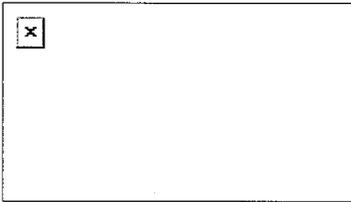
**SEXUAL/SOCIAL HISTORY:**

Victim of sexual assult/abuse? \_\_\_\_\_. If yes, what is the nature of sexual abuse/assault? \_\_\_\_\_. Abuse/Assault reported to Watch Commander \_\_\_\_\_.

**Examination**

Nursing Physical Assessment:

GENERAL APPEARANCE: \_\_\_\_\_. SIGNS OF DISTRESS: \_\_\_\_\_. NEURO: \_\_\_\_\_. AMBULATION/ GAIT: \_\_\_\_\_.  
RESPIRATORY: \_\_\_\_\_. GENITOURINARY: \_\_\_\_\_. AFFECTED AREA/SITE: \_\_\_\_\_. CHARACTER OF VITAL  
SIGNS: \_\_\_\_\_. PATIENT TEACHING: \_\_\_\_\_. PROVIDER REFERRAL: \_\_\_\_\_. PHOTOGRAPHS \_\_\_\_\_.  
ASSESSMENT FOR TETANUS VACCINE \_\_\_\_\_.

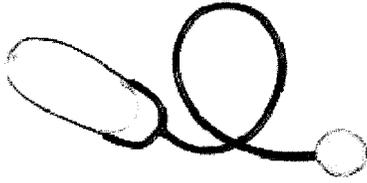


Electronically signed by Deborah Stampfle, RN on 06/05/2014 at 02:41 PM HST

Sign off status: Pending

Patient: T, TEMPLATES  
DOB: 01/01/1970

Provider:  
Date: 01/01/2001



**Special Needs Form**

<b>PATIENT NAME: T, TEMPLATES</b>	<b>FACILITY: PSD Healthcare Administration</b>
<b>SID: 0000000</b>	<b>BC No: 0</b>

I have reviewed the patient's record and I have found that patient will need the following Special Needs/Special Requirements

1. **Medical Needs : Brace with Metal Components ( 12/27/2013 - 03/29/2014 )**

<hr/>
<b>Signature</b>
<b>Stampfle, RN, Deborah 06/05/2014 03:09 PM</b>
<b>Print Name/Date/Time</b>



HEALTH STATUS CLASSIFICATION REPORT

NAME: \_\_\_\_\_ SID: \_\_\_\_\_ DOB: \_\_\_\_\_ FACILITY: \_\_\_\_\_

PURPOSE: Initial Health Evaluation Change in Health Status (check as many as apply.)
Hold for Health Care Evaluation/Treatment.

- 1. WORKLINE CLEARANCE:
CLEARED CLEARED W/RESTRICTIONS
HOLD DENIED

- 2. TRANSFER CLEARANCE:
CLEARED CLEARED W/RESTRICTIONS
HOLD DENIED

PLACED ON HEALTH CARE HOLD UNTIL:
1. Medical \_\_\_/\_\_\_/\_\_\_ month/day/year
2. Dental \_\_\_/\_\_\_/\_\_\_ month/day/year
3. Mental Health \_\_\_/\_\_\_/\_\_\_ month/day/year

3. CLEARED WITH THE FOLLOWING RESTRICTIONS: (Check as many Restrictions/Limitations as apply).

- A. Housing
1. Single Cell
2. Lower Bunk
3. No Stairs
4. Special Housing
5. Handicap Accessible
6. Other
B. Workline
1. No Heavy Lifting \_\_\_ lbs
2. Walking and Sitting Only
3. No Bending
4. No Prolonged Standing
5. Current Medications Require Indoor Work (sun sensitivity)
6. Other \_\_\_\_\_

- C. Special Needs / Equipment
1. Crutches
2. Cane/Walker
3. Wheel Chair
4. Assistance with ADLs
5. Shoes at all Times
6. Other \_\_\_\_\_

- D. Recreational Activities
1. Activity limited to walking & stretching
2. No basketball/handball or competitive sports
3. No vigorous sports activity or heavy weight lifting
4. Other \_\_\_\_\_

- E Facility Restrictions
1. No High Altitudes
2. Requires 24 hour Nursing Availability
3. Ambulance Response Within 30 Minutes
4. Requires Level or Paved Terrain
5. Other \_\_\_\_\_

1. Is there evidence or a diagnosis of a serious persistent mental health condition? NO YES.
2. If yes, and possible, refer to Mental Health for clearance. Date of Referral \_\_\_\_\_.
[Place patient on a Mental Health hold. The MH team shall clear, place on hold, deny or identify any mental health restrictions applicable for to the patient and sign off on this form.]

Comments: \_\_\_\_\_

Signature Health Care Staff /Title Date Signature of Mental Health Staff /Title Date