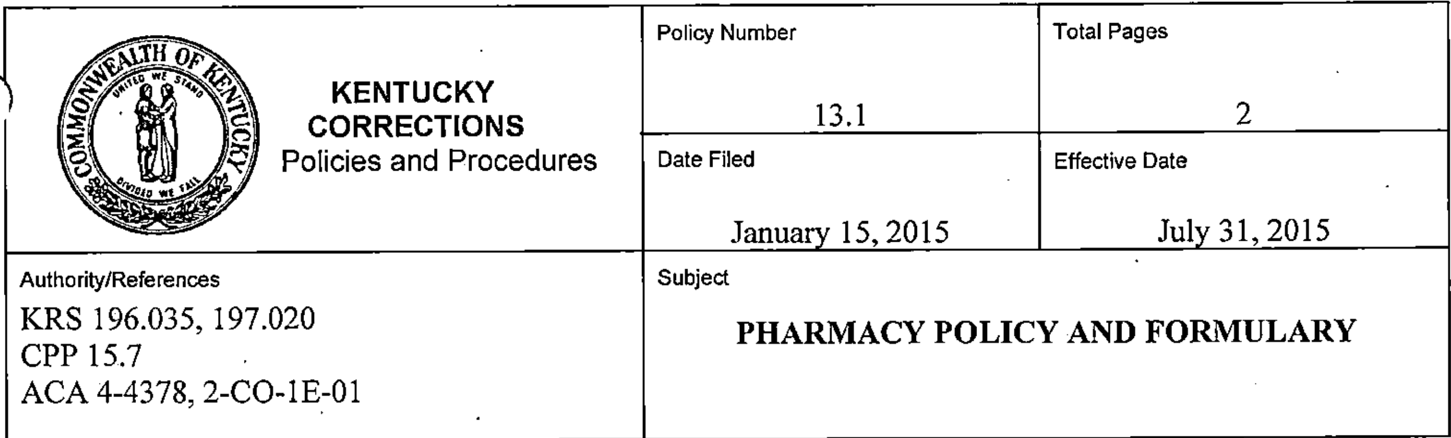


KENTUCKY CORRECTIONS Policies and Procedures	Policy Number: 13.1	Total Pages: 2
	Date Filed: January 15, 2015	Effective Date: July 31, 2015
Authority/References: KRS 196.035, 197.020; CPP 15.7; ACA 4-4378, 2-CO-1E-01	Subject: **PHARMACY POLICY AND FORMULARY**	

I. POLICY and PROCEDURES

A. PHARMACEUTICAL SERVICES

1. Pharmaceutical services shall be in conformity with federal and state statutes.

2. Pharmaceutical services shall be organized, directed and integrated with the total health care delivery system.

3. Corrections shall have available to medical staff a pharmaceutical formulary.

4. Corrections shall have access to the services of a pharmacy consultant.

B. NON-FORMULARY MEDICATION

1. Medical providers shall have the opportunity to justify and request the use of non-formulary medications by utilizing a written non-formulary request or an electronic non-formulary request mechanism.

2. Non-formulary requests shall be submitted to the Office of the Medical Director or designee for review.

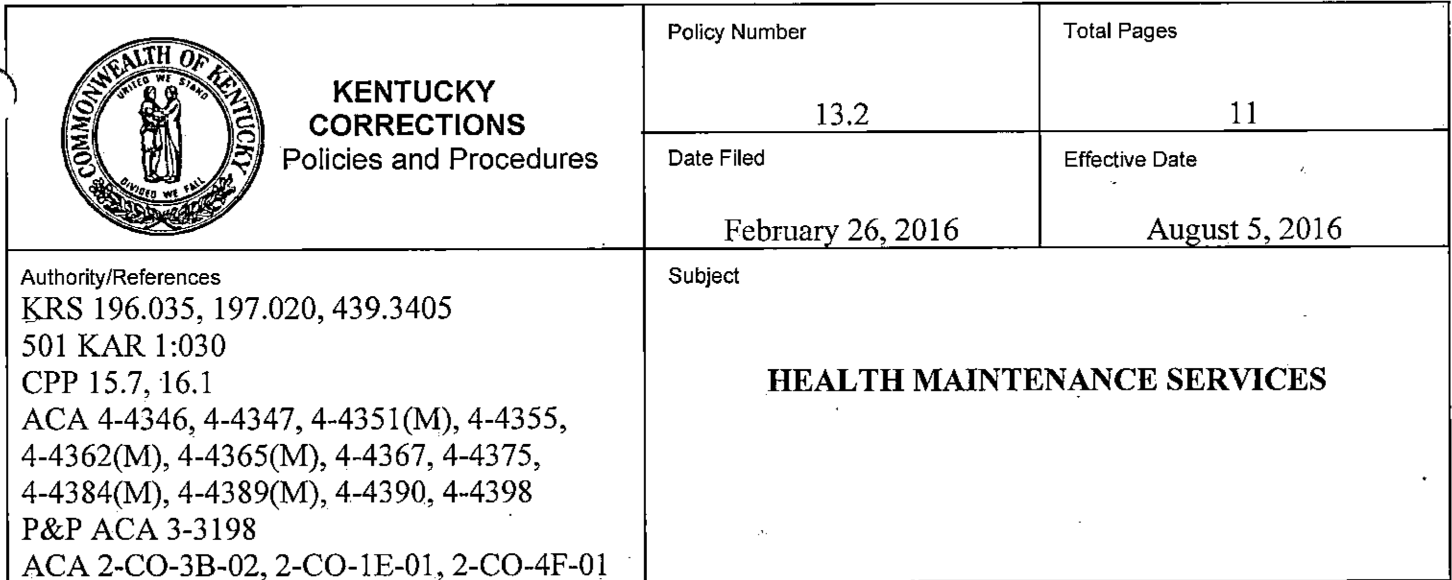
3. In emergency situations requiring non-formulary medication use, the Central Office Medical Duty Officer may be contacted for verbal approval.

C. INMATE CO-PAY

1. An inmate shall not be charged for formulary medications.

2. An inmate shall not be charged for non-formulary psychiatric medications.

3. Except for medications in C.2., an inmate shall be charged a $3.00 co-pay for each non-formulary prescription and for each subsequent refill of that prescription, unless indigent as defined in CPP 15.7.



KENTUCKY CORRECTIONS Policies and Procedures	Policy Number: 13.2	Total Pages: 11
	Date Filed: February 26, 2016	Effective Date: August 5, 2016
Authority/References KRS 196.035, 197.020, 439.3405 501 KAR 1:030 CPP 15.7, 16.1 ACA 4-4346, 4-4347, 4-4351(M), 4-4355, 4-4362(M), 4-4365(M), 4-4367, 4-4375, 4-4384(M), 4-4389(M), 4-4390, 4-4398 P&P ACA 3-3198 ACA 2-CO-3B-02, 2-CO-1E-01, 2-CO-4F-01	Subject **HEALTH MAINTENANCE SERVICES**	

I. DEFINITIONS

"Cosmetic services" means any procedure, treatment or surgery designed to enhance the appearance, but is non-essential to the maintenance of basic health.

"Elective services" means any procedure, including a diagnostic service, or surgical procedure that is considered optional within the standards of accepted medical practice within the organized medical community. These services shall not be for the convenience of the inmate, but may be evaluated by the primary care health team on a case-by-case basis.

"Medical emergency" means serious life threatening or disabling condition manifested by severe symptoms occurring suddenly and unexpectedly that may result in serious physical impairment or loss of life if not treated immediately.

"Physician consultant" means a doctor who is trained in a specific medical specialty, located within the community, who agrees to evaluate and recommend treatment for certain medical conditions, as requested by the primary care provider.

"Primary care provider" means the institutional physician, nurse practitioner or physician assistant who evaluates the inmate's total health needs; provides personal medical care; and, if medically needed, preserves continuity of care and coordinates other providers of health services.

"Recommended therapy" means

1. summary and any advisement regarding a specific problem provided to the primary care provider from a consulting practitioner; and

2. any advisement made to the inmate by the primary care provider to alleviate a current problem, prevent worsening of a problem or improve

general health. The recommendation may be largely behavioral and within the inmate's ability to carry out.

II. POLICY and PROCEDURE

A. An inmate shall be provided access to health care services.

In providing needed services, the emphasis within the institution shall be preventive in nature. The following preventive hierarchy shall be established by Corrections to meet the inmate's needs and provide a guide for services.

1. Prevention of death

2. Prevention of disease

3. Prevention of permanent disability

B. Basic Program Requirements

1. Credentials

a. A physician, dentist, nurse practitioner, pharmacist, nurse or other allied health professional shall comply with applicable state and federal licensure, certification, or registration requirements.

b. Verification of the current license, certification, or registration shall remain in the individual's institutional personnel file, if the individual is an employee of the Department of Corrections.

c. If an employee of the Department of Corrections, the individual shall also meet the specifications established by the Kentucky Department of Personnel.

d. Unlicensed or uncertified health care staff employed within the institution shall meet the Department of Personnel specifications and work under the direction of the professional staff person in the designated area.

2. Staffing

a. In order to maintain a sound program of care, adequate personnel shall be available within the institution for health assessments, the triaging of complaints and problems and follow-up services.

b. The institutional health administrator shall prepare and approve a written job description for each employee category.

c. Staffing patterns shall reflect current trends in patient care in correctional facilities.

3. Community Care

a. Each institution shall arrange twenty-four (24) hour services with a fully licensed community hospital.

b. Emergency services, major surgery and specialties shall be available to the inmate, as deemed appropriate, by the primary care provider.

C. Medical Services

1. Evaluation

a. An initial evaluation of the inmate's health shall occur immediately after admission to Corrections.

b. The receiving screening form shall be completed by a staff person prior to the inmate's placement in the assessment and classification unit or, if applicable, on death row.

c. This screening shall aid in identifying an inmate with a health problem that requires immediate medical intervention.

d. The health history shall be completed within forty-eight (48) hours after admission to the institution.

e. The history may be completed by a member of the medical department or by the inmate under the direction of a health care staff member. A physical examination including T.B. skin testing and venereal disease testing shall be completed within ten (10) working days of admission to Corrections.

f. The examining providers shall sign the physical examination report and health history to acknowledge the examination and review.

2. Medical Care

Based on the examining primary care provider's findings, the inmate's medical status shall be considered in developing the total incarceration plan. The following classification review shall be conducted for an inmate in each health category.

a. Any indication of a life threatening or potentially disabling condition: emergency action.

b. If a health problem is present on admission that, if left untreated, may cause deterioration of the inmate's general health or result in permanent disability:

1) The classification of work or activity shall be dictated by the primary care provider.

2) The care or services needed to maintain, at a minimum, the present level of health shall be provided within the institution.

c. If a health problem is present on admission that limits work and recreational activity but does not threaten the general health or welfare:

1) Follow the regular classification procedure. Any work assignment may vary from light duty to medical release from work depending on the nature and extent of the problem.

2) A work or activity assignment shall not be given that may aggravate the existing problem.

d. In good health: activity shall not be restricted.

3. Access

a. Routine Services:

1) Each institution shall establish a mechanism for addressing the routine health needs of the inmate population.

2) This shall be facilitated through standardizing the time and location of sick call.

3) Upon arrival at an institution, the inmate shall be informed about how to access health services and the grievance system. This information shall be communicated orally and in writing, and shall be conveyed in a manner that may be easily understood by each inmate.

4) The inmate shall be informed of the procedure for obtaining care during weekends, nights or holidays.

5) Custody staff shall not have the authority to deny access to these services within the institution.

6) An inmate shall be charged $3.00 for each non-emergency visit to sick call unless the inmate is indigent as defined in CPP 15.7. An inmate shall not be charged for chronic care clinics, intake screenings and appraisals, transfer screenings, or appointments initiated by medical staff.

7) An inmate shall not address more than two clinical concerns on a single sick-call slip. If two clinical issues are listed on a single sick-call slip, then the provider shall not decide to schedule two different clinic appointments unless absolutely necessary.

b. Special Services:

1) Any visit to a specialist shall be scheduled on a referral from the primary care provider.

2) Each institution shall maintain a current list of community consultants used that represent various specialties. This listing with addresses and telephone numbers shall be maintained in the medical area and updated as needed.

c. Community Practitioners

1) Two (2) types of primary care provider referrals to community practitioners may be considered:

a) A referral may be made for diagnostic evaluation and recommendation for treatment.

b) Referrals to specialists or sub-specialists for treatment of specific medical conditions.

2) Primary care providers shall review an inmate's consult and findings prior to making a follow-up appointment. A second opinion, if appropriate, shall be obtained from an objective source within the same medical specialty.

3) An inmate desiring a second opinion of his medical needs may make arrangements with a licensed physician of the inmate's choice.

a) The examination shall be conducted within the institution after the inmate has assumed responsibility for contact.

b) The inmate shall establish a reasonable appointment time, and make provision for full payment of expenses with the outside physician.

c) The physician, a special visitor, shall be received under CPP 16.1 Inmate Visits and bound by the specific institution's visiting procedure.

d) All recommendations made by the visiting physician shall be reviewed by the primary care provider before making a decision to implement the recommendation.

e) Since the inmate may not be the responsibility of the visiting physician, the inmate shall be followed by the primary care provider in accordance with his medical judgment.

D. Prosthesis

A prosthesis, or artificial device to replace a missing body part or compensate for defective bodily functions, may be provided if deemed essential for overall health maintenance by the primary care provider.

1. The prosthesis shall meet the minimum requirement for function.

2. A prosthetic device of a cosmetic nature only shall not be provided unless approved by the Medical Director or designee.

3. Once the prosthesis is issued, it becomes the property of the inmate. Breakage or malfunction, excluding proven defective product, occurring during what is considered the normal service life of the appliance shall be at the inmate's expense. Replacement of a lost prosthesis shall be at the inmate's expense. The Department of Corrections, in consultation with the medical director, may approve replacement of prosthesis because of normal wear and tear. Replacement of a medically related prosthesis shall be in accordance with this policy.

4. An inmate shall be charged a $10.00 co-pay for each prosthetic device issued including replacements, unless the inmate is indigent as defined in CPP 15.7.

E. Hearing Aids

1. A hearing aid shall be provided to an inmate if a hearing aid is determined to be medically necessary by a healthcare provider or audiologist. The expense of a medically necessary hearing aid shall be paid by the Department of Corrections. An inmate shall be charged a $10.00 co-pay for each hearing aid issued, including replacements. If the inmate is indigent as defined in CPP 15.7, the fee shall be waived.

2. The department shall maintain all medically necessary hearing aids in good working condition while the inmate is in DOC custody. A battery for a medically necessary hearing aid shall be provided at no cost to the inmate.

F. Eye Glasses

1. An inmate shall be charged a $5.00 co-pay per pair of state-issued eyeglasses, unless indigent as defined in CPP 15.7.

2. Eyeglasses issued by the state shall have state-issued plastic frames with state-issued lenses. Metal or wire reinforced frames or ear pieces shall not be permitted.

3. The department shall pay for the repair or replacement of eyeglasses damaged from normal wear or defects in materials or workmanship. Normal wear for a pair of glasses shall be expected to be a minimum of one (1) year. The department shall not pay to repair or replace eyeglasses that are lost or damaged by careless handling or willful negligence, unless recommended by the optometrist or ophthalmologist due to absolute clinical need. Repair or replacement of damaged or lost state-issued eyeglasses occurring within one (1) year of issuance shall be borne at the inmate's expense. The co-pay as stated in subsection 1 of this section shall apply to the repair or replacement of eyeglasses.

4. The Department shall provide new eyeglasses if the prescription changes greater than ½ diopter sphere or cylinder or the addition of increased power are indicated. In these cases, the inmate's co-pay shall apply.

5. Reading glasses shall be available for inmate use if indicated at no additional cost to the inmate other than the cost of the co-pay. An inmate with appropriate prescriptions may be offered over-the-counter reading glasses in lieu of prescription bifocals.

G. Contact Lenses

1. The department shall not furnish contact lenses and or maintenance supplies to an inmate except if indicated for specific diseases or conditions

as diagnosed by a licensed optometrist or ophthalmologist. In this case, the department shall issue lens solution to maintain the contact lenses.

2. An inmate who enters Corrections without other eyewear shall be allowed to keep contact lenses until state-issued glasses are provided. In this case, the department shall issue lens solution to maintain the contact lenses until the eyeglasses are available.

3. An inmate who currently has contact lenses shall not be allowed to replace them, except as provided in subsection 1 above. Regular issue prescription glasses may be acquired in accordance with subsection F of this policy.

H. Emergency Medical Services

1. Staff trained in first aid procedures shall be available on each shift.

2. Each institution shall have a standardized written emergency plan for providing emergency care at any location in the institution.

3. The plan shall be approved by the Warden and reviewed annually.

4. Each institution shall include in its plan the following.

   a. The location of first aid kits.

   b. The placement of medical emergency information with appropriate phone numbers.

   c. A written agreement for providing treatment on a twenty-four (24) hour basis by the primary community facility.

   d. A listing of community emergency transportation systems, including telephone numbers.

   e. The method and route of transporting a patient to the hospital.

   f. Directions to the receiving facility with approximate time and mileage.

   g. The medical emergency plan shall reflect the method of emergency coverage on weekends, holidays or second and third shifts and in the situation of more than one (1) casualty.

I. Physical Examinations

1. An inmate shall have a physical examination at least every three (3) years until the age of fifty (50).

2. An inmate enrolled in a chronic care clinic shall have a physical examination every year.

3. An inmate over the age of fifty (50) shall have a physical exam every year.

4. The physical examination shall be documented in the medical record and shall include the date performed and the signature of the provider conducting the examination.

5. A physical examination occurring during an inpatient hospitalization shall satisfy the requirement of this policy. However, the DOC primary care provider shall document that the physical examination findings have been reviewed. This documentation shall include the date of review and the signature of the reviewing provider.

J. Cosmetic and Elective Services and Procedures

1. In maintaining the health of an inmate, Corrections shall ensure that equitable services are available and needs are met in a reasonable and responsible manner.

2. A cosmetic or elective procedure requires the use of resources that may best be utilized in providing essential care to maintain basic health. A cosmetic surgery or procedure shall not be undertaken while the inmate remains in Corrections' custody.

3. To convey this emphasis to a community practitioner, a consultation request shall be clearly tagged "Corrections shall not pay for cosmetic or elective procedures" and it shall be clear which relevant procedures Corrections considers cosmetic or elective for which payment shall not be made.

K. Over-The-Counter Items

Each institution shall maintain in the medical area a list of over-the-counter items available in the canteen or through an institutionally approved source that may be used for a cosmetic or hygiene problem.

1. This list may be increased by the primary care provider, in consultation with the warden or his designee, based on population needs but shall include topical preparations for acne, lotion for dry skin, a denture cleaner and an anti-fungal powder or cream.

2. An inmate shall be directed to this source for a purchase for a problem that has a hygienic basis, is used to improve appearance, or to treat a minor health problem.

L. Elective Services

1. Elective services shall include a treatment or surgical procedure not requiring immediate attention and, therefore, planned for the inmate's convenience.

2. Any condition present prior to incarceration and those acquired during incarceration within this category shall be monitored by the primary care provider according to an individualized plan.

3. So long as the institution maintains the basic health of an inmate, corrective therapy shall not be undertaken if not in conflict with section II(C)(2)(b) of this policy.

M. In-patient and Outpatient Services

Corrections shall provide the most appropriate medical aids and level of service that may safely be provided. For a hospital stay, this means that acute care as an in-patient shall be necessary due to the kind of service the inmate is receiving or the severity of the inmate's condition, and that safe and adequate care cannot be received as an outpatient or in a less acute care medical setting.

N. Organ Transplants

Organ transplants are extraordinary medical procedures and shall be reviewed and approved by the Medical Director prior to being provided to an inmate through the Department of Corrections.

1. A request for an organ transplant shall be forwarded to the Medical Director, along with full documentation of the inmate's case, including complete medical diagnosis and prognosis, current sentence status, viability of options for early release or furlough of the inmate, and any other factor, including payment of costs that may affect the Medical Director's decision. Costs associated with an organ transplant shall be addressed, including available community resources and the inmate's ability to pay.

2. If the Medical Director confirms the inmate is a suitable candidate for an organ transplant that is needed to preserve the inmate's life or to prevent irreparable harm, he may request the Parole Board to consider an early release pursuant to 501 KAR 1:030. Any approval for an organ transplant

to be provided by Corrections shall be fully documented in writing by the Medical Director.

3. The Medical Director shall review the inmate's medical history to include his behavior, adherence to medical advice and living habits for the purpose of determining whether the inmate is deemed an appropriate candidate for a transplant.

O. Medical Recommendation for Early Parole Consideration

Corrections may recommend to the Parole Board that an inmate be reviewed for early parole consideration for medical reasons in accordance with KRS 439.3405.

DEPARTMENT OF CORRECTIONS

Receiving Screening Form

INMATE
NAME_______________________________DATE___________TIME_______

INMATE NUMBER ____________________

VISUAL OPINION

1. Is the inmate conscious? Yes No

2. Does the new inmate have obvious pain or bleeding or other symptoms suggesting need for emergency service? Yes No

3. Are there visible signs of trauma or illness requiring immediate emergency or doctor's care? Yes No

4. Is there obvious fever, swollen lymph nodes, jaundice, or other evidence of infection that might spread throughout the institution? Yes No

5. Is the skin in poor condition or show signs of vermin, rashes? Yes No

6. Does the inmate appear to be under the influence of alcohol? Yes No

7. Does the inmate appear to be under the influence of any drug? Yes No

8. Are there any visible signs of alcohol or drug withdrawal symptoms? (Extreme perspiration, shakes, nausea, pinpoint pupils, cramping, vomiting) Yes No

9. Does the inmate's behavior suggest the risk of suicide? Yes No

10. Does the inmate's behavior suggest the risk of assault to staff or other inmates? Yes No

11. Is the inmate carrying or claims to carry medication that requires constant availability? Yes No

12. Are there any obvious physical handicaps? Yes No

IF ANSWERED YES TO ANY QUESTIONS FROM 2-12, PLEASE SPECIFY WHY IN COMMENT SECTION BELOW.

STAFF INMATE QUESTIONNAIRE

13. Are you presently taking medication for diabetes, heart disease, seizures, arthritis, asthma, ulcers, high blood pressure, or psychiatric disorder? Circle condition. Yes No No Response

14. Do you have a special diet prescribed by a physician? Type______________________ Yes No No Response

15. Do you have history of venereal disease or abnormal discharge? Yes No No Response

16. Have you recently been hospitalized or recently seen a medical or psychiatric doctor for any illness? Yes No No Response

17. Are you allergic to any medication? Yes No No Response

18. Have you fainted recently or had a recent head injury? Yes No No Response

19. Do you have epilepsy? Yes No No Response

20. Do you have a history of tuberculosis? Yes No No Response

21. Do you have diabetes? Yes No No Response

22. Do you have hepatitis? Yes No No Response

23. Do you have a painful dental condition? Yes No No Response

24. Do you have any other medical problem we need know about? Yes No No Response

25. Do you have an alcohol or drug use history? Yes No No Response

If so, what type ________ How much ________
For how long ________ Last Used ________
How often ________

Any additional comments (i.e., unusual behavior):

____

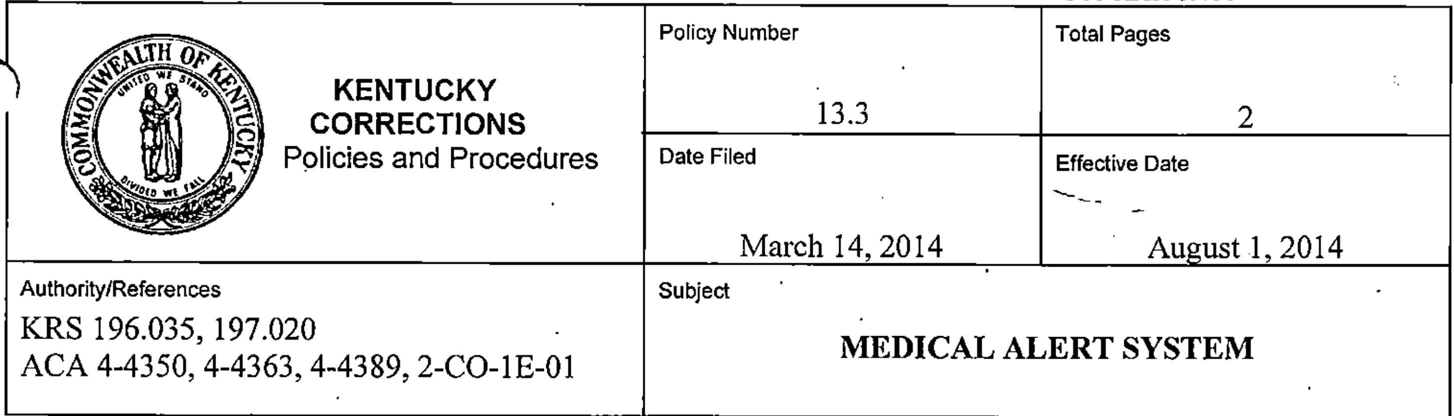
____

____

For Staff Member to Complete: This inmate has been informed how to access health services and the grievance system upon his admission. YES NO

____
Staff Signature

501 KAR 6:400



KENTUCKY CORRECTIONS Policies and Procedures	Policy Number 13.3	Total Pages 2
	Date Filed March 14, 2014	Effective Date August 1, 2014
Authority/References KRS 196.035, 197.020 ACA 4-4350, 4-4363, 4-4389, 2-CO-1E-01	Subject **MEDICAL ALERT SYSTEM**	

I. DEFINITIONS

"Medical alert system" means a system designed to provide immediate recognition of inmates who have specific illnesses.

II. POLICY and PROCEDURES

Inmates diagnosed with chronic conditions like allergies, asthma, diabetes, epilepsy, high blood pressure, heart disease, glaucoma or thyroid disease shall have available and participate in a medical alert system. Additionally, any inmate requiring dialysis shall have this noted according to the medical alert system. Inmates with chronic health problems shall be afforded care according to the individual treatment plan established by the institutional physician.

A. Purpose

1. An inmate having a chronic health problem may be subject to complications from the condition and may require immediate medical assistance. The medical alert system shall aid any employee in relaying accurate information in an emergency situation.

2. An individual with these conditions frequently have adverse responses to medication. The medical alert system shall enable medical staff to rapidly assess an inmate's medical needs and treat the inmate in an emergency situation.

B. Implementation

1. The medical department at each facility shall obtain a medical alert card from the Correctional Industries print shop.

2. After an inmate has been diagnosed as having a chronic medical condition, the medical record shall be tagged with this information. The medical department shall record the inmate's medical condition on a medical alert card and sign the card.

3. The card shall be laminated and issued to the inmate. It shall be worn at all times by the inmate along with the institutional identification card.

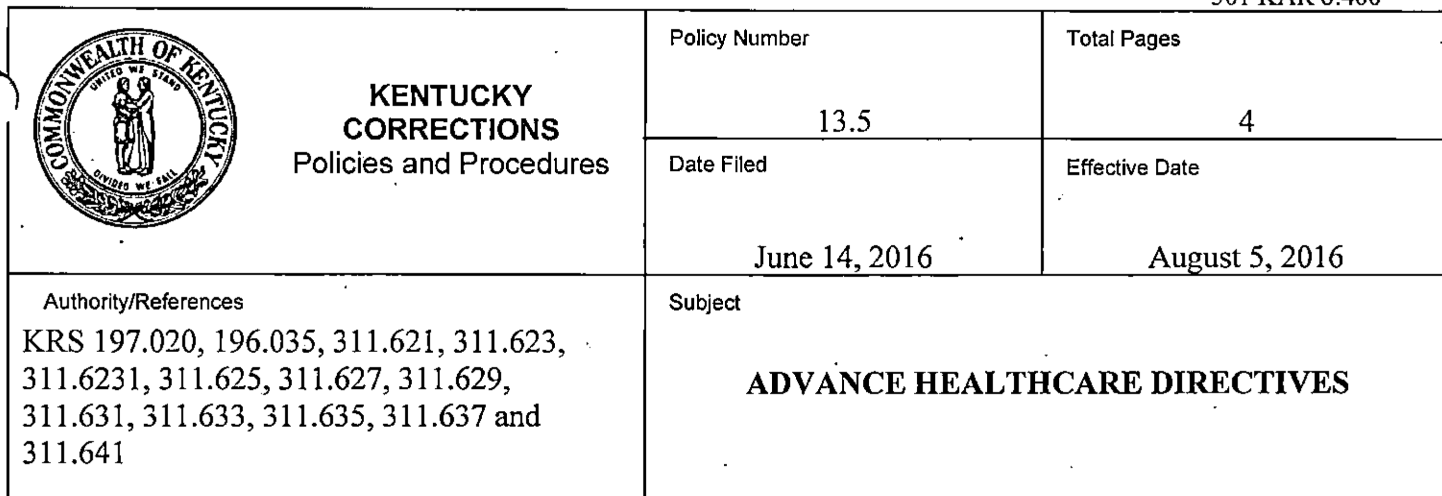
4. The medical department shall maintain a log of cards issued. Cards shall be numbered chronologically with the institutional designation or code letters following the number.

5. On transfer to another institution, the medical alert card shall remain with the inmate. On discharge, the card shall be filed with medical records.

CORRECTIONS CABINET MEDICAL ALERT CARD

Name ______________________ Number _________

_____________Asthma _____________Diabetes
_____________Diabetes _________Heart Disease
_____________Glaucoma _______Thyroid Disease
_______Renal Dialysis _______High Blood Pressure
_______Other _______________________________
Issuing Signature _____________________________
Date________________ Card No.______________



KENTUCKY CORRECTIONS Policies and Procedures	Policy Number: 13.5	Total Pages: 4
	Date Filed: June 14, 2016	Effective Date: August 5, 2016
Authority/References: KRS 197.020, 196.035, 311.621, 311.623, 311.6231, 311.625, 311.627, 311.629, 311.631, 311.633, 311.635, 311.637 and 311.641	Subject: **ADVANCE HEALTHCARE DIRECTIVES**	

I. DEFINITIONS

"Advance directive" is defined in KRS 311.621.

"Decisional capacity" is defined in KRS 311.621.

"Living will" means a document in which a person states his desire to have or not have extraordinary life-prolonging measures used when recovery is not possible from his terminal condition and complies with KRS 311.625.

"Health Care Surrogate" means an adult who has been designated to make health care decisions in accordance with KRS 311.621 to 311.643

"Life-prolonging treatment" is defined in KRS 311.621.

"Do Not Resuscitate Order" means a written order which authorizes medical personnel to withhold cardiopulmonary resuscitation, including artificial respiration, and defibrillation, from a particular patient in the event of cardiac or respiratory arrest. Such an order does not authorize the withholding of other medical interventions such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or to alleviate pain. A Do Not Resuscitate Order may hereinafter be referred to as a DNR Order.

"Permanently unconscious" is defined in KRS 311.621(13).

II. POLICY and PROCEDURE

A. Advance Directives

1. Advance directives are documents that specify end of life decisions and are signed only after the inmate receives appropriate information regarding the meaning and consequences of such decisions.

2. The Department of Corrections (DOC) shall accept all properly executed,

written advance directives and shall place the advance directives document after it is received in the inmate's medical record. The primary care provider or any medical department employee who receives an original or a copy of an inmate's advance directive upon admission, transfer, or commitment shall be responsible for ensuring that such original or copy is placed in the inmate's medical record.

B. Implementation

1. An inmate received by the Department of Corrections may upon admission be educated regarding the use of advance directives and Do Not Resuscitate Orders. The inmate may indicate his wishes through completion of an advance directive document that complies with Kentucky law.

2. The inmate may initiate advance directives at any time during incarceration.

3. The appropriate documents shall be read to an inmate who is not able to read, if the inmate is involved in the advance directive process during incarceration.

4 Any inmate whose decisional capacity is in question during the advance directive process shall be referred to a qualified mental health professional for a competency evaluation prior to completing any documents regarding advance directives.

5. Any inmate whose treating physician determines that his or her life expectancy is less than one year or who is to undergo a designated medical procedure shall be given the opportunity, before that procedure is performed, to sign or alter advance directives. The designated medical procedures shall include:

a. surgery
b. chemotherapy
c. admission to any outside hospital
d. admission to any DOC Medical Unit, including the Nursing Care Facility at Kentucky State Reformatory.

C. Changes in Directives

The inmate shall be offered the opportunity to update his advance directive document at least once each year, during the scheduled meeting with the Classification Committee.

D. Revocation

An inmate may revoke or alter any of his advance directives including the request for a DNR Order at any time without regard to his or her mental or physical condition. Revocation of any advance directive or DNR Order may be accomplished using any of the following means:

1. By written, signed, and dated declaration of the intent to revoke. An oral statement of intent to revoke may be made by any inmate with decisional capacity in the presence of two adults, one of whom shall be a health care provider.

2. By destruction of the original advance directives document by the inmate or by some person in the inmate's presence and at the inmate's direction.

3. An oral statement by an inmate with decisional capacity to revoke an advance directive shall override any previous written advance directive made.

4. When a revocation is communicated to any healthcare professional, that professional shall document this revocation in the inmate's medical record and immediately notify the responsible physician.

E. Implementation of Directives:

The DOC shall implement the advance directives of any inmate by the following procedure:

1. Upon completion, the advance directives document shall be placed in the inmate's medical file.

2. If the inmate is to be transported to any outside medical facility, the advance directive document shall be delivered to that facility.

3. If the inmate is admitted to the Nursing Care Facility or any other long-term medical unit within the DOC, the advance directive shall be placed in the medical chart for that unit.

F. Health Care Surrogate:

1. As part of the advance directive, an inmate can appoint a surrogate to make health care decisions for him when he no longer has decisional capacity. When making any health care decision for the inmate, the surrogate shall consider the recommendations of the primary care provider and attending physician and honor the decisions made by the inmate as expressed in his advance directive.

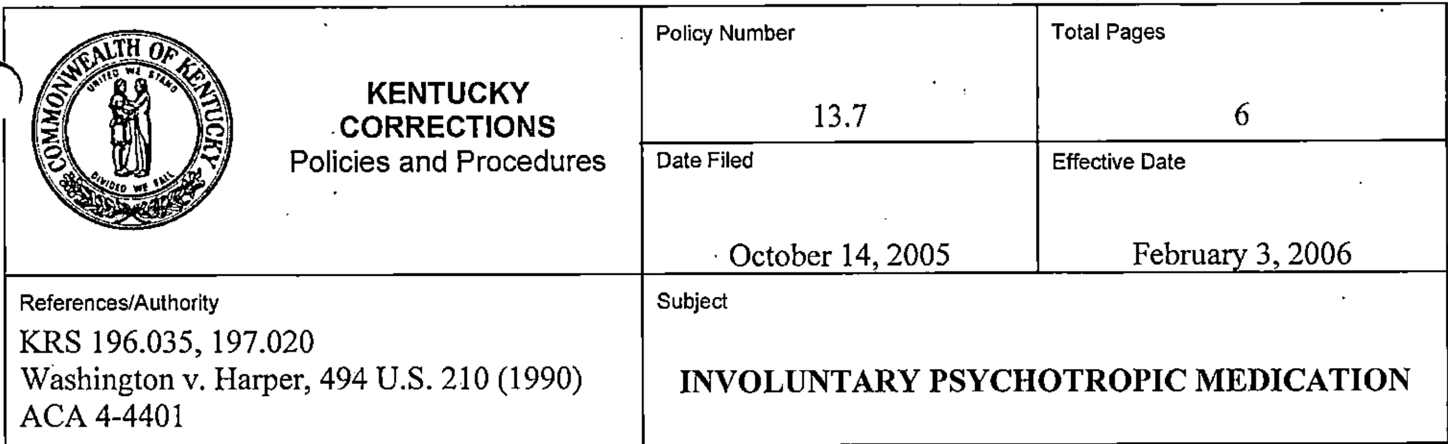
2. The surrogate shall not make a health care decision in any situation in

which the inmate's primary care provider or attending physician has determined in good faith that the inmate has decisional capacity.

3. An inmate may not appoint another inmate within the confines of the Kentucky Department of Corrections to be his health care surrogate. An exception may be made if the inmate surrogate is a relative.

4. Employees of the Department of Corrections shall not assume the role of designated health care surrogate for any inmate nor shall they witness advance directive documents or requests for DNR Orders unless they are a notary public.

501 KAR 6:400



KENTUCKY CORRECTIONS Policies and Procedures	Policy Number: 13.7	Total Pages: 6
	Date Filed: October 14, 2005	Effective Date: February 3, 2006
References/Authority: KRS 196.035, 197.020 Washington v. Harper, 494 U.S. 210 (1990) ACA 4-4401	Subject: **INVOLUNTARY PSYCHOTROPIC MEDICATION**	

I. DEFINITIONS

"Mental disorder" means any organic, mental, or emotional impairment which has a substantial adverse effect on an individual's cognitive and volitional functioning.

"Likelihood of serious harm" means a risk that a patient may inflict physical harm upon himself as evidenced by verbal or written threats, gestures, past behaviors or attempts to inflict physical harm on one's self; upon another; or upon the property of others.

"Gravely disabled" means a condition resulting from a mental disorder which causes a person to be in danger of serious physical harm resulting from a failure to provide for his own essential human needs for health or safety or in which the person manifests severe deterioration in routine functioning as evidenced by repeated and escalating loss of cognitive and volitional control over his actions and is not receiving care as essential for personal health and safety.

II. POLICY and PROCEDURES

Psychotropic medication shall be administered involuntarily only in emergencies or if special conditions exist and the due process procedures outlined below have been implemented. For involuntary medication to be administered, it shall be demonstrated that the patient suffers from a mental disorder and constitutes a likelihood of serious harm or is gravely disabled.

A. A physician may order involuntary medication in an emergency situation.

1. An emergency exists if, in the judgment of a physician, a patient suffers from a mental disorder and presents an imminent likelihood of serious harm to self or others, or is gravely disabled.

2. Emergency involuntary medication shall be administered only upon the order of a physician.

3. Emergency involuntary medication may be administered initially, and under the order of a physician, repeated if necessary for up to twenty-four

hours; however, if a physician orders, the period may be extended an additional forty-eight hours. The period during which emergency involuntary medication is administered shall not exceed seventy-two hours from the initial administration of medication.

4. If staff administers emergency involuntary medication, the patient shall be assessed and evaluated by medical personnel every hour for the initial four hours and every four hours during the designated time period.

5. If staff administers emergency involuntary medication, the patient shall be continuously supervised until medical personnel determine he is stable. Then the patient shall be placed on an appropriate security watch.

6. All actions regarding the administration of emergency involuntary medication shall be documented in the medical record and in an Extraordinary Occurrence Report.

7. If the physician orders emergency involuntary medication, medical staff shall immediately notify the Shift Captain or Supervisor who shall immediately notify the Warden or Institutional Duty Officer.

B. A psychiatrist may order non-emergency involuntary medication subject to the approval of the Involuntary Medication Hearing Committee if, in the judgment of a psychiatrist, a patient suffers from a mental disorder and poses a likelihood of serious harm to self, others or property, or may be gravely disabled.

1. The psychiatrist shall send written notification of the need to medicate to the institutional Warden.

2. The notice shall include an evaluation of the patient's current mental condition, the psychiatrist's opinion regarding the risk of harm or grave disability, and a description of the efforts taken to achieve voluntary medication compliance that were unsuccessful.

3. A staff person assigned by the Warden or designee to initiate procedures preparatory for convening an Involuntary Medication Hearing shall:

   a. Appoint a staff representative who is at least a Unit Manager and has not been involved in the current diagnosis or treatment of the patient.

   b. The patient and his staff representative, shall be given written, twenty-four hour advance notification of the intent to convene an Involuntary Medication Hearing. The notification shall include the following information:

1) Date and time of the hearing;

2) Diagnosis;

3) Information that reflects the factual basis for the diagnosis;

4) The basis for the determination that there is a medical necessity to involuntarily treat.

5) Notice of the patient's right to be present at the hearing and to present documentary evidence and to call witnesses on his behalf unless security and order dictate otherwise.

6) Notice of the patient's right to confront and cross-examine witnesses called by the institution unless security and order dictate otherwise.

c. The Warden or his designee shall appoint an Involuntary Medication Hearing Committee composed of members who are impartial, who have not been involved in the current diagnosis or treatment of the patient, and who have had appropriate training on this policy. The committee shall include:

1) A psychiatrist

2) A psychologist

3) An institutional or Central Office staff member Grade 13 or above who shall serve as the chair of the committee.

d. The hearing shall be recorded by an audio recording device.

1) A mental health professional shall present the case supporting the need for the administration of involuntary medication.

2) The committee shall decide the case by majority vote based on the evidence, provided the psychiatrist votes in the majority.

3) The decision of the committee shall be submitted in writing to the following:

a) The Warden;

b) The patient and his staff representative.

e. Approval by the committee to involuntarily medicate shall be granted initially for a period not to exceed fourteen (14) consecutive days from the date of the hearing.

C. If the treating psychiatrist determines continued involuntary medication shall be necessary beyond the initially approved fourteen day period, the psychiatrist shall send the Warden an involuntary medication progress report documenting the patient's response to medication, any changes in medication, any side effects and the patient's current attitude towards the medication.

1. Upon receipt of the psychiatrist's involuntary medication progress report, the Warden or designee shall appoint a second committee to review the need for continued involuntary medication.

   a. The committee, if possible, shall consist of the same persons who participated on the initial Involuntary Medication Hearing Committee.

   b. If any of the initial members are unavailable, the new committee shall include a psychiatrist, a psychologist and an institutional or Central Office staff member in accordance with Section II.B.3.c of this policy.

   c. The committee shall decide the case after a review of the patient's treatment record, health record and previous involuntary medication hearing records.

   d. The committee shall decide the case by majority vote provided the psychiatrist votes in the majority.

   e. The second committee may approve continued involuntary medication for a period not to exceed 180 consecutive days from the date of the second committee meeting.

2. The outcome of the second Involuntary Medication Committee's review shall be submitted in writing to the following:

   a. The Warden;

   b. The patient and his staff representative.

3. If the committee approves continued involuntary medication, the treating psychiatrist shall send the Warden an involuntary medication progress report every fourteen (14) days as long as medication administration remains involuntary.

D. Each time the treating psychiatrist determines it necessary to continue involuntary medication for an additional period of 180 days after the second review, the psychiatrist shall so state in the appropriate involuntary medication progress report to the Warden.

1. Upon receiving the psychiatrist's report, the Warden or designee shall appoint another Involuntary Medication Committee as described in Section II., B., 3., c.. to approve or disapprove continued involuntary medication for a period not to exceed 180 consecutive days.

2. Each committee shall decide the case based on the patient's treatment record, health record, and previous Involuntary Medication Committee hearing records.

3. Voting shall be conducted in the same manner as provided in Section II. B. 3. d. 2.

4. Each committee shall submit its decision in writing to the following:

   a. The Warden;

   b. The patient and his original staff representative.

5. The treating psychiatrist shall send the Warden an involuntary medication progress report every fourteen (14)days during each 180-day period.

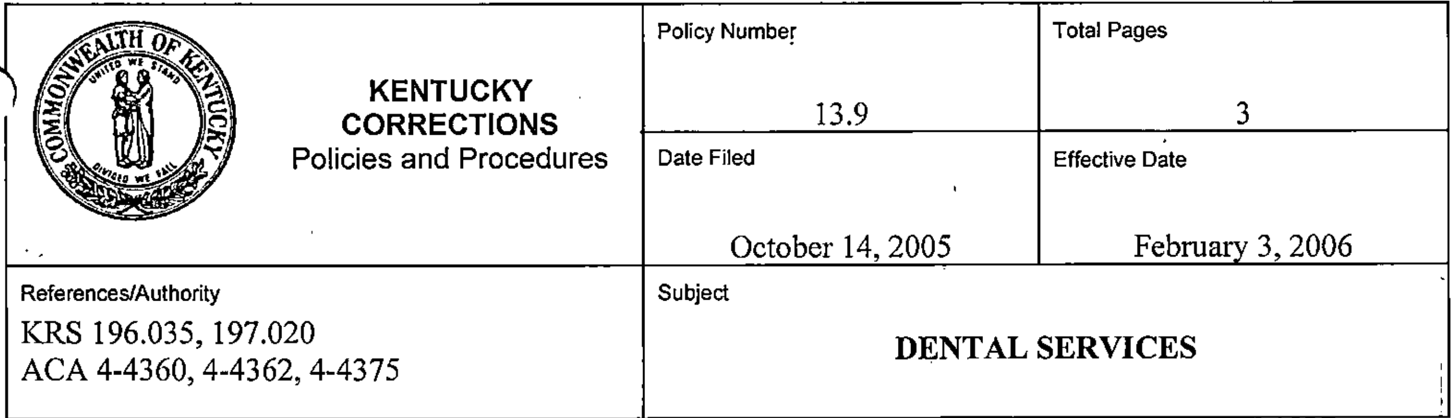
6. If the psychiatrist discontinues medication or if the patient begins to take medication voluntarily, the psychiatrist shall send the Warden a final involuntary medication progress report.

7. The patient through his staff representative has the right to appeal the decision of each Involuntary Medication Hearing or Committee review to the DOC Medical Director within forty-eight hours following receipt of written notification excluding weekends and holidays.

   a. The Director or designee shall review the appeal and respond in writing within forty-eight hours of the receipt of the appeal excluding weekends and holidays.

E. If the Warden has cause to believe that the continued administration of involuntary medication adversely affects the security of the institution or the safety of the staff or both, the Warden may reconvene the Involuntary Medication Hearing Committee for a second hearing with all the rights and procedures set out in Section II. B. 3.

F. If it is determined that involuntary medication shall be necessary beyond 180 days after the second review a new hearing shall take place in accordance with subsections II. A and B of this policy.



KENTUCKY CORRECTIONS Policies and Procedures	Policy Number 13.9	Total Pages 3
	Date Filed October 14, 2005	Effective Date February 3, 2006
References/Authority KRS 196.035, 197.020 ACA 4-4360, 4-4362, 4-4375	Subject **DENTAL SERVICES**	

I. DEFINITIONS

See CPP 13.2.

II. POLICY and PROCEDURES

A. Dental Services

The department shall provide maintenance dental care for any inmate, with his consent.

1. Dental Examination

A documented dental examination shall occur within ten (10) working days excluding weekends and holidays, of admission to Corrections. This examination shall include a history and examination of the hard and soft tissue of the oral cavity.

2. Dental Classification

At the initial examination, the patient shall be classified in the appropriate category according to the categories listed below. Documentation shall be noted in the medical record.

Class A This category indicates teeth requiring extraction due to:

a. Trauma

b. Teeth decayed beyond possibility of filling or injurious to the individual's health.

c. Root fragments remaining indicating pathology and interfering with construction of prosthetic appliance.

d. Pathology to hard and soft tissues.

e. A periodontal condition with severe bone loss.

f. Suspected ulcerative lesions or growths.

Class B — Teeth with carious lesions that may be restored.

Class C — Cases requiring oral prophylaxis and oral hygiene instruction.

Prophylaxis by the dentist or hygienist shall not exceed one (1) procedure per year.

Class D — This category involves prosthetic procedures.

Class E — The examination reveals dental work is not needed at this time.

3. Priorities for Treatment

   a. Class A and B cases shall be considered as the first priority.

   b. Class C and D cases shall be treated by appointment only and not during any period if work of a higher priority exists.

   c. If a patient refuses the Dentist's recommendation, the case shall be handled as a refusal of treatment.

4. Dental Prostheses, Orthodontic Devices or Root Canals

   a. Gold and Porcelain Crowns shall not be provided.

   b. Orthodontic devices shall be provided if an inmate's health is adversely affected without them.

   c. Prosthesis and any other procedure not included under classes A, B and C shall be provided at state expense only if necessary to address a serious medical need.

   d. If a prosthesis or orthodontic device is not deemed medically necessary it may be made available to the inmate at his own expense.

5. Any procedure not included under Classes A, B and C require authorization of the Dental Director

B. Inmate Responsibility

1. The inmate shall provide accurate information during the initial screening, examination and classification phases of the admission process.

2. The inmate shall be present for the appointment for examination or treatment.

C. Appointments

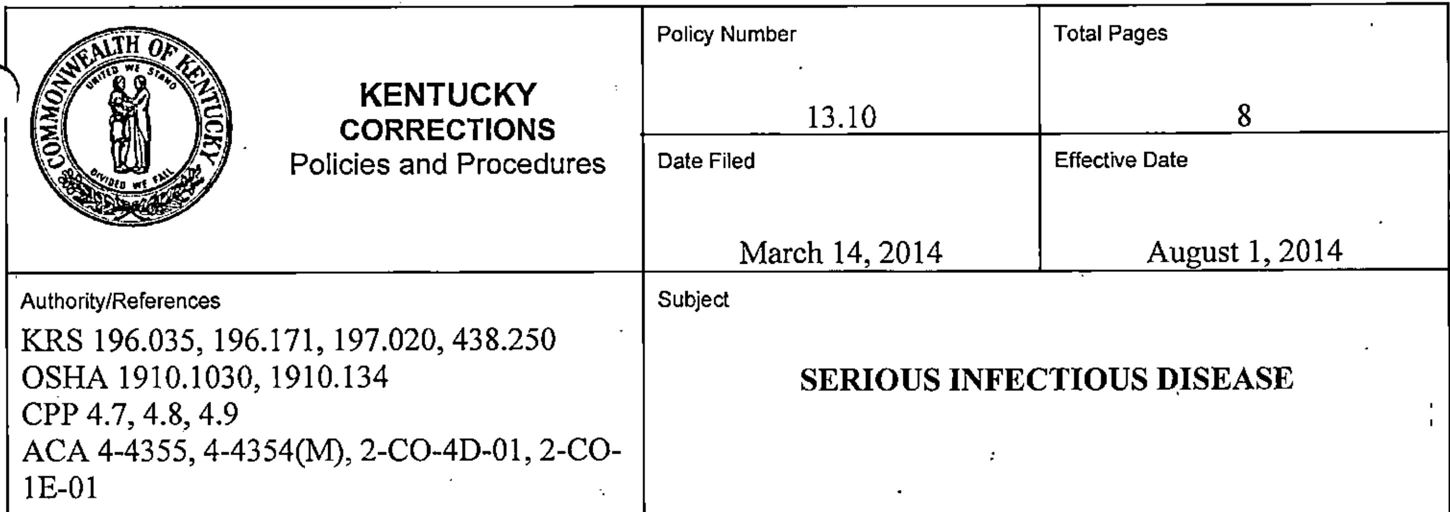
1. Each institution shall have an employee who schedules appointments for medical and dental care.

2. An inmate may be charged for dental care pursuant to KRS 197.020 and CPP 13.2.

3. Any patient failing to report for his appointment shall not routinely be provided a new appointment. His name shall be removed from the waiting list. These patients shall be required to contact the appropriate staff person in order to be returned to the bottom of the waiting list. A legitimate excuse may be considered on an individual basis, however, in all cases a notation shall be made in the individual record. A Category IV, item three disciplinary charge under CPP 15.2, may also be considered.

D. Emergency Dental Services

Each facility shall develop a method of addressing dental emergencies.



KENTUCKY CORRECTIONS Policies and Procedures	Policy Number: 13.10	Total Pages: 8
	Date Filed: March 14, 2014	Effective Date: August 1, 2014
Authority/References: KRS 196.035, 196.171, 197.020, 438.250 OSHA 1910.1030, 1910.134 CPP 4.7, 4.8, 4.9 ACA 4-4355, 4-4354(M), 2-CO-4D-01, 2-CO-1E-01	Subject: **SERIOUS INFECTIOUS DISEASE**	

I. DEFINITIONS

"Blood-borne pathogens" means pathogenic microorganisms present in human blood which may cause disease in humans, including Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV). Other pathogenic microorganisms may be identified or present during acute phases of other infectious diseases.

"Employee disease exposure kit" means an informational packet on procedures to follow after an occupational exposure to a possible serious infectious disease.

"Environmental controls" means guidelines or processes for promptly detecting infectious disease and evaluating environmental concerns.

"High risk behavior" means behavior which creates the possibility of transmitting a serious infectious disease, including tattooing, sexual contact, needle use, fighting or assaultive behavior, self-mutilation and body piercing.

"Infectious disease coordinator" means a designated medical staff in the Health Services Division appointed by the Commissioner to oversee infectious disease issues in Adult Institutions throughout Corrections.

"Occupational exposure" means a specific eye, mouth or other mucous membrane, non-intact skin or wound which comes in contact with blood or other potentially infectious material that may occur in the performance of an employee's duties.

"Personal protective equipment" (PPE) means specialized clothing or equipment which does not permit blood or other potentially infectious material to pass through or reach the employee's clothes or body and may include protective gloves, mask, protective shield, eye protection, mouthpiece or gown.

"Serious infectious disease" means tuberculosis, HIV or AIDS, hepatitis or other communicable disease that may pose a significant health risk.

"Universal precautions" means an approach to infection control that treats all human blood and certain human fluids, including semen and vaginal fluids, as if these are infected with HIV, Hepatitis B, Hepatitis C or other bloodborne pathogens.

II. POLICY AND PROCEDURE

A. Implementation

1. The Commissioner shall designate an Infectious Disease Coordinator.

2. The Infectious Disease Coordinator shall:

(a) be responsible for coordinating infectious disease issues at the institutional level throughout Corrections;
(b) remain informed of the current standards;
(c) maintain specific guidelines and recommendations; and
(d) advise and update the institutions of the guidelines and change in recommendations.

3. Each institution shall designate a medical staff manager to oversee serious infectious disease issues at the institutional level through the Infectious Disease Coordinator.

4. Under the direction of the Infectious Disease Coordinator, the medical staff manager of each institution shall implement procedures to identify and assess serious infectious disease related health risks and implement practices and procedures which reduce disease exposure.

5. All procedures shall conform to current standards of medical practice and take into consideration established guidelines and recommendations from:

(a) The Center for Disease Control and Prevention (CDC);
(b) The CDC's Advisory Committee for Immunization Practices (ACIP);
(c) The Occupational Safety and Health Administration (OSHA);
(d) The National Institutes for Occupational Safety and Health (NIOSH); and
(e) The Department of Health and Human Services (DHHS).

B. Training

1. Staff shall receive training as required in KRS 196.171 and the Staff

Training policies, CPPs 4.7, 4.8 and 4.9. This shall include training in universal precautions and airborne diseases precautions.

2. At the institution, staff shall receive training in bloodborne pathogens and tuberculosis in a two (2) hour orientation program. The person conducting this mandatory training shall be knowledgeable in the subject matter as it relates to the workplace.

3. Annual updates on bloodborne pathogens and tuberculosis shall be provided within one (1) year of the previous training.

4. Training records shall be maintained as required in CPPs 4.7, 4.8 and 4.9.

C. Disease Prevention

Serious infectious disease and health risks leading to disease may be identified by various means including health screening, risk assessment, physical examination, laboratory report, personal history, injury report and training and education. Staff shall be encouraged to participate in any immunization program offered by the institution for disease prevention.

D. Assessment

1. Upon entering Corrections, an inmate shall receive information regarding serious infectious diseases. The information shall be updated to reflect more recent medical findings. The staff involved in delivering this information shall be knowledgeable in the subject matter.

2. During the intake screening, all admissions shall be interviewed to identify an inmate who may have, or is at risk of, a serious infectious disease.

3. Upon receiving any intrasystem transfer, an inmate shall be interviewed by medical staff to identify the presence or risk of a serious infectious disease.

4. If an inmate is suspected of being in a situation involving a high risk of exposure to a serious infectious disease, he shall submit to testing deemed necessary by the appropriate medical staff, which may include:

   (a) an x-ray;
   (b) a skin test;
   (c) a sputum test;
   (d) a blood test; or
   (e) other test necessary to diagnose a serious infectious disease.

5. An inmate shall be tested for TB upon his admission to Corrections.

6. An inmate shall submit to TB testing annually in his birth month. The schedule for testing shall be established and conducted at the institution that the inmate is housed.

7. If an inmate is diagnosed with active TB or converts his TB Test, he shall submit to examination, testing and treatment determined necessary by the appropriate medical staff.

8. If an inmate is diagnosed with a serious infectious disease, he shall follow all reasonable precautions to prevent the transmission of the disease as instructed by the medical department, including:

   (a) use of personal protective equipment; and
   (b) avoidance of high risk behavior.

E. Universal Precautions

Universal Precautions shall be used to prevent contact with blood or other potentially infectious material.

1. Handwashing

   Hands shall be washed:

   (a) after touching blood, body fluids, secretions, excrement, or a contaminated item, regardless of whether gloves are worn;

   (b) immediately after gloves are removed; and

   (c) if otherwise indicated to avoid transfer of a serious infectious disease.

2. Personal Protective Equipment (PPE)

   PPE shall be available to each employee. If there is a high risk of exposure to a serious infectious disease, if administering cardio-pulmonary resuscitation (CPR) the appropriate PPE shall, if readily available, be used. PPE shall include:

   (a) Disposable Gloves

   Disposable, single use, gloves shall be worn during a procedure if there is contact with potentially infectious body fluids of another

person. Hands shall be washed immediately after completing the procedure.

(b) Mask, eye protection, face shield or gown

A mask, eye protection or a face shield shall be worn to protect mucous membranes of the eyes, nose, and mouth during a procedure if conditions are likely to generate splashes or sprays of blood, body fluids, secretions and excretions.

(c) Reusable Equipment: shields, handcuffs, duffel bags, restraints, and so on.

Reusable Equipment shall not be used on another person until it is properly cleaned and disinfected. Commercial products shall be available for disinfecting.

(d) Microshields

A microshield shall be used if administering CPR.

If rescue breathing or other occupational exposure occurs during CPR in the absence of a microshield, the employee involved shall be issued an employee disease exposure kit and referred to the institution's Medical Department or to the local community medical facility for follow-up.

(e) Disposable Equipment

Disposable or a single-use item including a microshield, flexcuff or plastic bag shall be properly discarded.

(f) Any vehicle used to transport an inmate shall be equipped with the appropriate PPE.

F. Environmental Controls

All areas shall be routinely cleaned and disinfected according to institutional procedures which meet OSHA standards as outlined under (d) Method of Compliance and (4) Housekeeping, Bloodborne Pathogens 1910.1030 published by the Kentucky Labor Cabinet.

Environmental Controls may include negative pressure room, ventilation system, microbial filtration device, disinfectant including a germicidal, bleach, and soap that isolates or removes pathogens from the work and living environment.

G. Occupational Health and Responsibilities

Staff shall be responsible for preventing injury if using a needle, scalpel or other sharp instrument or device. A used needle shall not be recapped or manipulated by hand. A used disposable syringe and needle, scalpel blade or other sharp item shall be placed in an appropriate puncture-resistant container located as close as practical to the area in which the item is used.

H. Airborne Precautions

1. Airborne precautions shall be used for a person known or suspected of being infected with a disease like TB that is transmitted through the air. Exposure may occur during coughing, sneezing or talking. Medical Staff shall advise of proper precautions.

2. An inmate suspected of having an airborne disease shall wear a surgical mask during contact with another person.

3. If having contact with an inmate suspected of having an airborne disease, an employee shall wear an OSHA approved mask and shall follow proper procedures as instructed by the medical department to insure an adequate fit. Airborne precautions shall meet OSHA Standard 1910.134.

I. Institutional Housing

1. If an inmate is diagnosed with a serious infectious disease, he shall be maintained in housing appropriate to:

   (a) control and reduce the risk of transmission of the disease as long as medically necessary; or
   (b) control the high risk behavior of the inmate.

2. The Medical Director shall work with the Classification Branch Manager to determine appropriate institutional housing to meet the medical and security needs of the inmate. Appropriate housing may include isolation or quarantine.

J. Work Assignments

An inmate diagnosed with a serious infectious disease shall be eligible to receive a work assignment, which is consistent with his medical status. The risk of transmission of the disease shall be considered in making a work assignment. An inmate known to have a serious infectious disease shall not be assigned to the Food Service Department.

K. Laundry

All laundry that may be contaminated shall be double bagged using a water-soluble bag as the inner bag. A written notification shall be attached to the bag noting its contents. An employee who has contact with contaminated laundry shall wear protective gloves and PPE. Contaminated laundry shall be bagged at the location of use. Laundry shall not be sorted or rinsed at the location of use. The contaminated laundry shall be transported to the Laundry. Contaminated laundry shall be washed in hot water, preferably with bleach, to kill pathogenic microorganisms.

L. Infectious Waste

Infectious waste handling and discarding shall meet the specifications set forth in OSHA standard 1910.1030. Each institution shall follow its waste management and waste handling policies.

M. High Risk Behavior

1. The following shall be reported to the Medical Department as soon as possible for necessary testing and follow-up:

   (a) an exposure to blood; or

   (b) an inmate has engaged in, or is suspected of, high risk behavior.

2. If an employee has an occupational exposure to a possible serious infectious disease, he shall be issued an employee disease exposure kit.

3. An inmate involved in high risk behavior shall be referred to the Medical Department. The inmate may be charged with the appropriate offense outlined in CPP 15.2 Offenses and Penalties.

4. If an inmate is charged with an offense for high risk behavior, the investigating officer shall, prior to a disciplinary hearing, immediately notify the Medical Department. The medical staff manager shall review the offense to determine if testing is necessary.

5. The medical staff manager and designated security staff shall determine if additional action is necessary to control the inmate's behavior and reduce the risk of transmission of the disease. This information shall be forwarded to Classification Staff for appropriate classification action.

6. An inmate who voluntarily engages in high risk behavior shall be charged the fee for testing in accordance with KRS 197.020 and CPP 13.2 and 15.2.

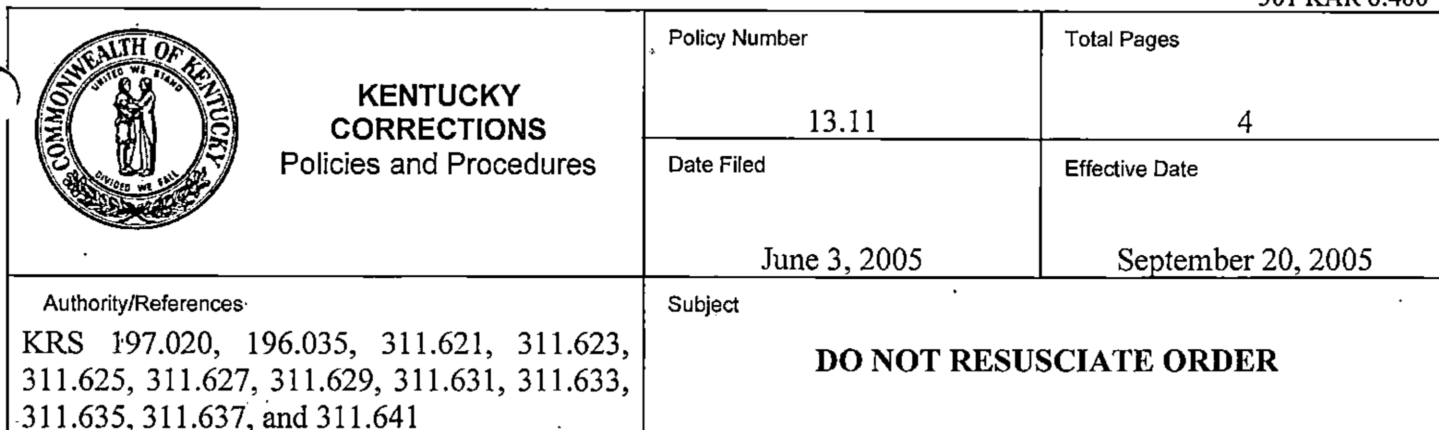
N. Refusal or Interfering with Health Care

1. If an inmate refuses the care that is deemed appropriate by medical staff for assessment or treatment pursuant to the provisions of this policy, he shall be subject to disciplinary action as a Category VI offense under CPP 15.2 Offenses and Penalties.

2. If an inmate creates a health hazard by conduct that may spread a serious infectious disease, he shall be subject to disciplinary action as a Category VI offense under CPP 15.2 Offenses and Penalties.

O. Confidentiality

The inmate's institutional file, offender record and medical record, including all information related to the inmate's serious infectious disease, shall be confidential. Access to a medical record shall be restricted to the medical staff who may communicate information within the medical department if necessary in the course of the inmate's medical care. Information regarding the inmate's medical condition may be provided to other staff if a legitimate need to know is established. This shall include any disciplinary report and life threatening situation. Every effort shall be made to contain sensitive information. Communication shall be limited to individuals who have to make a decision based on accurate information.



KENTUCKY CORRECTIONS Policies and Procedures	Policy Number 13.11	Total Pages 4
	Date Filed June 3, 2005	Effective Date September 20, 2005
Authority/References KRS 197.020, 196.035, 311.621, 311.623, 311.625, 311.627, 311.629, 311.631, 311.633, 311.635, 311.637, and 311.641	Subject **DO NOT RESUSCIATE ORDER**	

I. DEFINITIONS:

"Advance directive" is defined in KRS 311.621

"Decisional capacity" is defined in KRS 311.621.

"Designated health care surrogate" means a surrogate as defined in KRS 311.621.

"Do Not Resuscitate Order or DNR Order" means a written order which authorizes medical personnel to withhold cardiopulmonary resuscitation, including artificial respiration and defibrillation, from a particular patient in the event of cardiac or respiratory arrest. Such an order does not authorize the withholding of other medical interventions such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or to alleviate pain.

"Life-prolonging treatment" is defined in KRS 311.621.

"Permanently unconscious" is defined in KRS 311.621.

II POLICY and PROCEDURES:

The Department of Corrections shall provide resuscitative measures as deemed medically necessary, except when the inmate has conferred with the inmate's attending physician and completed a DNR order. The DNR order and advanced directive documents shall be placed in the inmate's medical record. A DNR order shall be consistent with sound medical practice and shall not in any way be associated with assisting suicide, voluntary euthanasia, or expediting the death of an inmate.

A. Before a DNR order may be written, the following shall be documented:

1. The inmate's attending physician has determined that the inmate is suffering from a terminal illness or injury and death is inevitable or likely to occur during the course of hospitalization.

2. The inmate's attending physician shall fully discuss the medical condition with the inmate. A competent inmate shall be encouraged to

participate in the decision and may voluntarily request and agree that a DNR order be placed in his medical record. The inmate shall be encouraged to discuss this subject with those persons close to him, including family members.

3. Community medical standards shall be used in determining an inmate's competency to voluntarily request or agree that a DNR order be placed in the medical record. If there are concerns regarding an inmate's competency, a consultation from another physician or qualified mental health professional may be requested. The conclusions and recommendations from the consultant physician or qualified mental health professional shall be documented in the inmate's medical record.

4. When the inmate is determined to be incompetent, unconscious, or otherwise unable to participate in the DNR decision, the ensuing guidelines shall be followed:

   a) The inmate's institutional physician may rely on an advanced directive document. This declaration shall be substantially consistent with the form approved by Kentucky law. The original health care declaration shall be contained in the inmate's medical record at the time the DNR is written.

   b) Every reasonable effort shall be made to obtain the written concurrence of a designated health care surrogate. If no advanced directive exists, reasonable efforts shall be made to obtain the written concurrence of one or several members of the inmate's immediate family. The inmate's attending physician shall document these efforts in the medical record. Resuscitative services shall not be withheld when a designated health care surrogate or an immediate family member is in disagreement.

5. A DNR order completed in an emergency situation outside a Department of Corrections facility shall not be honored once the emergency situation resolves and the inmate returns to a Department of Corrections facility. If a DNR order is appropriate at that time, a new, non-emergency DNR shall be completed upon return to the Department of Corrections facility.

B. Documentation:

1. Proper documentation of a valid DNR order in the inmate's medical record shall include, but not be limited to:

a) The diagnosis;

b) The prognosis;

c) If available, documentation of informed consent;

d) The inmate's expressed wishes (accompanied by written documentation by the patient), when possible. The DNR order shall be legibly written and signed by the inmate and witness. The witness shall not be a Department of Corrections employee unless the employee is a notary public;

e) The wishes of the immediate family member(s), when possible; and

f) The reference concerning the affected inmate's competency, when the decision was based on his concurrence.

2. The front of the inmate's medical record shall be appropriately marked to indicate the entry of the DNR order..

C. Review Process

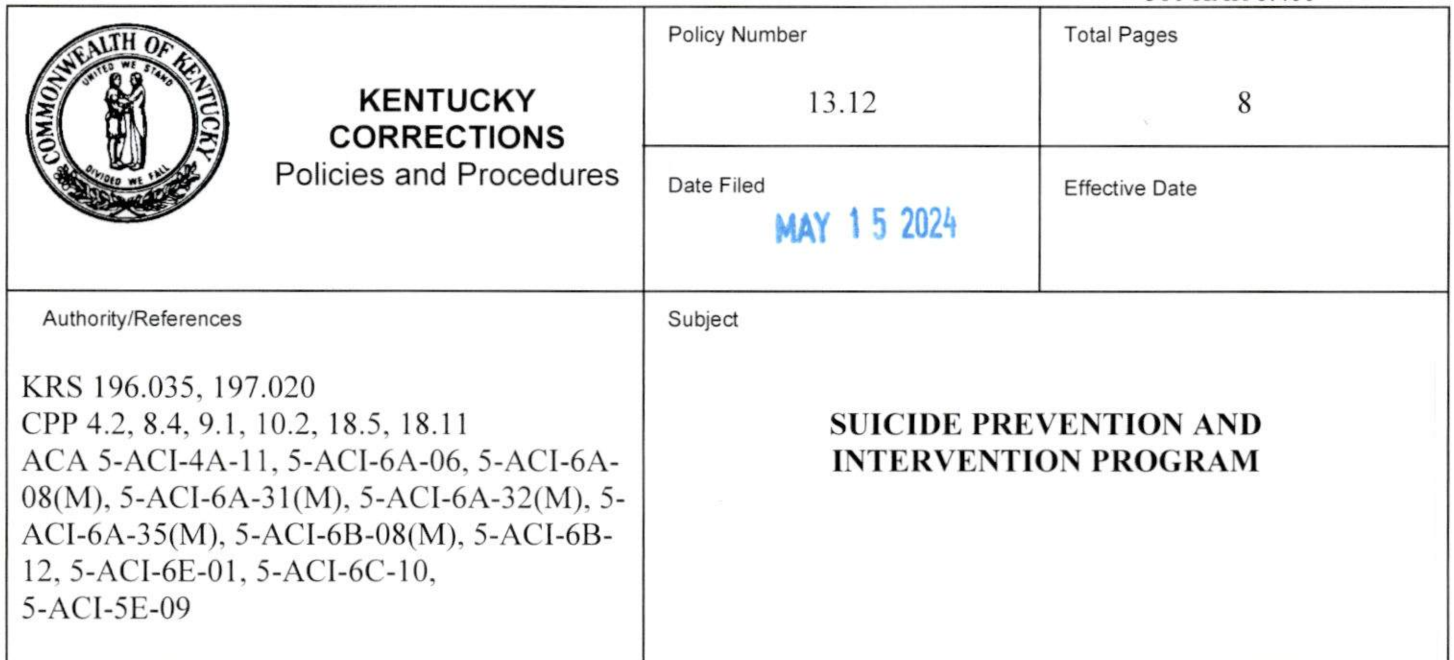
1. A DNR order shall be subject to regular review by the inmate's attending physician. The physician's review of the DNR order shall be documented in the inmate's medical record.

2. Any member of the medical staff, including nursing staff, may notify the medical supervisor in documenting a conflict in the decision making process. If a conflict arises, the medical supervisor, in conjunction with the inmate's attending physician, shall thoroughly review the inmate's medical record to determine if the DNR order is in compliance with all applicable standards and policies.

D. Rescinding: A DNR order shall remain in effect unless rescinded by the inmate or the inmate's attending physician. An inmate may rescind a DNR order at any time either verbally or in writing. If the inmate rescinds the DNR verbally, then staff shall immediately document the inmate's decision in the medical record and have the inmate sign the documented request, or have a witness sign the documented request in the presence of the inmate. All DNR alerts in the medical record shall be immediately removed and the attending physician shall be immediately notified.

E. Privacy Considerations: Consent shall be obtained from the inmate prior to medical staff discussing a competent inmate's medical condition with a family member. An inmate's refusal to consent discussion of his medical condition and treatment decisions with family members shall be documented in the inmate's medical record. If an inmate becomes incompetent to make decisions on his behalf, the designated health care surrogate or immediate family members may be contacted to discuss the inmate's medical condition and treatment decisions.

F. Related Medical Care: An inmate with a DNR order shall receive the maximal therapeutic efforts short of resuscitation. The DNR order shall not be justification for ignoring the inmate's welfare or comfort. The inmate's attending physician shall explain to the inmate that other treatment may be provided regardless of the DNR order in the medical record.



KENTUCKY CORRECTIONS Policies and Procedures	Policy Number: 13.12	Total Pages: 8
	Date Filed: MAY 15 2024	Effective Date:

Authority/References	Subject
KRS 196.035, 197.020 CPP 4.2, 8.4, 9.1, 10.2, 18.5, 18.11 ACA 5-ACI-4A-11, 5-ACI-6A-06, 5-ACI-6A-08(M), 5-ACI-6A-31(M), 5-ACI-6A-32(M), 5-ACI-6A-35(M), 5-ACI-6B-08(M), 5-ACI-6B-12, 5-ACI-6E-01, 5-ACI-6C-10, 5-ACI-5E-09	**SUICIDE PREVENTION AND INTERVENTION PROGRAM**

I. DEFINITIONS

"Continuous observation" means constant, uninterrupted supervision and is reserved for inmates believed to be at high-risk for harm as determined by a mental health professional. Continuous observation may be conducted by a Correctional Officer or by a trained inmate observer.

"Crisis Treatment Plan" means written tactic containing general objectives reflecting the overall strategy for managing a suicidal inmate.

"Inmate observer" means an inmate that is selected and approved by the mental health, medical, and administrative staff for a work assignment with specialized training to assist in the monitoring and observation of inmates on suicide watch.

"Restrictive Housing inmate" means an inmate separated from general population offenders who poses a direct and clear threat to the safety of persons or are a clear threat to the safe and secure operation of the institution.

"Special Management inmate" means an inmate requiring particular supervision for administrative, disciplinary, behavioral or other reasons.

"Suicide attempt" means a conscious, deliberate, self-injurious act intended to take one's own life or commit suicide with non-fatal outcome. The conscious and deliberate act intended to take one's own life or commit suicide may include injury by jumping, asphyxiation, laceration, overdose, hanging, drowning, injury by firearm, and poisoning. A determination concerning the act is the responsibility of the institution's mental health professional.

"Suicide Watch" means that the inmate will be observed every 15 minutes if deemed by a mental health professional to not be actively suicidal but has expressed suicidal ideation or has a recent history of suicide and is exhibiting significant symptoms of mental illness.

II. POLICY AND PROCEDURE

A suicide prevention and intervention program that emphasizes training, screening and identification, communication and referral, housing, assessment, levels of supervision, documentation, intervention, and reporting and review has been developed and implemented by the Kentucky Department of Corrections (DOC). All staff with responsibility for inmate supervision, including Correctional Officers, mental health professionals, administrative staff, and medical personnel shall be trained and responsible for the implementation of this program. The goal of these procedures is to reduce the potential for suicides and suicide attempts by inmates and to minimize the harm when suicide attempts occur. The procedures are consistent with security requirements and accepted mental health practices.

III. Training

A. Basic Pre-Service Training

1. Special training in the supervision and interaction with an inmate who has experienced suicidal thoughts or prior suicide attempts shall be incorporated into basic pre-service training for all staff with responsibility for inmate supervision. This training shall be an integral part of a workshop, which shall focus on the Special Management inmate and Restrictive Housing inmate. The training will be reviewed annually by the Division of Mental Health and Substance Abuse for revisions that reflect updates in the literature.

2. In general, this training module shall present a basic overview of the Special Management inmate and Restrictive Housing inmate and emphasis shall be placed on identification of individuals at-risk for suicide. The lesson plan shall also include methods for effective communication with a Special Management inmate and Restrictive Housing inmate and techniques for documenting observations regarding these individuals.

a. Identifying the warning signs and symptoms of impending suicidal behavior;

b. Understanding the demographic and cultural parameters of suicidal behavior, including incidence and variations in precipitating factors;

c. Responding to suicidal and depressed inmates;

d. Communication between correctional and health care personnel;

e. Referral procedures;

f. Housing observation and suicide watch level procedures;

g. Follow-up monitoring of inmates who attempt suicide;

h. Review of institutional procedures regarding suicide prevention including the location, access to, and use of the approved cut-down device.

B. Annual In-Service Training

1. Suicide prevention and intervention shall be offered as a component of the mental health training provided as part of the annual in-service training for all institutional staff. The training lesson plan shall be reviewed annually by the Division of Mental Health and Substance Abuse for revisions that reflect updates in the literature.

2. In general, the purpose of the training shall be to enhance the knowledge base and set of skills designed to enable a correctional professional to perform the work of handling inmate crises and suicide prevention and intervention with a greater degree of confidence and efficiency.

3. The suicide prevention and intervention portion of the training shall include the following areas:

a. During the in-service training, the staff member shall review the major characteristics of behavior that indicate suicide symptomology.

b. The staff member shall be advised to document and report any threats, changes in behavior or warning signals that indicate an inmate may be contemplating suicide.

c. A review of appropriate therapeutic techniques that may be used with an inmate who has experienced suicidal thoughts or prior suicide attempts shall accompany this lesson plan (for example: specific methods of communicating with an inmate).

d. An emphasis on documenting, referring, and report writing, shall be included in this training.

e. An open forum shall be included to allow in-service trainees to ask

questions that pertain to suicide related issues.

IV. Screening and Identification

A. All inmates entering or transferring within the Department of Corrections shall be screened for suicide potential as part of the mental health screening and mental health appraisal procedure.

1. A mental health screening shall be completed on all intra and intersystem inmate transfers upon admission.

2. Mental health appraisals shall be completed within 14 days for intersystem inmate transfers.

B. Special Management and Restrictive Housing Units including mental health units shall include routine monitoring for onset of depression and suicidal ideation among inmates assigned to their unit.

1. A Classification and Treatment Officer shall tour an assigned walk or wing once each week and document these interactions.

2. Mental health professionals shall conduct an initial 30-day screen and thereafter 90-day evaluation.

3. Correctional Officers shall conduct rounds every 30 minutes.

C. All inmates interviewed for identification and screening of suicide risk shall be seen in an environment that ensures privacy and protects confidentiality. Barriers to meeting with the inmate individually must be documented in the mental health progress note.

D. Inmates who are pregnant while in the custody of the DOC shall be provided pre- and post-natal, mental health services. All pregnant women shall be screened for depression at regular intervals throughout their pregnancy. Any results indicating depression or suicidal ideation or intent shall initiate a referral to mental health services in order that a treatment plan can be created to guide appropriate services or watch status.

V. Communication and Referral

A. Any staff member that hears an inmate verbalizing a desire or intent to commit suicide, observes an inmate making an attempt or gesture, receives information from the community of an inmate's suicide risk, or otherwise believes an inmate is at risk for suicide shall take immediate steps to ensure that the inmate is continuously observed and prevented from self-harm until appropriate medical,

mental health, or supervisory assistance is obtained, consistent with existing security procedures. The inmate shall remain on continuous watch in a safe cell until the inmate's mental health status can be assessed by a mental health professional.

B. Any staff member shall immediately refer both verbally and in writing, an inmate who exhibits behavior that is indicative of potential suicide to the institutional mental health professional.

C. The Major, Warden, or Deputy Warden shall ensure that appropriate correctional staff is properly informed of the status of each inmate placed on suicide watch. The previous shift captain shall be responsible for briefing the incoming shift captain on the status of all inmates on suicide watch.

D. A summary Suicide Watch Log entry shall be completed on all inmates placed on suicide watch by the assigned observing officer and trained inmate observer, if applicable, each shift and for any unusual occurrences.

VI. Housing Placement in a Safe Cell

If physical plant permits, the following shall apply:

A. Safe Cells

Suicide watches shall only occur in approved locations:

a. Single cell within a mental health unit; and

b. Segregation cell, for brief assignment unless necessitated by documented security concerns.

B. Specifications of Safe Cells

A safe cell shall meet the following specifications:

1. Stainless fixture sink/toilet combination with push button flush and faucet. (Push button is important so the inmate cannot hang himself from the faucet handles, etc);

2. High security bed bolted to the floor are acceptable. The bed may be 12" off the floor. However, all bedposts or bars at the head and foot of the bed shall be removed and the sharp edges covered;

3. Fixtures, pipes, etc. that an inmate may use to hang himself shall be covered with steel or fine mesh. Fine mesh shall be placed over windows and should

be hinged to allow cleaning on both sides. Hinging should be between the screen and windows with a key lock rather than a padlock;

4. No furniture attached or unattached to walls and floor, other than stated in this policy;

5. Visibility to all areas of the cell. Convex mirrors may be used if needed. Convex mirror's edges shall be flush with the wall so that nothing can hang from them;

6. If there is a shower, fixtures shall be breakaway or recessed with push buttons;

7. Cuff port or tray slot;

8. No functional electrical outlets or switch plates;

9. Adequate ventilation;

10. Adequate lighting; and

11. Camera in cell, if available, although this shall not take the place of direct observation.

C. For each inmate placed on suicide watch the following shall occur:

1. The inmate shall be housed in a safe cell, if available.

2. The safe cell shall be inspected immediately before the inmate's placement. Documentation of the cell search shall be entered into the Suicide Watch Log.

3. The inmate shall be strip-searched before being placed in the designated safe cell and the search shall be documented in the Suicide Watch Log.

4. A Department of Corrections approved suicide-resistant gown or suicide blanket shall be provided at the conclusion of the strip search. Provision shall be made to supply the inmate with a security garment that promotes inmate safety in a way designed to prevent humiliation and degradation.

VII. Assessment

A. All inmates placed on a suicide watch shall be evaluated by the institutional mental health professional as soon as possible, but no later than 24 hours after the initiation of the watch excluding weekends and holidays. Assessments shall be conducted

following a review of the inmate's mental health file.

B. A mental health professional's evaluation may include both subjective and objective methods of gathering information regarding the inmate's psychological state and intent to do self-harm.

C. Based on this evaluation, the mental health professional shall determine the appropriate level of monitoring, which will include either Continuous Watch or 15 Minute Watch.

D. The mental health professional shall communicate to the Unit Administrator and security staff the level of monitoring required.

E. Reassessment of the suicide status shall occur daily by the mental health professional. A reassessment shall not be conducted without access to, and a full review of, any day-to-day changes after the initial review of the mental health file.

F. The mental health professional shall monitor inmate as needed and adjust the Watch Status as appropriate. The watch status may only be terminated by a mental health professional.

G. While an inmate is on suicide watch, physical restraints for mental health purposes may only be used as a last resort for periods in which the inmate is physically engaging in self-destructive behavior. The restraint shall be in compliance with CPP 9.1.

VIII. Suicide Watch – Levels of Observation and Supervision

A. Continuous Observation

1. A Correctional Officer or trained inmate observer shall observe inmates on a continuous, uninterrupted basis at this level.

2. If the cells used for suicide watch at a given institution are physically located next to one another, with an unobstructed view of both inmates and their entire cells, one officer or trained inmate observer may be assigned to observe two inmates at this level of observation.

3. Property shall be limited to mattress, approved suicide-resistant gown or suicide blanket, and other items at the discretion of the mental health professional. Any property of an offender placed on continuous observation may have property removal or allowance reviewed by the Warden or designee for appropriateness.

4. Any staff member may place an inmate on Continuous Observation through

the shift supervisor until the inmate is seen by a mental health professional.

B. 15 Minute Watch

1. This level of watch requires that staff observe inmates at irregular, staggered intervals, not to exceed 15 minutes, with documentation of the inmate's condition as the observation occurs.

2. The property of the inmate shall be determined at the discretion of the mental health professional. Any property of an offender placed on 15 Minute Watch may have property removal or allowance reviewed by the Warden or designee for appropriateness.

3. Any staff member may request upgrading the suicide watch level of an inmate from 15 Minute Watch to Continuous Watch by notifying the shift supervisor. However, only a mental health professional may downgrade suicide watch from Continuous Watch to a 15 Minute Watch or discontinue a suicide watch after a face-to-face assessment in an environment that ensures confidentiality.

IX. Documentation

A. The Suicide Watch Log shall be completed on all inmates placed on suicide watch.

B. The mental health professional shall respond as soon as possible upon notification of the watch request to conduct a face-to-face evaluation of the inmate in an individual session. A brief progress note shall be made in the inmate's medical record with reference to the completed suicide consultation, any clinical intervention used to stabilize the inmate, and the Crisis Treatment Plan.

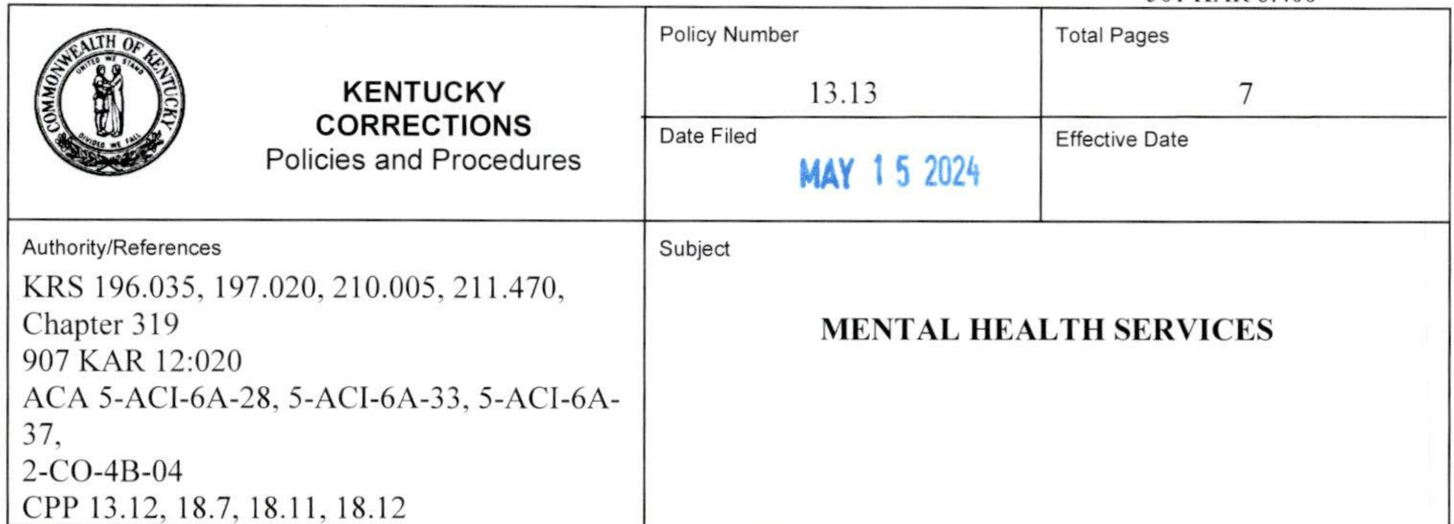
C. Reassessments or changes in watch status shall be completed by the mental health professional and documented in the medical record.

D. The mental health professional shall make daily progress notes in the medical record of inmates on suicide watch. Any changes in property or Crisis Treatment Plan shall be included in the daily progress note.

E. The discontinuation of or any changes in watch status shall be documented by the mental health professional in the medical record.

F. The correctional officer or trained inmate observer shall maintain the Suicide Watch Log until the mental health professional removes the watch.

G. The Shift Supervisor sign the Suicide Watch Log being used on their shift during the Shift Supervisor's institution rounds.



KENTUCKY CORRECTIONS Policies and Procedures	Policy Number: 13.13	Total Pages: 7
	Date Filed: MAY 15 2024	Effective Date:
Authority/References: KRS 196.035, 197.020, 210.005, 211.470, Chapter 319 907 KAR 12:020 ACA 5-ACI-6A-28, 5-ACI-6A-33, 5-ACI-6A-37, 2-CO-4B-04 CPP 13.12, 18.7, 18.11, 18.12	Subject: **MENTAL HEALTH SERVICES**	

I. DEFINITIONS

"Developmental disability" is defined by 907 KAR 12:020(3).

"DSM" means the current Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Intellectual disability" is defined by 907 KAR 12:020(6).

"Kentucky State Reformatory Correctional Psychiatric Treatment Unit (KSR CPTU) and Kentucky Correctional Institution for Women Psychiatric Care Unit (KCIW Lonnie Watson C-Wing)" mean units that provide specialized housing as well as mental health treatment programs provided by the Department of Corrections Division of Mental Health to meet an inmate's mental health needs.

"Mental Health Authority" means the Director of the Kentucky Department of Corrections Division of Mental Health.

"Mental illness" is defined by KRS 210.005(2).

"Outpatient psychiatric services" means the psychiatric providers who conduct initial psychiatric reviews and conduct regularly occurring follow-up appointments with inmates who are diagnosed with mental illness.

"Program staff" means any employee of the Department of Corrections whose primary job tasks include classification or program functions as opposed to security functions and includes classification and treatment officers and unit administrators.

"Psychological provider" means a person who provides professional services for the Department of Corrections and is licensed or certified to practice psychology pursuant to KRS Chapter 319.

"Recreational staff" means any employee of the Department of Corrections whose primary job tasks include supervision or management of inmate recreation or recreational programs

at a DOC institution and includes recreation leaders.

"Serious mental illness" or "SMI" is defined through diagnosis, duration, and significant functional impairment and:

A. Means:

1. A current diagnosis by a Department of Corrections psychological or psychiatric provider that includes (in accordance with the DSM) one or more of the following:

    a. Schizophrenia and the spectrum of diagnoses that make up psychotic disorders which result in a significant break from reality (delusional disorder, schizophreniform disorder, and schizoaffective disorder);
    b. The subset of depression disorders classified as "severe" or "with psychotic features" including major depression disorder (single or recurrent episode);
    c. The subset of bipolar and related disorder classified as "severe" or "with psychotic features" including bipolar I disorder; or
    d. The subset of neurocognitive disorders with the specifier of "major" including: Neurocognitive Disorder related to Alzheimer's, Lewy Bodies, Frontotemporal Disorder, Traumatic Brain Injury, HIV Infection, Prion Disease, Parkinson's Disease, Huntington's Disease, or Multiple Organic Etiologies including Vascular;

2. A duration of at least one (1) year; and

3. The manifestation of significant functional impairment that has been documented in the medical record, and is readily observable by custody or mental health staff; and

B. Does not mean inmates with a primary diagnosis of substance abuse or dependence, developmental disorders, or personality disorders.

"Significant functional impairment" means a determination by a Department of Corrections psychological or psychiatric provider that the inmate has consistently demonstrated difficulty in his or her ability to engage in activities of daily living, including eating, grooming, personal hygiene, maintenance of housing area, participation in recreation, or ambulation as a consequence of any diagnosis set out in the definition of serious mental illness, or the inmate has consistently demonstrated serious dysfunctional or disruptive social interactions including withdrawal, bizarre or disruptive behavior as a consequence of any diagnosis set out in the definition of serious mental illness.

"Social Services Clinician" (SSC) means any employee of the Department of Corrections so designated by personnel specification.

"Traumatic brain injury" is defined by KRS 211.470(3).

II. POLICY AND PROCEDURE

It is the policy of the Kentucky Department of Corrections (DOC) to offer a comprehensive program of mental health services, staffed by qualified personnel, to meet the needs of the inmate population. The programs shall include various levels of treatment and inmates shall be evaluated and referred to specific program components based on need. An inmate may seek psychological or psychiatric services or may be referred by institutional staff.

A. Mental Health Services – General Provisions

1. All decisions involving medical judgment relative to mental health issues, including detection, diagnosis, treatment, and referral; shall be made by mental health or medical personnel, under the overall direction and supervision of the Health Services Division.

2. The DOC shall provide a variety of mental health services through psychologists, when indicated, including:

   a. Initial diagnostic screening and appraisals;

   b. Psychological evaluation;

   c. Referrals to outpatient psychiatric services (OPS) to determine appropriateness of treatment with psychotropic medication;

   d. Group counseling;

   e. Brief, solution-focused individual counseling;

   f. Sex Offender Treatment Program;

   g. Referral to the Correctional Psychiatric Treatment Unit (CPTU) at Kentucky State Reformatory or to the Lonnie Watson C-Wing at Kentucky Correctional Institution for Women with programs provided by the Division of Mental Health;

   h. Segregation reviews;

   i. Pregnant and post-partum inmates;

   j. Treatment plans; and

   k. Crisis intervention and completion of an appropriate crisis follow-up treatment plan.

3. The psychiatric providers shall provide a variety of mental health services

including:

a. Initial diagnostic screening;

b. Psychiatric evaluation;

c. Psychiatric follow up;

d. Referrals to Psychology; and

e. Referral to CPTU or Lonnie Watson C-Wing.

4. Mental health services shall be provided by, or under the supervision of, mental health professionals, who meet the educational and licensing or certification criteria of their professional discipline. These services may be provided by contract workers or state employees.

5. Institutional level policies, procedures and schedules of activities, that relate to mental health activities, shall be reviewed and approved by the Mental Health Authority, prior to implementation. Department level policies and procedures, controlling the Sex Offender Treatment Program (SOTP), CPTU, and Lonnie Watson C-Wing programs, shall be approved at the Central Office level by state employees.

6. Any student or intern providing mental health services shall work under the direct supervision of a mental health professional, commensurate with his or her level of training.

B. Mental Health Services Referral Process

1. Within twenty-four (24) hours of entry into any institution, an inmate shall receive an initial mental health screening by a mental health trained or mental health professional. All inmates shall receive a mental health appraisal by a mental health professional within 14 days of admission.

2. Within three (3) working days of the inmate's entry into the institution, the assigned Classification and Treatment Officer shall interview the inmate and review the inmate's institutional records.

3. Any inmate admitted with a guilty but mentally ill verdict shall be referred for services in accordance with CPP 18.12.

4. Non-Emergency Referrals by Non-Mental Health Staff

a. Non-emergency referrals shall include the inmate's identifying information and reason for referral. A mental health referral form may be completed by any staff member and forwarded to mental health.

b. Upon receipt of the written referral, the psychologist shall schedule an appointment for the psychological evaluation and interview, directed toward determining the basis for the behavior and its remediation.

c. Future appointments for individual counseling may be set up, provided the inmate agrees to further counseling and further counseling is indicated.

d. If deemed appropriate, the inmate may be referred to the consulting psychiatrist for further evaluation or possible medication.

e. An inmate may self-refer by signing up for sick call to see psychology staff at no charge.

5. Emergency Referrals by Non-Mental Health Staff

a. During regular business hours, an inmate may be brought to Psychological Services by the referring person or a phone call may be made informing the psychologist of the need for evaluation. After regular business hours, a phone call may be made informing the psychologist of the need for evaluation. A suicidal inmate shall be managed as indicated in CPP 13.12. A transfer to a treatment unit shall be conducted as indicated in CPP 18.11.

b. Disposition of the inmate including need for a mental health watch or psychiatric referral shall be determined by the mental health professional and communicated to the Warden or his designee.

6. Upon completion of the initial case review, the psychologist may:

a. Find that no further action is needed. This finding shall be documented in the inmate's electronic medical record.

b. Refer the inmate to the appropriate programming. Examples include: the Sex Offender Treatment Program, Alcoholics Anonymous, group counseling, and the Substance Abuse Treatment Program, and serious mental illness programs at CPTU or Lonnie Watson C-Wing.

c. Conduct a full psychological evaluation, to further assess the inmate's need or to diagnosis the inmate's problem. Evaluations may include any of the following: clinical interview; diagnostics for intellectual, personality, substance abuse, trauma, adaptive functioning; consultation with family members; record reviews; or review of offense in order to determine the most appropriate treatment decisions.

d. Refer the inmate for a psychiatric evaluation through the OPS.

7. If no mental health problems are apparent at admission, but possible problems are observed at a later date, the inmate shall be brought to the attention of the institutional psychologist and the above mentioned referral process shall be followed.

8. If a full psychological evaluation is prepared by the institutional psychologist:

   a. The evaluation shall include a review of mental health screening and appraisal data.

   b. The evaluation shall include direct observation of the inmate's behavior by the psychologist and other staff.

   c. The psychologist may collect and review additional data from individual diagnostic interviews and tests assessing personality, intellect, and coping abilities.

   d. The evaluation shall include a compilation of the individual's mental health history.

   e. The evaluation shall include the development of an overall treatment management plan with appropriate referrals.

   f. The evaluation shall be completed within fourteen (14) days of the date of referral.

C. Mental Health Services - Emergency Care

1. Mental health emergencies requiring on-site crisis intervention shall be handled in accordance with CPP 13.12.

2. In the case of mental health emergencies requiring emergency transportation of the inmate from the institution, the transportation shall be handled in accordance with CPP 18.7.

D. Assignment - Mental Illness or Intellectual/Developmental Disabilities or Neurocognitive Disorders

1. If possible, an inmate with intellectual/developmental disabilities or mental illness shall be housed in the general institutional population, provided the inmate is functioning at a level that permits general population living.

2. An inmate, who is intellectually disabled to the degree that does not permit successful general population living, shall be referred for evaluation for

placement in either a treatment program or a specially designed living area.

3. An inmate whose current mental health situation does not permit successful placement in general population shall be assigned to the least restrictive institutional environment, which may include CPTU, Lonnie Watson C-Wing, or a specially designed living unit for inmates that require more support.

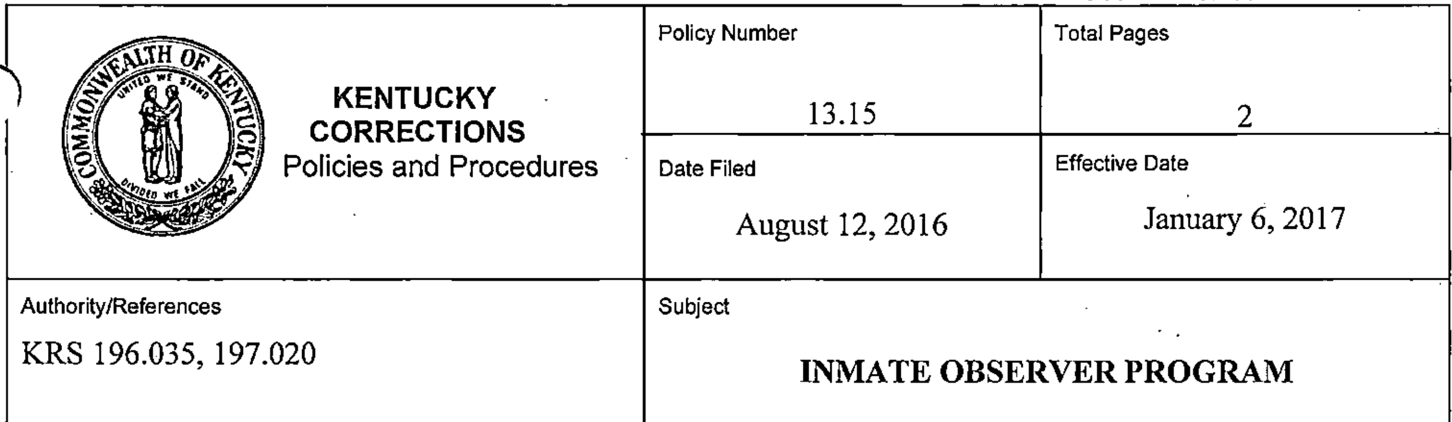
4. An inmate presenting with a severe mental illness shall be housed in the least restrictive environment that is deemed safe by the multidisciplinary service team and does not adversely lead to imminent danger to the inmate, others, or the safety and security of the institution.

5. Except in emergencies, a representative of the warden and a representative of the Mental Health Authority shall consult prior to making housing and program assignments, transfer recommendations, and prior to the imposition of disciplinary action for an inmate who meets the criteria for serious mental illness.

E. Continuity of Care for Seriously Mentally Ill Inmates

1. At each regularly scheduled reclassification or other qualifying event, such as transfer, an inmate identified as mentally ill or seriously mentally ill shall be reviewed by the classification committee and psychology staff to ensure that an appropriate level of care is being provided.

2. Ongoing mental health services grounded in evidence based practices including individual and group counseling shall be provided to an inmate who agrees to such services and for whom ongoing treatment is indicated.



KENTUCKY CORRECTIONS Policies and Procedures	Policy Number 13.15	Total Pages 2
	Date Filed August 12, 2016	Effective Date January 6, 2017
Authority/References KRS 196.035, 197.020	Subject **INMATE OBSERVER PROGRAM**	

I. DEFINITIONS

None

II. POLICY and PROCEDURE

The intent of the Inmate Observer Program is to utilize trained, specially selected offenders to monitor other offenders that have been placed on watch status.

A. Selection

1. Because of the sensitive nature of observation assignments, the selection of Inmate Observers shall be done with great care. Inmates wishing to be trained and employed as Inmate Observers shall be considered on an individual basis and shall require approval from mental health, medical, and administrative staff. The assignment shall be posted as required; except, an inmate shall not be considered for selection without a written endorsement from staff.

2. Criteria that may be used in the selection process includes:

   a. Disciplinary history
   b. Nature of crime
   c. Mental and medical health status
   d. Educational achievement
   e. Interaction skills

B. Training

1. Selected Inmate Observers shall also complete a training program offered by a member of the mental health or health staff. The Classification and Treatment Officer (CTO) shall document completion of this training in the Inmate Observer's Institutional Record.

2. The training program shall include the following topics:

   a. Confidentiality and privacy considerations

b. Signs and symptoms of mental illness and self injurious behavior
c. How to summon staff during any shift
d. Appropriate recording of behavior
e. Appropriate interaction with inmate being observed

3. Additional training may be offered or required for Inmate Observers

C. Hours of Compensation

1. Inmate Observers shall work eight (8) hour shifts and occasionally may be required to work seven (7) days per week. They shall receive a rate of pay commensurate with the assignment.

2. Inmate Observers shall have at least one (1) ten (10) minute break every hour and one (1) thirty minute break for a meal during the shift.

D. Monitoring of Inmate Observers

Although Inmate Observers are carefully selected, they shall be supervised by staff. The supervision shall be provided by staff in the immediate area and shall consist of checks, at least every fifteen (15) minutes. An inmate shall not be assigned to a watch without adequate provisions for staff supervision and the ability to obtain rapid assistance.

E. Removal

An inmate Observer may be removed from his positions as observer, upon the recommendation of any two (2) staff members. Removal may be a result of inattentiveness or other acts of indiscretion.