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| <u>ADMINISTRATIVE REGULATION</u> | | REGULATION NUMBER 700-31 | PAGE NUMBER 1 OF 4 |
|  COLORADO DEPARTMENT OF CORRECTIONS | | CHAPTER: Offender Health Services | |
| | | SUBJECT: Fort Lyon Correctional Facility Special Medical Needs Unit Admission Process | |
| RELATED STANDARDS: ACA Standards 4-4133 and 4-4399 | | EFFECTIVE DATE: December 15, 2010 | |
| | | SUPERSESION: 11/01/09 | |
| OPR: OCS | REVIEW MONTH: December |  Aristedes W. Zavaras Executive Director | |

I. POLICY

It is the policy of the Colorado Department of Corrections (DOC) to evaluate the needs of offenders with medical conditions or physical disabilities that require a higher level of nursing care that cannot be provided in most DOC facilities. Based on objective qualified medical criteria, offenders who are in greatest need of specialized treatment and management will be assigned to the Fort Lyon Correctional Facility (FLCF) Special Medical Needs Unit (SMNU). [4-4133] [4-4399]

II. PURPOSE

The purpose of this administrative regulation (AR) is to define criteria and procedures governing placement and release from the Fort Lyon Correctional Facility Special Medical Needs Unit.

III. DEFINITIONS

- A. Activities of Daily Living (ADL): The acts of completing personal hygiene, toileting, showering, bathing, and transferring between wheelchair and bed or toilet.
- B. Admission Review Committee: A committee chaired by the health services administrator, or designee, and comprised of multi-disciplinary members to include, but not limited to: the FLCF warden, or designee, and the case manager supervisor.
- C. Contract Worker: Any person employed under contractual arrangement to provide services to the DOC: any person employed by private or public sector agencies who is serving under DOC special assignment to provide services or support to DOC programs. The employee/employer relationship lies with the contractor. All Department agreements are for a specified period and are renewable.
- D. DOC Employee: Someone who occupies a classified, full or part-time position in the State Personnel System in which the Department has affect over pay, tenure, and status.
- E. Impairment: The severity of an offender's disability related to a medical or mental health condition with associated symptoms requiring a higher level of care.
- F. Special Medical Needs Unit: A 48 bed specialized unit located within the facility operated by Clinical Services to provide 24 hour supervised nursing care for those offenders who cannot be adequately cared for in general population housing units, but who do not require hospitalization.

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IV. PROCEDURES

A. Recommendation Guidelines for Placement Criteria

1. ***Offenders with a medical condition or physical disability that inhibits their ability to perform daily living activities, or presents them at risk of victimization due to their diagnosis or natural aging process. [4-4133]***
2. Offenders coded as an M3, M4, or M5, and/or P1, P2, or P3 are eligible for admission to any of the two levels of medical care depending on the medical level determined by the "FLCF Acuity Assessment Form" (Attachment "A"). (Offenders rated as P4 and P5 will require special review by the admission committee.)
3. Offenders with a custody level of minimum, minimum-restricted, or medium that meet the criteria listed above. (Acceptance of close custody offenders is at the warden's discretion.)

B. Referral Processes

1. ***Any DOC employee or contract worker who believes an offender may meet the criteria for placement in the Special Medical Needs Unit (SMNU) may recommend referral to the facility health services administrator (HSA). The referring facility HSA will conduct a facility staffing which may include case management, custody/control, mental health and medical personnel to determine if the offender meets placement criteria. [4-4399]*** The referring facility medical DOC employee or contract worker will conduct an assessment of the offender's activities of daily living (ADL) in the living environment within his/her assigned unit, using the "FLCF Acuity Assessment Form" (Attachment "A").
2. The facility HSA will ensure that the "FLCF Acuity Assessment Form" (Attachment "A"), the "FLCF Medical Admission Referral Form" (Attachment "B"), copies of the Brief Psychiatric Rating Scale (BPRS), the Resource Consumption Scale (RCS), the Colorado Inter-Correctional Medical Summary Transfer Report (CIMST), and a QT profile and QT appointments are completed and forwarded to the HSA at FLCF.
3. The HSA/designee at FLCF will review each offender referred for placement. This could include a face to face interview with the offender being referred. The HSA may discuss any questionable cases with the chief medical officer.
4. The FLCF HSA will conduct a facility staffing which may include case management, custody/control, mental health, and medical personnel to determine if the offender meets placement criteria. If the offender is not appropriate, then the referring HSA will be notified. The offender may be eligible for general population at FLCF, but this will be determined during the review process and recommendations made to Offender Services.
5. Once the patient has been determined to be eligible and accepted to the SMNU for admission, the referral packet must be signed by both the warden and the FLCF HSA.
6. A prioritized waiting list will be maintained by the FLCF HSA when the number of offenders referred for placement exceeds the number of available beds.
7. If placed on the waiting list and more than six months has elapsed since date of referral an updated referral form will be requested.

C. Bed Management [4-4399]

1. The FLCF HSA, or designee, and Offender Services will coordinate movement for the next offender on the waiting list when bed space becomes available.
2. The FLCF HSA will review the waiting list and determine placement based on medical acuity.

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D. Transfer to Parole or Discharge from DOC

1. The receiving parole officer will be contacted and, if possible, included in staffings, release planning, and aftercare.
2. Discharge planning will be coordinated by the HSA, Mental Health, and case management.
3. Medications will be ordered by the appropriate practitioner for all parolees. A ten day supply of medications will be supplied to offenders when they are discharged, paroled, or placed in Community Corrections. A 30 day supply will be provided to offenders requiring psychotropic medications. Offenders who are placed in the IRT program will receive a 60 day supply of medications.
4. The release plan will include coordination to appropriate facilities or services, which may include, but not be limited to:
 - a. Social Security or other social services agencies.
 - b. Community health centers.
 - c. Extended care facilities.
 - d. Alternative housing.
 - e. Families or other support systems.

E. Discharge from the Inpatient Special Medical Needs Unit

1. Clinical Services DOC employees or contract workers can refer offenders to the HSA who will review the medical record for appropriateness of discharge.
2. A medical practitioner must evaluate the offender and write a discharge order.
3. HSA will document disposition of discharge.
4. All close custody offenders that are eligible for discharge from the Special Medical Needs Unit are to be immediately reported to the warden and Offender Services for appropriate placement prior to discharge.

V. RESPONSIBILITY

- A. Referring HSA shall ensure that all referrals are staffed and reviewed at the referring facility prior to submission, pursuant to this administrative regulation.
- B. The FLCF HSA shall be responsible for reviewing the referral package and coordinating with the warden the approval for admission to FLCF.
- C. The FLCF health care practitioners shall ensure that offenders assigned to the Special Medical Needs Unit are monitored for further debilitation that would require hospitalization.

VI. AUTHORITY

CRS 17-1-103. Duties of the executive director.

VII. HISTORY

November 1, 2008

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November 1, 2007
November 1, 2006
November 1, 2005
May 1, 2005

- ATTACHMENTS:
- A. AR Form 700-31A, FLCF Acuity Assessment Form
 - B. AR Form 700-31B, FLCF Medical Admission Referral Form
 - C. AR Form 100-01A, Administrative Regulation Implementation/Adjustments

FLCF ACUITY ASSESSMENT FORM

NAME: _____ DOC#: _____

Referring Facility: _____

Age: _____ M-code: _____

Diagnosis: _____ P-code: _____

Language Spoken: _____ S-code: _____

CH: _____

ADVANCED DIRECTIVES

DNR Signed: Yes _____ No _____ (if no, chart must have documented physician discussion with offender regarding DNR status)

Living Will Completed: Yes _____ No _____

Durable Medical Power of Attorney signed: Yes _____ No _____

CLINICAL SERVICES MEDICAL ASSESSMENT

Check Box If Applicable

- | | | |
|-----------------------|------------------------|--------------------------|
| Mental Status: | Alert and oriented x 3 | <input type="checkbox"/> |
| | Alert and oriented x 2 | <input type="checkbox"/> |
| | Alert and oriented x 1 | <input type="checkbox"/> |
| | Disoriented x 3 | <input type="checkbox"/> |

Comments: _____

Respiratory: O2 _____ L

Tracheostomy:

Special supplies used: _____

CPAP/BiPAP

Mobility: List all DMEs used: _____

Ambulates

Independent w/o assistance device - specify: _____

Independent with assistance device - specify: _____

Requires some assistance (occasional standby)

Requires some assistance (standby at all times)

Patient is unable to ambulate

Patient is able to ambulate _____ feet before tires.

W/C (wheelchair) Mobility

Independently propels w/c most of time

Requires some assistance some of time

Requires some assistance most of time

Requires total assistance all of time

Transfers

Independently transfers from: bed to chair

chair to bed

Requires some assistance: bed to chair

chair to bed

Requires total assistance: bed to chair

chair to bed

Independently transfers from: chair to shower

shower to chair

Requires some assistance: chair to shower

shower to chair

Requires total assistance: chair to shower

shower to chair

ROM (range of motion) Upper Extremities

Full ROM bilateral upper extremities

Full ROM unilateral - list specific arm: _____

Partial ROM bilateral upper extremities - list: _____

Partial ROM unilateral - list spec arm: _____

ROM bilaterally - describe: _____

List any assistance device used: _____

Prosthetics - fully functional:

Prosthetics - partially functional:

ROM Lower Extremities

Full ROM bilateral lower extremities:

Full ROM unilateral - list specific leg: _____

Partial ROM bilateral lower extremities - list: _____

Partial ROM unilateral - list specific leg: _____

ROM bilaterally - describe:

List any assistance device used: _____

Prosthetics - fully functional:

Prosthetics - partially functional:

Comments: _____

Nutrition: Special Diet: _____

Dentures/partials: _____

Wt: _____

Choking history: _____

Meal Service

Independently goes thru chow line

Requires some assistance

Requires total assistance

Tray Set Up

Independent

Some assistance needed

Full assistance needed

Feeding

Independently feeds self

Requires some assistance and uses adaptive devices

device: _____

Requires total assistance

Tube feeding

Comments: _____

Genitourinary: Continent of Bowel or Bladder or both

- Continent and independently handles all B&B needs
- Continent but requires some assistance with B&B
- Continent but requires total assistance with B&B needs

Incontinent of Bowel or Bladder or both

- Incontinent and independently handles all B&B needs
- Incontinent but requires some assistance
- Incontinent and requires total assistance

Colostomy

- Independently handles all colostomy needs
- Requires some assistance
- Requires total assistance

Urinary Catheter

- Foley
- Suprapubic
- Self Catheterization

List any adaptive equipment patient requires related to B&B or colostomy needs:

Ileostomy

- Independently handles all needs
- Requires some assistance
- Requires total assistance

List any adaptive equipment patient requires related to Ileostomy needs:

Integumentary: Integrity

- Independently handles all skin care needs
(wash and dry hand/face, shower, lotion...)
- Requires minimal assistance with skin care needs
- Requires total assistance with skin care needs
- Skin is intact - little or no concerns
- Skin is impaired and requires treatment

List any problem areas:

List specific needs:

Comments:

Falls Assessment: Risk Factors

Confusion/Disorientation/Depression

Medications that increase risk.

Elimination problems (incontinence/nocturia/frequency)

Recent history of falls

Non-adaptive mobility/generalized weakness

Dizziness/Vertigo

Specific patient condition

Other:

Sensory Needs: Vision

Impaired vision

Wears glasses/contacts

Vision correction status

Hearing

Impaired hearing

Wears hearing aide

Hearing correction status

Assistive equipment:

Comments:

Neurological: Eyes Open Pupil Reaction Size: _____

Spontaneously

To speech

To pain

None

Best Verbal Response

Oriented

Confused

Inappropriate Words

Incomprehensible

None

Best Motor Skills

Obeys commands

Localized to pain

Flexes to pain

Abnormal flexion

Abnormal extension

Flaccid

Comments:

Medications: Self-meds

No medications needed

Self-meds administered independently

Self-meds administered with occasional assistance

Self-meds administered with constant assistance

Med-line

Compliant - able to independently come to med line

Compliant - needs some help to come to med line

Non-compliant - unable to come to med line*

*list possible reason for missing med line: _____

List medications and comments:

Treatment Plan:

Is a treatment plan established for the offender? Y N

Is the offender compliant with the treatment plan? Y N

Explain answers above:

Special Circumstances: (Example: current consults, upcoming appointments etc...)

Comments or concerns:

Other Comments/Concerns:

Nurses Signature Date

MH dx: _____

Axis I: _____

Axis II: _____

MENTAL HEALTH ASSESSMENT

Check Box If Applicable

Treatment Outside DOC:

None

CMHIP, Fort Logan, Community Mental Health, etc.

Comments:

Treatment Inside DOC:

None

Inconsistent

Consistent

Comments:

History of Placements:

Present Symptoms: ف Appears tearful.

ف Appears apprehensive.

ف Appears angry.

ف Appears depressed.

ف History of suicide attempt(s).

ف Other: _____

Dangerous to Self or Others:

Facility Management Problems:

Medication Compliance:

Consistently and independently handles all self-meds

Consistently-yet requires some assistance with self-meds

Consistently-yet requires total assistance with self-meds

Handles all med needs-does not require supervision

Handles all med needs-requires some supervision

Handles all med needs-requires total supervision

Non-compliant-requires help administering all meds

Changes or Problems:

Current Psychotropic Medications:

Date Last Seen by Psychiatrist: _____

Reason for Referral:

Other Comments/Concerns:

Clinician Signature

Date

FLCF Medical Admission Referral Form

Referring Facility: _____ Date _____

Offender Name _____ CDOC Number _____

DOB _____ Custody Level _____ STG Affiliation _____

M Code _____ P Code _____ Dental Code _____

Diagnosis _____

Comments: _____

Attachments:

Admission Assessment Tool

BPRS

RCS

CIMST

QT Profile and QT Appointments

Please attach all documents and forward to the FLCF health services administrator.

ADMINISTRATIVE REGULATION
IMPLEMENTATION/ADJUSTMENTS

AR Form 100-01A (04/15/08)

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(FACILITY/WORKUNIT NAME) _____
WILL ACCEPT AND IMPLEMENT THE PROVISIONS OF THE ABOVE ADMINISTRATIVE REGULATION:

AS WRITTEN NOT APPLICABLE WITH THE FOLLOWING PROCEDURES TO ACCOMPLISH THE INTENT
OF THE AR

(SIGNED) _____ (DATE) _____
Administrative Head