State of Iowa Department of Corrections

Policy and Procedures

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1. PURPOSE

To provide guidelines regarding medical housing operations in Iowa Department of Corrections (IDOC) institutions.

2. POLICY

It is the policy of the IDOC to provide specialized housing where such housing is necessary in order to meet patient medical treatment needs. Designation of these specialized housing areas is the responsibility of the IDOC Health Administrator. Medical services provided shall be in accordance with IDOC Health Services policies. Where practicable, conditions within the housing area, and the privileges afforded to patients housed there, shall be consistent with the custody level and security needs of the individual patient.

Some of the provisions of this policy may not, at this time, be fully implemented in all settings due to physical plant or staffing issues. The Health Administrator shall work collaboratively with the Warden and institutional staff to ensure compliance wherever possible.

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3. DEFINITIONS - As used in this document:

A. Activities of Daily Living (ADLA) Assistant - A specially trained incarcerated individual worker responsible for assisting other incarcerated individuals (hereafter referred to as "patients"), who require assistance completing activities of daily living. Activities of daily living include self-care activities such as personal hygiene and grooming, dressing/undressing, self-feeding, functional transfers (e.g., getting from bed to wheelchair, getting onto or off of toilet, etc.), bowel/bladder management, ambulation/mobility, and other activities such as housekeeping, use of telephone or technology, etc.

B. Care Review Committee - Institutional-based committee that addresses cases that fail to achieve anticipated health outcomes, require transfer to another facility when necessary level of health care is not available in-house, require adaptations to traditional treatment services, or require customized treatment interventions/services. Committee membership is a cross-representation of staff, which may include Nurse Supervisor, Health Services Administrator, physician (includes PA, NP), psychiatrist, social workers, psychologists, Unit Managers, Correctional Counselors, Program Staff, Activity Staff, Security Supervisors, involved security line staff and/or Associate Warden.

C. Executive Healthcare Team - Team comprised of the Healthcare Services

Administrator, Health Administrator, Mental Health Director and Nurse Executive Administrator.

D. Hospice Housing - Designated beds, typically located in medical housing, designed to provide a caring environment for meeting the physical and emotional needs of a terminally ill patient.

E. Limited Activity Notice (LAN) - Patients experiencing a change in health status of limited duration that does not require their medical work classification to be changed. LAN information reflects the restrictions, the length of restriction/limited activity, and special instructions. Under these circumstances, patient activities, including work, may be modified for up to 90 days.

F. Medical Assisted Living Housing - Designated housing for patients who require a higher level of observation by health services staff and proximity to health care treatment. It provides for medical care following surgery or injury or a life-threatening event, and/or short-term or long-term unstable chronic care, palliative and/or hospice care, and/or dementia care.

G. Medical Care Provider - Qualified health care professionals who by virtue of their education, credentials and experience are permitted by law to prescribe medications. These include physicians, physician assistants and nurse practitioners.

H. Medical Housing - Housing and/or beds comprised of medical assisted living housing, hospice housing, and skilled nursing housing.

I. Medical Professional - Qualified health care professional who by virtue of their education, credentials and experience are permitted to care for the medical health needs of patients. These include physicians, physician assistants and nurse practitioners, and licensed nurses.

J. Medical Work Classification - A component of routine health screening and assessment (**HSP-508** *Medical Work Classification*). A medical form **(HSF-508)** that outlines a patient's physical and/or environmental restrictions or limitations related to housing, sports, work, and transports, and authorized medical equipment.

K. Skilled Nursing Housing - Designated housing for the care and treatment of the acute and subacute patients including those requiring medical isolation. It provides for the evaluation and monitoring of symptoms and clinical status that requires contact with medical care provider and 24/7 nursing care consistent with **(HSF-601A)**.

L. Treatment Plan - A series of written statements that specify the particular course of therapy and the roles of medical and nonmedical personnel in carrying it out. A treatment plan is individualized, based on assessment of the individual patient's needs and includes a statement of the short- and long-term measureable goals and the methods by which the goals will be pursued. When clinically indicated, the treatment plan provides patients with access to a range of supportive and rehabilitative services such as individual or group counseling and/or self-help groups that the physician deems appropriate.

M. Treatment Team - Team of interdisciplinary staff that includes at minimum, health services staff, medical care provider, security - supervisor/unit manager and line staff, and correctional counselor. The team is responsible for the medical treatment needs and the operational requirements of patients in medical housing. Institutions shall establish the positions that comprise the Treatment Team.

4. PROCEDURES

A. Housing Assignment

1. Patients shall be admitted to medical housing when their health issue/condition cannot be effectively managed within their assigned living unit.

   Patients retain their disciplinary detention status or any other status while in medical housing. Modifications to another status shall be approved by the Care Review Committee and outlined in the Patient's treatment plan.

2. An individualized treatment plan shall be developed for each patient assigned to medical housing. Institutions shall develop the mechanism by which staff can readily identify patients' individual treatment plan directives.

3. ADLA workers will be assigned to assist patients who are not physically able to complete or participate in medical housing responsibilities, programs, services or activities. A patient's treatment plan shall outline responsibilities of assigned ADLA workers. ADLA workers shall receive training on the proper extent, means and methods for assisting patients with physical disabilities.

(see **HSP-205** *Incarcerated Individuals Working in a Health Services Environment*)

4. Health services staff approves a patient's placement within medical housing and assigns the specific type of medical housing.

    a. Admission to skilled nursing for less than 24 hours is determined by a Medical Professional.

    b. Admission to skilled nursing for longer than 24 hours requires the order of a Medical Care Provider.

    c. Admission to medical assisted living is determined by a Medical Professional.

    d. Where and when available, and where applicable patients may be housed in hospice housing in accordance with **HSP-623** *Hospice Services*.

    e. Admission to medical housing for chronically ill, physically disabled, or geriatric patients shall be made in consultation with the Treatment Team.

5. Security staff shall notify their supervisor and health services of those patients observed who may require the specialized care that medical housing offers. Indicators for medical housing include a patient's deteriorating health condition, new health condition requiring observation by health services staff, or injuries incidental to an altercation or accident.

6. Each shall outline the authority medical housing staff has to take immediate measures to separate or isolate patients in urgent or emergency situations.

7. When an institution is unable to meet or when another institution is better equipped to meet a patient's health care needs, the Treatment Team shall forward the case to the Care Review Committee. A Care Review Committee member shall consult with the proposed receiving facility's health services administrator or Care Review Committee to evaluate the suitability and efficacy of the proposed transfer prior to initiating an intra-system transfer. Such transfers shall be in compliance with IDOC Policies **HSP-502** *Intra-System Transfers* and **HSP-603** *Medical Levels of Care* and shall be coordinated through the Deputy Director of Institution

Operations/Designee.

8. Institutional procedures shall outline the process for patient bed assignments (initial, reassignment) in medical housing consistent with **IO-HO-01** *Unit Management*. The input of health services staff and the following factors shall be considered in making bed assignments in medical housing:

    a. Proximity to the nursing station or health clinic

    b. Health care need

    c. Security level

    d. Keep separate

    e. Access to activities/programs

    f. Sexually violent propensity status

    g. Bed assignments shall be reviewed by the Treatment Team.

9. Patients will only be discharged from skilled nursing housing upon order of the Medical Care Provider.

10. A Medical Professional initiates a patient's discharge from medical assisted living housing. The Medical Professional submits a recommendation for discharge from medical housing to the Treatment Team. The Treatment Team shall consider available information regarding the health status of the patient, including the recommendation of the Medical Provider. If the patient is returned to another institution, the transfer shall be coordinated through the Deputy Director of Institution Operations/Designee.

11. In the event the Care Review Committee and the Medical Provider disagree regarding a patient's release from medically assisted living housing, the Care Review Committee shall submit the case for final resolution with the Executive Healthcare Team in accordance with **HSP-603** *Medical Levels of Care*.

B. Medical Housing Orientation

1. All patients shall be oriented to medical housing within 72 hours of

assignment. In the event that the patient cannot be oriented within 72 hours due to his/her medical condition, that shall be documented in the health care record and added as a goal on the patient's treatment plan.

2. Orientation may include written and/or posted materials and shall include the opportunity for patients to seek clarification and receive answers to their questions. Orientation topics shall include, at a minimum:

    a. Medical housing schedule

    b. Medical housing rules/regulations

    c. Medical housing activities

    d. Patient accountability

    e. Patient expectations – conduct rules, property, dress, etc.

    f. Access to programs and services

    g. Avenues for resolving conflict and grievances

3. Specific individual accommodations may be required for delivery of orientation depending on need, as determined by the Treatment Team.

C. Operations – Security

1. Security operations shall be consistent with general population unless specified herein.

2. Institutions shall establish procedures governing the types and frequency of area searches within medical housing, and documentation of such.

3. Consistent with **IO-SC-18** *Searches*, institutions shall establish procedures governing personal searches to include at a minimum:

    a. Entry/exit to/from medical housing

b. Entry/exit to/from the housing unit, if applicable

c. Type of searches

d. Random searches (and frequency)

e. Documentation of searches

f. Routine searches of hospice rooms are not required; however shall be conducted between patients housed in hospice beds. Institutional procedures shall govern who determines and approves need for, and any special considerations that must be addressed in conducting such searches.

4. Institutions shall establish procedures to prevent unauthorized access to medical housing.

5. Institutional procedures shall outline exceptions to security measures that directly affect medical housing operations for any security topics including:

    a. Medical Housing Control Center, if applicable

    b. Counts

    c. Security inspections

    d. Searches

    e. Key control

    f. Tool control

    In lieu of including these institutional procedures within this policy, institutions may elect to provide the required information in a separate policy. At a minimum, the corresponding policy and procedure shall be identified.

6. The determination of leaving a patient's cell door opened or closed in medical housing shall be determined by the housing officer and treatment team and documented in the unit log.

7. Institutional procedures shall outline property items (and quantities)

that a patient may retain while assigned to medical housing. Exceptions to property retained by a patient in medical housing shall be outlined in the patient's treatment plan.

a. Authorized medical equipment shall be included in the electronic unit log and in ICON.

b. Authorized medical equipment shall be designated as either temporary (limited activity notice) or permanent (**HSP-508** *Medical Work Classification*).

D. Operations - Out of Cell

1. Consistent with the institution's custody designation, patients' classification status, level incentive program assignment, and physical plant restrictions or opportunities, institutions shall maximize opportunities for out-of-cell time for patients housed in medical housing.

2. Out-of-cell time shall include both formal opportunities such as programs, work assignments and yards, as well as medical housing activities such as dayroom time, access to exercise yards, and access to unit services. Authorized medical equipment shall not automatically preclude participation in programs, work assignments or activities.

3. Institutional procedures shall implement out-of-cell time; procedures shall also address quiet hours, lights out, etc. through institutional schedules that reflect the unique physical plant program opportunities, and other local factors.

4. In collaboration with the Warden, the Deputy Director of Institution Operations and the IDOC Health Services Administrator may require that institutional operations be adjusted to maximize opportunities for out-of-cell time for patients housed in medical housing.

E. Operations – Movement

1. Institutions shall establish procedures governing movement in/out of and within medical housing. The movement procedures shall address any documentation accounting for movement that is required. Procedures will address the following types of movement at a

minimum:

a. Escorted movement

b. Directed movement

c. Observed movement

2. A patient's treatment plan may modify a movement type based on the patient's mobility and/or need for assistance.

F. Operations - Managing Patient Behavior

1. To the extent feasible, Unit Managers shall ensure officers are assigned to medical housing for a period of time to maximize the consistency of operations while maintaining awareness of the potential for over-familiarity and unprofessional conduct.

2. In order to promote and encourage prosocial behavior and minimize disruptive behavior, staff will actively supervise patients. Active supervision requires staff to:

   a. Be a prosocial role model,

   b. Clearly communicate expectations for patients,

   c. Have positive and appropriate interaction with patients,

   d. Resolve concerns at the lowest level possible,

   e. Be approachable and responsive to patients and their needs,

   f. Manage conflict using de-escalation techniques, and

   g. Be responsive to patient health care needs.

3. Living Unit Officers shall conduct formal rounds of medical housing observing and interacting with all patients at least once every 30 minutes on an irregular basis. During rounds, staff will communicate with incarcerated individual workers and patients, observe patient's health status, look for damage and contraband, inspect to identify safety and security issues, resolve minor issues, report any changes

in condition/behavior, etc. Formal rounds shall be documented in the Post Logbook.

4. Staff shall manage patient behavior using a variety of strategies that routinely initiate interaction with patients and provide continual visual observation of medical housing. Staff shall:

    a. Monitor all incarcerated individuals and patients in all areas,

    b. Respond to patient requests in a timely and fair manner,

    c. Report changes in a patient's health,

    d. Investigate any activities or changes in incarcerated individual or patient behavior appearing out of the ordinary,

    e. Recognize potential problems between and/or among both incarcerated individuals and patients and move swiftly to resolve them,

    f. Enforce facility rules consistently,

    g. Provide feedback that encourages self-assessment and self-correction, and assists in developing personal responsibility by advancing patient self-sufficiency, and

    h. Communicate with incarcerated individuals and patients in a respectful and courteous manner.

5. Living Unit Staff shall be watchful for patients who are able and who are not actively participating in medical housing activities or are not productively engaged and, when appropriate, staff shall work with the patient and unit team members to advance constructive use of the patient's time.

6. Institutions shall establish procedures that outline the extent of authority Living Unit Staff have regarding independently modifying privileges, imposing sanctions (rule violations), developing and administering incentives, addressing negative or noncompliant behavior, etc.

7. Staff shall remain on post in medical housing until properly relieved or directed otherwise by proper authority or institutional procedures.

8. The Warden or designee, Deputy Warden, Nurse Supervisor, and designated department heads shall visit each medical housing at least weekly to promote informal contact with staff and incarcerated individual workers and patients and to informally observe living and working conditions. Such visits shall be noted in the appropriate Post Logbook.

9. Staff shall be observant and cognizant of ADLA worker assignments and monitor for behavior and whereabouts that do not support the incarcerated individual's work assignment responsibilities. Institutional procedures shall outline responses when ADLA workers are found out of place or not fulfilling their work responsibilities.

G. Operations - Leisure Activities

1. Institutions shall incorporate a wide range of leisure time activities within medical housing to keep patients productively engaged, to reduce idleness, to build socialization skills, and to create opportunities for self-awareness, character building and team building. The degree to which activities are offered shall be guided by the institution's transition incentive program, physical plant, staffing levels, patient custody status, commensurate with the abilities of the population, etc.

2. Leisure time opportunities shall be afforded in a variety of settings within medical housing, which may include:

    a. Group and individual leisure activities,

    b. Organized events,

    c. Nonscheduled activities,

    d. Peer-led activities/events

3. Leisure activities may include, but are not limited to:

    a. Television

    b. Telephone

    c. Games – board, card

d. Computer

e. Exercise yard

f. Publications

g. Late night

h. Books (on-unit library, medical housing)

i. Self-help groups

j. Arts and crafts

k. Hobbycraft (may require a permit)

l. Special events/activities

m. Personal fitness

n. Community service activities

o. Electronic/Media devices

p. Musical instruments

4. The Unit Manager shall designate a lead staff member who has oversight responsibility for the leisure time activities program for patients assigned to medical housing, and who shall coordinate with the Treatment Team to provide for modification of offered activities to meet the individual physical limitations of patients in medical housing. The types of leisure time activities offered shall be informed by patient and staff surveys, the results of completed assessments and treatment plan and be reflective of patients' needs and preferences. The leisure time activity program shall be evaluated on a periodic basis as determined by the institution, but at least quarterly.

5. Medical equipment shall not preclude patient participation in activities. Authorized medical equipment shall be designated as either temporary (limited activity notice) or permanent (medical work classification).

6. A range of leisure activities shall be available when access to the

medical housing's common area is allowed.

7. Leisure activities shall be available and scheduled at various times during the day/week to accommodate various patient schedules.

H. Operations - Programs and Services

1. When feasible, programs and services are delivered at the unit level. This will allow institutions to be more responsive to the needs of specific populations, will increase the frequency and quality of interaction between staff and patients, will create opportunities for unit staff to build rapport and will make certain that program decisions are made by those who are most familiar with the patient.

2. Staff shall follow patients' treatment plans. Any deviation from or modification of the treatment plan is first approved by the Shift Supervisor or Unit Manager, and only in those circumstances where to follow the treatment plan jeopardizes safety or security. Staff approving deviation from or modification of a treatment plan, shall submit a written notice outlining the situation and action(s) taken to the Treatment Team who shall review the circumstances and amend the treatment plan when deemed appropriate.

3. Program assignments for chronically ill, physically disabled, or geriatric patients assigned to medical housing shall be determined by the Treatment Team.

4. Patients in medical housing shall be afforded programs and services similar to those provided in general population consistent with custody/classification and ability to accommodate physical abilities/limitations.

5. Institutional procedures shall determine how patients in medical housing access (institutional schedule, treatment plan, medical housing schedule) the following programs and services:

    a. Meals*

    b. Mail

    c. Health care

    d. Personal hygiene

e. Self-help groups

f. Commissary

g. Religious programs

h. Social services

i. Education

j. Counseling

k. Visits

l. Work assignments (on-unit, medical housing)

m. Library (on-unit, medical housing)

n. Laundry (on-unit, medical housing)

*Meal procedures shall address whether attendance at centralized dining (if applicable) is mandatory or voluntary. If mandatory, procedures shall address what happens when a patient refuses to go to dining. If voluntary, procedures shall address whether non-participating patients shall remain in medical housing or other designated location. In addition, meal procedures shall address the provision of meals for those temporarily unable to attend centralized dining due to illness or other authorized reason.

In lieu of including these institutional procedures within the policy, institutions may elect to provide the required information in a separate policy. At a minimum, the corresponding policy and procedure shall be identified.

6. Equipment, facilities and support necessary to perform self-care and personal hygiene in a reasonably private environment shall be made available to patients with disabilities.

7. ADLA workers will be assigned to assist patients who are not physically able to complete or participate in programs, services or activities.

I. Operations – Housekeeping

1. Medical housing shall maintain a clean and healthy environment in order to mitigate safety hazards and prevent infection and illness, while enhancing incarcerated individual life skills.

2. Institutional procedures shall outline a housekeeping plan for medical housing. Institutions may elect to provide the required information in a separate policy and/or within this policy. At a minimum, the corresponding policy and procedure shall be identified.

3. Housekeeping plans shall require, at a minimum:

    a. Daily cleaning and routine sanitizing of occupied cells/rooms

    b. Daily cleaning and sanitizing of dayrooms and common areas

    c. Routine cleaning and sanitizing of unoccupied cells/rooms

    d. Routine cleaning and sanitizing of unoccupied areas

    e. Distribution, handling and storage of cleaning supplies/materials

    f. Handling and disposal of hazardous materials

    g. Sanitation inspections on a daily, weekly, monthly and annual basis

4. ADLA workers will be assigned to assist patients who are not physically able to complete housekeeping activities.

J. Medical Housing Documentation

1. Medical housing staff shall be required to document a full range of activities and tasks, including but not limited to:

    a. Medical housing and cell/bed/room assignments

    b. Entry/exit of staff, volunteers, visitors

    c. Safety and security rounds begin and end times

d. Deviation from scheduled activities

e. Critical and unusual incidents

f. Area searches

g. Strip searches

h. Headcounts

i. Shift activity updates/briefings

j. Shift changes

2. Institutions shall establish procedures that outline the information to be recorded, the form of the documentation, and the staff post/position responsible for the documentation.

3. Designated supervisor(s) shall review required documentation on a routine, regular basis to determine whether the required information is being properly documented, whether formal rounds are being performed in accordance with established procedure, if there are gaps in scheduled activities/services, trends in medical housing activity, etc. The designated supervisor shall take the necessary steps to resolve any identified discrepancies or deficiencies in documentation.