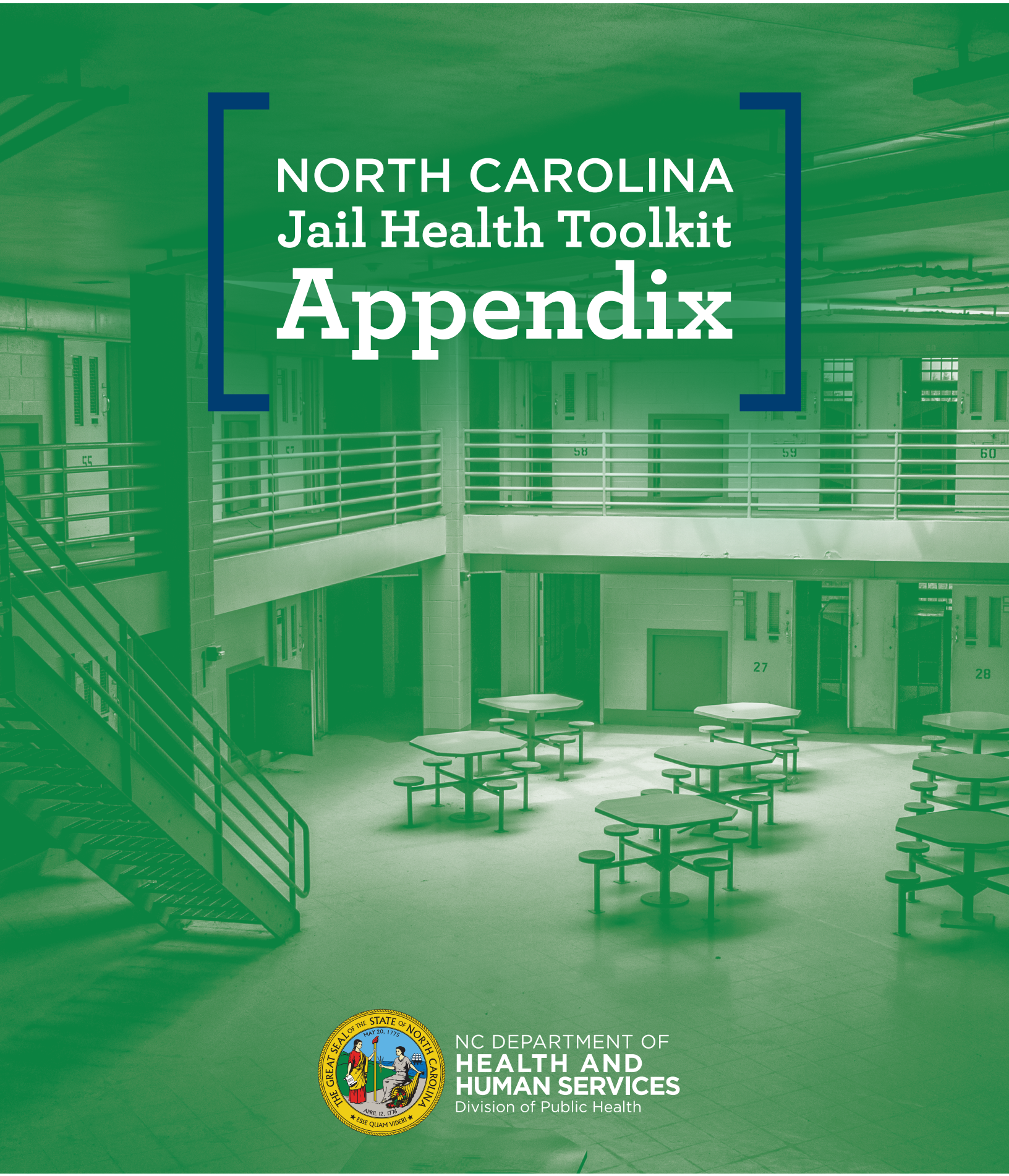

NORTH CAROLINA Jail Health Toolkit Appendix

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health

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NC General Statutes - Jail Health

Selected Jail Health Statutes, NC General Statutes
Chapter 153A. Counties
Part 2. Local Confinement Facilities

§ 153A-216. Legislative policy.
The policy of the General Assembly with respect to local confinement facilities is:

(1) Local confinement facilities should provide secure custody of persons confined therein in order to protect the community and should be operated so as to protect the health and welfare of prisoners and provide for their humane treatment.
(2) Minimum statewide standards should be provided to guide and assist local governments in planning, constructing, and maintaining confinement facilities and in developing programs that provide for humane treatment of prisoners and contribute to the rehabilitation of offenders.
(3) The State should provide services to local governments to help improve the quality of administration and local confinement facilities. These services should include inspection, consultation, technical assistance, and other appropriate services.
(4) Adequate qualifications and training of the personnel of local confinement facilities are essential to improving the quality of these facilities. The State shall establish entry level employment standards for jailers and supervisory and administrative personnel of local confinement facilities to include training as a condition of employment in a local confinement facility pursuant to the provisions of Article 1 of Chapter 17C and Chapter 17E and the rules promulgated thereunder. (1967, c. 581, s. 2; 1973, c. 822, s. 1; 1983, c. 745, s. 4; 2018-5, s. 17.1(a).)

§ 153A-221. Minimum standards.
(a) The Secretary shall develop and publish minimum standards for the operation of local confinement facilities and may from time to time develop and publish amendments to the standards. The standards shall be developed with a view to providing secure custody of prisoners and to protecting their health and welfare and providing for their humane treatment. The standards shall provide for all of the following:

(1) Secure and safe physical facilities.
(2) Jail design.
(3) Adequacy of space per prisoner.
(4) Heat, light, and ventilation.
(5) Supervision of prisoners.
(6) Personal hygiene and comfort of prisoners.
(7) Medical care for prisoners, including mental health, behavioral health, intellectual and other developmental disability, and substance abuse services.
(8) Sanitation.
(9) Food allowances, food preparation, and food handling.
(10) Any other provisions that may be necessary for the safekeeping, privacy, care, protection, and welfare of prisoners.
(11) Compliance with the requirements of Part 2B of Article 10 of Chapter 153A of the General Statutes, Dignity for Women Incarcerated in Local Confinement Facilities.

(b) In developing the standards and any amendments thereto, the Secretary shall consult with organizations representing local government and local law enforcement, including the North Carolina Association of County Commissioners, the North Carolina League of Municipalities, the North Carolina Sheriffs' Association, and the North Carolina Police Executives' Association. The Secretary shall also consult with interested State departments and agencies, including the Division of Prisons of the Department of Adult Correction, the Department of Health and Human Services, the Department of Insurance, and the North

Carolina Criminal Justice Education and Training Standards Commission, and the North Carolina Sheriffs' Education and Training Standards Commission.

(c) Before the standards or any amendments thereto may become effective, they must be approved by the Commission and the Governor. Upon becoming effective, they have the force and effect of law.

(d) Notwithstanding any law or rule to the contrary, each dormitory in a county detention facility may house up to 64 inmates as long as the dormitory provides all of the following:

(1) A minimum floor space of 70 square feet per inmate, including both the sleeping and dayroom areas.
(2) One shower per eight inmates, one toilet per eight inmates, one sink with a security mirror per eight inmates, and one water fountain.
(3) A telephone jack or other telephone arrangement provided within the dormitory.
(4) Space designed to allow a variety of activities.
(5) Sufficient seating and tables for all inmates.
(6) A way for officers to observe the entire area from the entrance.

(e) A local confinement facility shall be subject to the requirements of Part 2B of Article 10 of Chapter 153A of the General Statutes. (1967, c. 581, s. 2; 1973, c. 476, ss. 128, 133, 138; c. 822, s. 1; 1983, c. 745, s. 6; c. 768, s. 20; 1991, c. 237, s. 1; 1997-443, s. 11A.118(a); 2008-194, s. 10(a), (b); 2011-145, s. 19.1(h); 2011-324, s. 1; 2014-22, s. 1; 2017-186, s. 2(eeeeeeeee); 2019-76, s. 30; 2021-143, s. 3(b); 2021 180, s. 19C.9(p); 2022 74, s. 9K.2(a).)

§ 153A-224. Supervision of local confinement facilities.

(a) No person may be confined in a local confinement facility unless custodial personnel are present and available to provide continuous supervision in order that custody will be secure and that, in event of emergency, such as fire, illness, assaults by other prisoners, or otherwise, the prisoners can be protected. These personnel shall supervise prisoners closely enough to maintain safe custody and control and to be at all times informed of the prisoners' general health and emergency medical needs.

(b) In a medical emergency, the custodial personnel shall secure emergency medical care from a licensed physician according to the unit's plan for medical care. If a physician designated in the plan is not available, the personnel shall secure medical services from any licensed physician who is available. The unit operating the facility shall pay the cost of emergency medical services unless the inmate has third-party insurance, in which case the third-party insurer shall be the initial payor and the medical provider shall bill the third-party insurer. The county shall only be liable for costs not reimbursed by the third-party insurer, in which event the county may recover from the inmate the cost of the non-reimbursed medical services.

(c) If a person violates any provision of this section, he is guilty of a Class 1 misdemeanor. (1967, c. 581, s. 2; 1973, c. 822, s. 1; 1993, c. 510, c. 539, s. 1061; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 153A-225. Medical care of prisoners.

(a) Each unit that operates a local confinement facility shall develop a plan for providing medical care for prisoners in the facility. The plan:

(1) Shall be designed to protect the health and welfare of the prisoners and to avoid the spread of contagious disease;
(2) Shall provide for medical supervision of prisoners and emergency medical care for prisoners to the extent necessary for their health and welfare;
(3) Shall provide for the detection, examination and treatment of prisoners who are infected with tuberculosis or venereal diseases; and
(4) May utilize Medicaid coverage for inpatient hospitalization or for any other Medicaid services allowable for eligible prisoners, provided that the plan includes a reimbursement process which pays to the State the State portion of the costs, including the costs of the services provided and any administrative costs directly related to the services to be reimbursed, to the State's Medicaid program.

The unit shall develop the plan in consultation with appropriate local officials and organizations, including the sheriff, the county physician, the local or district health director, and the local medical society. The plan must be approved by the local or district health director after consultation with the area mental health, developmental disabilities, and substance abuse authority, if it is adequate to protect the health and welfare of the prisoners. Upon a determination that the plan is adequate to protect the health and welfare of the prisoners, the plan must be adopted by the governing body.

As a part of its plan, each unit may establish fees of not more than twenty dollars ($20.00) per incident for the provision of nonemergency medical care to prisoners and a fee of not more than ten dollars ($10.00) for a 30-day supply or less of a prescription drug. In establishing fees pursuant to this section, each unit shall establish a procedure for waiving fees for indigent prisoners.

(b) If a prisoner in the custody of a local confinement facility dies, the medical examiner and the coroner shall be notified immediately, regardless of the physical location of the prisoner at the time of death. Within five days after the day of the death, the administrator of the facility shall make a written report to the local or district health director and to the Secretary of Health and Human Services. The report shall be made on forms developed and distributed by the Department of Health and Human Services.

(b1) Whenever a local confinement facility transfers a prisoner from that facility to another local confinement facility, the transferring facility shall provide the receiving facility with any health information or medical records the transferring facility has in its possession pertaining to the transferred prisoner.

(c) If a person violates any provision of this section (including the requirements regarding G.S. 130-97 and 130-121), he is guilty of a Class 1 misdemeanor. (1967, c. 581, s. 2; 1973, c. 476, ss. 128, 138; c. 822, s. 1; 1973, c. 1140, s. 3; 1989, c. 727, s. 204; 1991, c. 237, s. 2; 1993, c. 539, s. 1062; 1994, Ex. Sess., c. 24, s. 14(c); 1995, c. 385, s. 1; 1997-443, s. 11A.112; 2003-392, s. 1; 2004-199, s. 46(a); 2011-145, s. 31.26(f); 2011-192, s. 7(n); 2013-387, s. 2; 2013-389, s. 1; 2018-76, s. 1.)

§ 153A-225.1. Duty of custodial personnel when prisoners are unconscious or semiconscious.

(a) Whenever a custodial officer of a local confinement facility takes custody of a prisoner who is unconscious, semiconscious, or otherwise apparently suffering from some disabling condition and unable to provide information on the causes of the condition, the officer should make a reasonable effort to determine if the prisoner is wearing a bracelet or necklace containing the Medic Alert Foundation's emergency alert symbol to indicate that the prisoner suffers from diabetes, epilepsy, a cardiac condition or any other form of illness which would cause a loss of consciousness. If such a symbol is found indicating that the prisoner suffers from one of those conditions, the officer must make a reasonable effort to have appropriate medical care provided.

(b) Failure of a custodial officer of a local confinement facility to make a reasonable effort to discover an emergency alert symbol as required by this section does not by itself establish negligence of the officer but may be considered along with other evidence to determine if the officer took reasonable precautions to ascertain the emergency medical needs of the prisoner in his custody.

(c) A prisoner who is provided medical care under the provisions of this section is liable for the reasonable costs of that care unless he is indigent.

(d) Repealed by Session Laws 1975, c. 818, s. 2. (1975, c. 306, s. 2; c. 818, s. 2.)

§ 153A-225.2. Payment of medical care of prisoners.

(a) Counties shall reimburse those providers and facilities providing requested or emergency medical care outside of the local confinement facility the lesser amount of either a rate of seventy percent (70%) of the provider's then-current prevailing charge or two times the then-current Medicaid rate for any given service. Each county shall have the right to audit any provider from whom the county has received a bill for services under this section but only to the extent necessary to determine the actual prevailing charge to ensure compliance with this section.

(b) Nothing in this section shall preclude a county from contracting with a provider for services at rates that provide greater documentable cost avoidance for the county than do the rates contained in subsection (a) of this subsection or at rates that are less favorable to the county but that will ensure the continued access to care.

(c) The county shall make reasonable efforts to equitably distribute prisoners among all hospitals or other appropriate health care facilities located within the same county and shall do so based upon the licensed acute care bed capacity at each of the hospitals located within the same county. Counties with more than one hospital or other appropriate health care facility shall provide semiannual reports conspicuously posted on the county's Web site that detail compliance with this section, including information on the distribution of prisoner health care services among different hospitals and health care facilities.

(d) For the purposes of this section, "requested or emergency medical care" shall include all medically necessary and appropriate care provided to an individual from the time that individual presents to the provider or facility in the custody of county law enforcement officers until the time that the individual is safely transferred back to the care of county law enforcement officers or medically discharged to another community setting, as appropriate. (2013-387, s. 1.)

Part 2B. Dignity for Women Incarcerated in Local Confinement Facilities.

§ 153A-229.1. Definitions.

As used in this Article, the following definitions apply:

(1) Body cavity searches. - The probing of body orifices in search of contraband.

(2) Escape risk. - An incarcerated person who is determined to be at high risk for escape based on an individualized risk assessment.

(3) Facility employee. - Any person who is employed by the local government and who works at or in a local confinement facility.

(4) Important circumstance. - There has been an individualized determination that there are reasonable grounds to believe that the female incarcerated person presents a threat of harming herself, the fetus, or any other person, or an escape risk that cannot be reasonably contained by other means, including the use of additional personnel.

(5) Incarcerated person. - Any person incarcerated or detained in a local confinement facility who is accused of, convicted of, sentenced for, or adjudicated delinquent for violations of criminal law or the terms and conditions of parole, probation, pretrial release, or a diversionary program.

(6) Local confinement facility. - "Local confinement facility" includes a county or city jail, a local lockup, a regional or district jail, a juvenile detention facility, a detention facility for adults operated by a local government, and any other facility operated by a local government for confinement of persons awaiting trial or serving sentences except that it shall not include a county satellite jail/work release unit governed by Part 3 of Article 10 of Chapter 153A of the General Statutes.

(7) Menstrual products. - Products that women use during their menstrual cycle. These include tampons and sanitary napkins.

(8) Postpartum recovery. - The six-week period following delivery, or longer, as determined by the health care professional responsible for the health and safety of the female incarcerated person.

(9) Restraints. - Any physical or mechanical device used to restrict or control the movement of an incarcerated person's body, limbs, or both.

(10) Restrictive housing. - Any type of detention that involves removal from general population and an inability to leave a room or cell for the vast majority of the day. This term shall not include any of the following:

a. Single-cell accommodations in facilities that provide those accommodations to all incarcerated persons.

b. Single-cell accommodations in facilities that provide those accommodations to all persons of a certain sex or gender.
c. Single-cell accommodations provided for medical reasons, except when pregnancy, alone, is the medical reason for the single-cell accommodations.
d. Single-cell accommodations provided when an individualized determination has been made that there are reasonable grounds to believe that there exists a threat of harm to the female incarcerated person or the fetus.
e. Single-cell accommodations provided at the request of the incarcerated person.

(11) State of undress. - A situation when an incarcerated person is partially or fully naked, either in the shower, toilet areas, a medical examination room, or while having a body cavity search conducted. (2021-143, s. 3(a).)

§ 153A-229.2. Care for female incarcerated persons related to pregnancy, childbirth, and postpartum recovery.

(a) Limitation on Use of Restraints. - Except as otherwise provided in this subsection, facility employees shall not apply restraints on a pregnant female incarcerated person during the second and third trimester of pregnancy, during labor and delivery, and during the postpartum recovery period.

A female incarcerated person who is in the postpartum recovery period may only be restrained if a facility employee makes an individualized determination that an important circumstance exists. In this case, only wrist handcuffs held in front of the female incarcerated person's body may be used and only when she is ambulatory. The facility employee ordering use of restraints on any female incarcerated person while in the postpartum recovery period shall submit a written report to the sheriff or administrator of the local confinement facility within five days following the use of restraints. The report shall contain the justification for restraining the female incarcerated person during postpartum recovery.

Nothing in this subsection shall prohibit the use of handcuffs or wrist restraints held in front of the female incarcerated person's body when in transport outside of the local confinement facility, except that these restraints shall not be used in transport when the female incarcerated person is in labor or is suspected to be in labor.

Nothing in this subsection shall prohibit the use of medical restraints by a licensed health care professional to ensure the medical safety of a pregnant female incarcerated person.

(b) Body Cavity Searches. - No facility employee, other than a certified health care professional, shall conduct body cavity searches of a female incarcerated person who is pregnant or in the postpartum recovery period unless the facility employee has probable cause to believe that the female incarcerated person is concealing contraband that presents an immediate threat of harm to the female incarcerated person, the fetus, or another person. In this case, the facility employee shall submit a written report to the sheriff or administrator of the local confinement facility within five days following the body cavity search, containing the justification for the body cavity search and the presence or absence of any contraband.

(c) Nutrition. - The sheriff or the administrator of the local confinement facility shall ensure that pregnant female incarcerated persons are provided sufficient food and dietary supplements and are provided access to food at appropriate times of day, as ordered by a physician, a physician staff member, or a local confinement facility nutritionist in accordance with the guidelines for women who are pregnant or lactating as set forth in the most recent edition of Dietary Guidelines for Americans published by the United States Department of Health and Human Services and the United States Department of Agriculture. Orders by a physician or physician staff regarding dietary needs or restrictions for any particular pregnant incarcerated person shall take precedence over the Dietary Guidelines for Americans. While in the hospital, pregnant female incarcerated persons and female incarcerated persons in the postpartum recovery period shall have access to the full range of meal options provided by the hospital to ensure that each meal meets the female incarcerated person's nutritional needs.

(d) Restrictive Housing. - The sheriff or the administrator of the local confinement facility shall not place any pregnant female incarcerated person, or any female incarcerated person who is in the postpartum recovery period, in restrictive housing unless a local confinement facility employee makes an individualized determination that an important circumstance exists. In this case, the facility employee authorizing the placement of the female incarcerated person in restrictive housing shall submit a written report to the sheriff or administrator of the local confinement facility within five days following the transfer. The report shall contain the justification for confining the female incarcerated person in restrictive housing.

(e) Bed Assignments. - The sheriff or the administrator of the local confinement facility shall not assign any female incarcerated person who is pregnant or in postpartum recovery to any bed that is elevated more than 3 feet from the floor of the local confinement facility.

(f) Cost of Care. - While a pregnant female incarcerated person is incarcerated, the pregnant female incarcerated person shall be provided necessary prenatal, labor, and delivery care as needed at no cost to the pregnant female incarcerated person.

(g) Bonding Period. - Following the delivery of a newborn by a female incarcerated person, the administrator of the local confinement facility shall permit the newborn to remain with the female incarcerated person while the female incarcerated person is in the hospital, unless the medical provider has a reasonable belief that remaining with the female incarcerated person poses a health or safety risk to the newborn.

(h) Nutritional and Hygiene Products During the Postpartum Period. - During the period of postpartum recovery, the sheriff or administrator of the local confinement facility shall make available the necessary nutritional and hygiene products, including sanitary napkins, underwear, and hygiene products for the postpartum female incarcerated person. The products shall be provided at no cost to the female incarcerated person.

(i) Reporting. - The sheriff or administrator of the local confinement facility shall compile a monthly summary of all written reports received pursuant to this section and G.S. 148-25.3. (2021-143, s. 3(a); 2022 74, s. 9K.2(b).)

§ 153A-229.3. Inspection by facility employees.

(a) Inspections When a Female Incarcerated Person is in the State of Undress. - To the greatest extent practicable and consistent with safety and order in a local confinement facility, there shall be a limitation on inspections by male facility employees when a female incarcerated person is in a state of undress. Nothing in this section shall limit the ability of a male facility employee from conducting inspections when a female incarcerated person may be in a state of undress if no female facility employees are available within a reasonable period of time.

(b) Documentation Requirement. - If a male facility employee deems it is appropriate to conduct an inspection or search while a female incarcerated person is in a clear state of undress in an area such as the shower, the medical examination room, toilet areas, or while a female incarcerated person is having a body cavity search, the male local confinement facility employee shall submit a written report to the sheriff or administrator of the local confinement facility within five days following the inspection or search, containing the justification for a male facility employee to inspect the female incarcerated person while in a state of undress. (2021-143, s. 3(a).)

§ 153A-229.4. Access to menstrual products.

Access to Menstrual Products. - The sheriff or the administrator of the local confinement facility shall ensure that sufficient menstrual products are available at the local confinement facility for all female incarcerated persons who have an active menstrual cycle. Female incarcerated persons who menstruate shall be provided menstrual products as needed at no cost to the female incarcerated person. (2021-143, s. 3(a).)

Chapter 148. State Prison System.

Article 2. Prison Regulations.

§ 148-19.3. Health care services to county prisoners.

(a) All charges that are the responsibility of the transferring county for health care services provided to prisoners held under a safekeeping order pursuant to G.S. 162-39, or the Statewide Misdemeanant Confinement Program pursuant to G.S. 148-32.1, shall not be paid by the Department and shall be submitted by the health care provider to the Inmate Medical Costs Management Plan through the North Carolina Sheriffs' Association for the Plan to review and negotiate all charges for health care services to avoid overpayment and reduce overall health care service costs. The Department shall notify the health care provider when services are being provided to the prisoner that the invoice for health care services shall be submitted by the provider directly to the Plan. In the event an invoice is sent to the Department by a health care provider for health care services provided to a safekeeper under this section or G.S. 148-32.1, the Department shall forward the invoice to the Plan within three days of receipt. All unreimbursed charges for health care services provided shall be documented and presented to the county for payment in accordance with G.S. 162-39 or the Statewide Misdemeanant Confinement Program in accordance with G.S. 148-32.1. Upon expiration of the terms of the order and a determination that the prisoner may be safely returned to the custody of the county, the Department shall notify the sheriff, or the sheriff's designee, by telephone and electronic mail and request the transfer of the prisoner to the custody of the county.

(b) The Department shall update the medical services schedule of charges assessed to counties for the provision of health care services to county prisoners housed in the State prison system pursuant to safekeeping orders under G.S. 162-39 or the Statewide Misdemeanant Confinement Program under G.S. 148-32.1. In updating the schedule of charges, at a minimum, the Department shall consider the actual rate for services provided and current established Medicaid rates for respective services. The schedule of charges shall be updated annually and shall be included in the Department's policies and procedures. The Department shall assess charges to counties for health care services provided to county prisoners at all State prison facilities. (2019-171, s. 2(a); 2020-83, s. 9(a).)

Article 3. Labor of Prisoners.

§ 148-32.1. Local confinement, costs, alternate facilities, parole, work release.

(a) Repealed by Session Laws 2009-451, s. 19.22A, effective July 1, 2009.

(b) In the event that the custodian of the local confinement facility certifies in writing to the clerk of the superior court in the county in which the local confinement facility is located that the local confinement facility is filled to capacity, or that the facility cannot reasonably accommodate any more prisoners due to segregation requirements for particular prisoners, or that the custodian anticipates, in light of local experiences, an influx of temporary prisoners at that time, or if the local confinement facility does not meet the minimum standards published pursuant to G.S. 153A-221, any judge of the district court in the district court district as defined in G.S. 7A-133 where the facility is located, or any superior court judge who has jurisdiction pursuant to G.S. 7A-47.1 or G.S. 7A-48 in a district or set of districts as defined in G.S. 7A-41.1 where the facility is located may order that a prisoner not housed pursuant to the Statewide Misdemeanant Confinement Program established in subsection (b2) of this section be transferred to any other qualified local confinement facility within that district or within another such district where space is available, including a satellite jail unit operated pursuant to G.S. 153A-230.3 if the prisoner is a non-violent misdemeanant, which local facility shall accept the transferred prisoner.

If no other local confinement facility is available and the reason for the requested transfer is that the local confinement facility that would be required to house the prisoner cannot reasonably accommodate any more prisoners due to segregation requirements for particular prisoners or

the local facility does not meet the minimum standards published pursuant to G.S. 153A-221, then the judge may order that a prisoner not housed pursuant to the Statewide Misdemeanant Confinement Program established in subsection (b2) of this section be transferred to a facility operated by the Division of Prisons of the Department of Adult Correction as designated by the Division of Prisons. In no event, however, shall a prisoner whose term of imprisonment is less than 30 days be assigned or ordered transferred to a facility operated by the Division of Prisons.

(b1) It is the intent of the General Assembly to authorize the Division of Prisons to enter into voluntary agreements with counties to provide housing for misdemeanants serving periods of confinement of more than 90 days and for all sentences imposed for impaired driving under G.S. 20-138.1, regardless of length. It is further the intent of the General Assembly that the Division of Adult Correction and Juvenile Justice, in conjunction with the North Carolina Sheriffs' Association, Inc., establish a program for housing misdemeanants serving periods of confinement of more than 90 days and for all sentences imposed for impaired driving under G.S. 20-138.1, regardless of length. It is also the intent of the General Assembly that the Division of Prisons contract with the North Carolina Sheriffs' Association, Inc., to provide a service that identifies space in local confinement facilities that is available for housing these misdemeanants.

The General Assembly intends that the cost of housing and caring for these misdemeanants, including, but not limited to, care, supervision, transportation, medical, and any other related costs, be covered by State funds and not be imposed as a local cost. Therefore, the General Assembly intends that the funds appropriated for the Statewide Misdemeanant Confinement Program be used to provide funding to cover the costs of managing a system for providing that housing of misdemeanants in local confinement facilities as well as reimbursing the counties for housing and related expenses for those misdemeanants.

(b2) The Statewide Misdemeanant Confinement Program is established. The Program shall provide for the housing of misdemeanants from all counties serving sentences imposed for a period of more than 90 days and for all sentences imposed for impaired driving under G.S. 20-138.1, regardless of length. Those misdemeanants shall be confined in local confinement facilities except as provided in subsections (b3) and (b4) of this section. The Program shall address methods for the placement and transportation of inmates and reimbursement to counties for the housing of those inmates. Any county that voluntarily agrees to house misdemeanants from that county or from other counties pursuant to the Program may enter into a written agreement with the Department of Adult Correction to do so.

The North Carolina Sheriffs' Association shall:

(1) Report no later than the fifteenth day of each month to the Office of State Budget and Management and the Fiscal Research Division on the Statewide Misdemeanant Confinement Program. Each monthly report shall include all of the following:
   a. The daily population delineated by misdemeanant or DWI monthly housing.
   b. The cost of housing prisoners under the Program.
   c. The cost of transporting prisoners under the Program.
   d. Personnel costs.
   e. Inmate medical care costs.
   f. The number of counties that volunteer to house inmates under the Program.
   g. The administrative costs paid to the Sheriffs' Association and to the Department of Adult Correction.

(2) Report no later than October 1 of each year to the chairs of the House of Representatives Appropriations Committee on Justice and Public Safety and the Senate Appropriations Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Justice and Public Safety on the Statewide Misdemeanant Confinement Program. The report shall include the following with respect to the prior fiscal year:
   a. The cost of housing prisoners by county under the Program.
   b. The cost of transporting prisoners by county under the Program.
   c. Personnel costs by county.

d. Inmate medical care costs by county.
e. The number of counties that volunteer to house inmates under the Program.
f. The administrative costs paid to the Sheriffs' Association and to the Department of Adult Correction.

(b3) The custodian of a local confinement facility may request a judicial order to transfer a misdemeanant housed pursuant to the Statewide Misdemeanant Confinement Program to a facility operated by the Division of Prisons by certifying in writing to the clerk of the superior court in the county in which the local confinement facility is located that one of the following conditions is met:

(1) The misdemeanant poses a security risk because the misdemeanant:
   a. Poses a serious escape risk.
   b. Exhibits violently aggressive behavior that cannot be contained and warrants a higher level of supervision.
   c. Needs to be protected from other inmates, and the county jail facility cannot provide such protection.
   d. Is a female or a person 18 years of age or younger, and the county jail facility does not have adequate housing for such prisoners.
   e. Is in custody at a time when a fire or other catastrophic event has caused the county jail facility to cease or curtail operations.
   f. Otherwise poses an imminent danger to the staff of the county jail facility or to other prisoners in the facility.

(2) The misdemeanant requires medical or mental health treatment that the county decides can best be provided by the Division of Prisons.

(3) The local confinement facility that would be required to house the prisoner (i) cannot reasonably accommodate any more prisoners due to segregation requirements for particular prisoners, or the local facility does not meet the minimum standards published pursuant to G.S. 153A-221, and (ii) no other local confinement facility is available.

Upon receiving such request and certification in writing, any superior or district court judge for the district in which the local confinement facility is located may, after ascertaining that the request meets the criteria set forth in subdivision (1), (2), or (3) of this subsection, order the misdemeanant transferred to a unit of the State prison system designated by the Secretary of the Department of Adult Correction or the Secretary's authorized representative. Individuals meeting the condition set forth in subdivision (2) of this subsection may be ordered to be transferred for an initial period not to exceed 30 days. The sheriff of the county from which the prisoner is removed shall be responsible for conveying the prisoner to the prison unit where the prisoner is to be held and for returning the prisoner to the jail of the county from which the prisoner was transferred. The officer in charge of the prison unit designated by the Secretary of Adult Correction shall receive custody of the prisoner in accordance with the terms of the order. Prior to the conclusion of the 30-day period, the Division of Prisons shall conduct an assessment of treatment and venue needs. The assessment shall be conducted by the attending medical or mental health professional and shall assess the medical and mental health needs of the prisoner and make a recommendation on whether the prisoner should remain in the custody of the Division of Prisons of the Department of Adult Correction or if the prisoner should be returned to the custody of the county. To extend the order beyond the initial 30-day period, the sheriff shall provide the Division of Prisons assessment and any other relevant information to the resident judge or the superior court or any judge holding superior court in the district or any district court judge who shall determine whether to extend the transfer of the prisoner to a unit of the State prison system beyond the initial 30-day period. If the judge determines that the prisoner should remain in the custody of the Division of Prisons, the judge shall renew the order and include a date certain for review by the court. Prior to the date of review, the Division shall conduct a reassessment of treatment and venue needs and the sheriff shall provide the reassessment and any other relevant information to the court, as described in this subsection. If the judge determines that the prisoner should not remain in the custody of the Division of Prisons, the

officer in charge of the prison unit designated by the Secretary of Department of Adult Correction shall release custody of the prisoner in accordance with the court order and the instructions of the attending medical or mental health professional. The Division of Prisons shall be reimbursed from the Statewide Misdemeanant Confinement Fund for the costs of housing the misdemeanant, including the care, supervision, and transportation of the misdemeanant.

(b4) A misdemeanant housed under the Statewide Misdemeanant Confinement Program established pursuant to subsection (b2) of this section may be transferred to a facility operated by the Division of Prisons if the North Carolina Sheriffs' Association, Inc., determines that the local confinement facilities available for housing misdemeanants under the Program are filled to capacity. The Division of Prisons shall be reimbursed from the Statewide Misdemeanant Confinement Fund for the costs of housing the misdemeanant, including the care, supervision, and transportation of the misdemeanant.

(c) Repealed by Session Laws 2015-40, s. 6.

(d) When a prisoner serving a sentence of 30 days or more in a local confinement facility is placed on work release pursuant to a recommendation of the sentencing court, the custodian of the facility shall forward the prisoner's work-release earnings to the Division of Prisons, which shall disburse the earnings as determined under G.S. 148-33.1(f). When a prisoner serving a sentence of 30 days or more in a local confinement facility is placed on work release pursuant to an order of the sentencing court, the custodian of the facility shall forward the prisoner's work-release earnings to the clerk of the court that sentenced the prisoner or to the Division of Prisons, as provided in the prisoner's commitment order. The clerk or the Division, as appropriate, shall disburse the earnings as provided in the prisoner's commitment order. Upon agreement between the Division of Prisons and the custodian of the local confinement facility, however, the clerk may disburse to the local confinement facility the amount of the earnings to be paid for the cost of the prisoner's keep, and that amount shall be set off against the reimbursement to be paid by the Department to the local confinement facility pursuant to G.S. 148-32.1(a).

(e) Upon entry of a prisoner serving a sentence of imprisonment for impaired driving under G.S. 20-138.1 into a local confinement facility or to a detention facility approved by the Division of Juvenile Justice Section of the Department of Public Safety pursuant to this section, the custodian of the local confinement facility or detention facility shall forward to the Post-Release Supervision and Parole Commission information pertaining to the prisoner so as to make him eligible for parole consideration pursuant to G.S. 15A-1371. Such information shall include date of incarceration, jail credit, and such other information as may be required by the Post-Release Supervision and Parole Commission. The Post-Release Supervision and Parole Commission shall approve a form upon which the custodian shall furnish this information, which form will be provided to the custodian by the Division of Prisons. (1977, c. 450, s. 3; c. 925, s. 2; 1981, c. 859, s. 25; 1985, c. 226, s. 3(1), (2); 1985 (Reg. Sess., 1986), c. 1014, ss. 199, 201(e); 1987, c. 7, ss. 2, 6; 1987 (Reg. Sess., 1988), c. 1037, s. 120; c. 1100, s. 17.4(a); 1989, c. 1, s. 2; c. 761, s. 3; 1991, c. 217, s. 6; 1993, c. 538, s. 33; 1994, Ex. Sess., c. 14, s. 65; c. 24, s. 14(b); 1995, c. 324, s. 19.9(f); 1997-456, s. 23; 2004-199, s. 48; 2004-203, s. 54; 2009-451, s. 19.22A; 2011-145, s. 19.1(h), (i); 2011-192, s. 7(a), (d), (e), (g); 2014-100, s. 16C.1(f); 2015-40, s. 6; 2016-94, s. 17C.1(d); 2017-186, s. 2(vvvvvvv); 2020-83, ss. 8(m), 9(b) ; 2021 180, ss. 19C.2, 19C.9(p), (q), (z); 2023 121, s. 16(g).)

Chapter 162. Sheriff.

Article 4. County Prisoners.

§ 162-39. Transfer of prisoners when necessary for safety and security; application of section to municipalities.

(a) Whenever necessary for the safety of a prisoner held in any county jail or to avoid a breach of the peace in any county or whenever prisoners are arrested in such numbers that

county jail facilities are insufficient and inadequate for the housing of such prisoners, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a fit and secure jail in some other county where the prisoner shall be held for such length of time as the judge may direct.

(b) Whenever necessary to avoid a security risk in any county jail, or whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the housing of such prisoners, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a unit of the State prison system designated by the Secretary of Department of Adult Correction or his authorized representative. For purposes of this subsection, a prisoner poses a security risk if the prisoner:

(1) Poses a serious escape risk;
(2) Exhibits violently aggressive behavior that cannot be contained and warrants a higher level of supervision;
(3) Needs to be protected from other inmates, and the county jail facility cannot provide such protection;
(4) Is a female or a person 18 years of age or younger, and the county jail facility does not have adequate housing for such prisoners;
(5) Is in custody at a time when a fire or other catastrophic event has caused the county jail facility to cease or curtail operations; or
(6) Otherwise poses an imminent danger to the staff of the county jail facility or to other prisoners in the facility.

(b1) The Health Services Division of the Department of Adult Correction shall maintain records of prisoners transferred to a unit of the State prison system pursuant to subsection (b) of this section. The records shall utilize unique identifiers for each transferred prisoner and shall include all of the following information:

(1) The date the transfer order was received.
(2) The statutory basis upon which the order was granted.
(3) The date the prisoner was transferred to State custody.
(4) The State prison facility where the prisoner was transferred.
(5) The county where the prisoner was removed.
(6) The dates the prisoner received health services from the Department.
(7) A list of health services provided to the prisoner and the corresponding charges.
(8) The date the Department determined that the prisoner no longer needs health services to be provided by the State prison system.
(9) The date and method used by the Department to notify the county that the prisoner should be transferred back to the custody of the county.
(10) The date that the prisoner is returned to the custody of the county.

(c) The sheriff of the county from which the prisoner is removed shall be responsible for conveying the prisoner to the jail or prison unit where the prisoner is to be held, and for returning the prisoner to the common jail of the county from which the prisoner was transferred. The return shall be made at the expiration of the time designated in the court order directing the transfer unless the judge, by appropriate order, directs otherwise. The sheriff or keeper of the jail of the county designated in the court order, or the officer in charge of the prison unit designated by the Secretary of Adult Correction, shall receive and release custody of the prisoner in accordance with the terms of the court order. If a prisoner is transferred to a unit of the State prison system, the county from which the prisoner is transferred shall pay the Division of Prisons of the Department of Adult Correction for maintaining the prisoner for the time designated by the court at the per day, per inmate rate at which the Division of Prisons of the Department of Adult Correction pays a local jail for maintaining a prisoner. The county shall also pay the Division of Prisons of the Department of Adult Correction for the costs of medical care incurred while the prisoner was in the custody of the Division, defined as follows:

(1) Medical expenses incurred as a result of providing health care to a prisoner as an inpatient (hospitalized).

(2) Other medical expenses when the total cost exceeds thirty-five dollars ($35.00) per occurrence or illness as a result of providing health care to a prisoner as an outpatient (nonhospitalized).

(3) Cost of replacement of eyeglasses and dental prosthetic devices if those eyeglasses or devices are broken while the prisoner is incarcerated, provided the prisoner was using the eyeglasses or devices at the time of his commitment and then only if prior written consent of the county is obtained by the Division.

(4) Transportation and custody costs associated with the transfer of prisoners receiving health care outside of the prison facility. The county shall reimburse the State for services provided to the prisoner at the same mileage reimbursement rate and hourly custody rate that are reimbursed pursuant to the Statewide Misdemeanant Confinement Program.

(5) Cost of sick call encounters at the rate charged to State prison inmates.

(c1) If the prisoner is transferred to a jail in some other county, the county from which the prisoner is transferred shall pay to the county receiving the prisoner in its jail the actual cost of maintaining the prisoner for the time designated by the court. Counties are authorized to enter into contractual agreements with other counties to provide jail facilities to which prisoners may be transferred as deemed necessary under this section.

(c2) Whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the safekeeping of such prisoners, the resident judge of the superior court or any superior or district court judge holding court in the district may order the prisoners transferred to a unit of the Division of Prisons of the Department of Adult Correction designated by the Secretary of the Department of Adult Correction or the Secretary's authorized representative, where the prisoners may be held for such length of time as the judge may direct, such detention to be in cells separate from those used for imprisonment of persons already convicted of crimes, except when admission to an inpatient prison medical or mental health unit is required to provide services deemed necessary by a prison health care clinician. The sheriff of the county from which the prisoners are removed shall be responsible for conveying the prisoners to the prison unit or units where they are to be held, and for returning them to the common jail of the county from which they were transferred. However, if due to the number of prisoners to be conveyed the sheriff is unable to provide adequate transportation, the sheriff may request the assistance of the Division of Prisons of the Department of Adult Correction, and the Division of Prisons of the Department of Adult Correction is hereby authorized and directed to cooperate with the sheriff and provide whatever assistance is available, both in vehicles and manpower, to accomplish the conveying of the prisoners to and from the county to the designated prison unit or units. The officer in charge of the prison unit designated by the Secretary of the Department of Adult Correction or the Secretary's authorized representative shall receive and release the custody of the prisoners in accordance with the terms of the court order. The county from which the prisoners are transferred shall pay to the Division of Prisons of the Department of Adult Correction the actual cost of transporting the prisoners and the cost of maintaining the prisoners at the per day, per inmate rate at which the Division of Prisons of the Department of Adult Correction pays a local jail for maintaining a prisoner, provided, however, that a county is not required to reimburse the State for transporting or maintaining a prisoner who was a resident of another state or county at the time the prisoner was arrested. However, if the county commissioners shall certify to the Governor that the county is unable to pay the bill submitted by the Division to the county for the services rendered, either in whole or in part, the Governor may recommend to the Council of State that the State of North Carolina assume and pay, in whole or in part, the obligation of the county to the Division, and upon approval of the Council of State the amount so approved shall be paid from the Contingency and Emergency Fund to the Division of Prisons of the Department of Adult Correction.

(c3) When, due to an emergency, it is not feasible to obtain from a judge of the superior or district court a prior order of transfer, the sheriff of the county and the Division of Prisons of the Department of Adult Correction may exercise the authority hereinafter conferred; provided, however, that the sheriff shall, as soon as possible after the emergency, obtain an order from the judge authorizing the prisoners to be held in the designated place of confinement for such period as the judge may direct. All provisions of this section shall be applicable to municipalities whenever prisoners are arrested in such numbers that the municipal jail facilities and the county jail facilities are insufficient and inadequate for the safekeeping of the prisoners. The chief of police is hereby authorized to exercise the authority herein conferred upon the sheriff, and the municipality shall be liable for the cost of transporting and maintaining the prisoners to the same extent as a county would be unless action is taken by the Governor and Council of State as herein provided for counties which are unable to pay such costs.

(d) Whenever a prisoner held in a county jail requires medical or mental health treatment that the county decides can best be provided by the Division of Prisons of the Department of Adult Correction, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a unit of the State prison system designated by the Secretary of the Department of Adult Correction or the Secretary's authorized representative for an initial period not to exceed 30 days. The sheriff of the county from which the prisoner is removed shall be responsible for conveying the prisoner to the prison unit where the prisoner is to be held, and for returning the prisoner to the jail of the county from which the prisoner was transferred. The officer in charge of the prison unit designated by the Secretary shall receive custody of the prisoner in accordance with the terms of the order. Prior to the conclusion of the 30-day period, the Division of Prisons of the Department of Adult Correction shall conduct an assessment of treatment and venue needs. The assessment shall be conducted by the attending medical or mental health professional and shall assess the medical and mental health needs of the prisoner and make a recommendation on whether the prisoner should remain in the custody of the Division of Prisons of the Department of Adult Correction or if the prisoner should be returned to the custody of the county. To extend the order beyond the initial 30-day period, the sheriff shall provide the Division of Prisons of the Department of Adult Correction's assessment and any other relevant information to the resident judge of the superior court or any judge holding superior court in the district or any district court judge who shall determine whether to extend the transfer of the prisoner to a unit of the State prison system beyond the initial 30-day period. If the judge determines that the prisoner should remain in the custody of the Division of Prisons of the Department of Adult Correction, the judge shall renew the order and include a date certain for review by the court. Prior to the date of review, the Division shall conduct a reassessment of treatment and venue needs and the sheriff shall provide the reassessment and any other relevant information to the court, as described in this subsection. If the judge determines that the prisoner should not remain in the custody of the Division, the officer in charge of the prison unit designated by the Secretary of the Department of Adult Correction shall release custody of the prisoner in accordance with the court order and the instructions of the attending medical or mental health professional. The county from which the prisoner is transferred shall pay the Division for maintaining the prisoner for the period of treatment at the per day, per inmate rate at which the Division pays a local jail for maintaining a prisoner, and for extraordinary medical expenses as set forth in subsection (c) of this section.

(e) The number of county prisoners incarcerated in the State prison system pursuant to safekeeping orders from the various counties pursuant to subsection (b) of this section or for medical or mental health treatment pursuant to subsection (d) of this section may not exceed 200 at any given time unless authorized by the Secretary of Public Safety. The Secretary may refuse to accept any safekeeper and may return any safekeeper transferred under a safekeeping order when this capacity limit is reached. The Secretary shall not refuse to accept a safekeeper because a county has failed to pay the Department of Adult Correction for

services rendered pursuant to this section.

(f) If, after 10 days of receiving notification and request for transfer from the Department of Adult Correction pursuant to G.S. 148-19.3(a), the sheriff fails to assume custody of the county prisoner from the State prison facility to which the prisoner was assigned, then, in addition to the actual cost of transporting the prisoner and the cost of maintaining the prisoner at the per day, per inmate rate at which the Division of Prisons of the Department of Adult Correction pays a local jail for maintaining a prisoner, the county shall be liable to the State for an additional per day, per inmate rate not to exceed twenty dollars ($20.00) for each day the sheriff fails to assume custody of the prisoner, unless the sheriff has obtained an extension of the order because the inmate cannot be safely housed in the local jail. The section chief of the Health Services Section may waive up to 10 days of the additional per day rate if the sheriff provides documentation of extenuating circumstances. (1957, c. 1265; 1967, c. 996, ss. 13, 15; 1969, cc. 462, 1130; 1973, c. 822, s. 3; c. 1262, s. 10; 1983, c. 165, ss. 1-4; 1985 (Reg. Sess., 1986), c. 1014, s. 198(a)-(c); 1989, c. 1, s. 7; 1991, c. 535, s. 1; 1991 (Reg. Sess., 1992), c. 983, s. 1; 2002-126, s. 17.1; 2011-145, s. 19.1(h), (i); 2012-83, s. 60; 2017-186, s. 2(kkkkkkkkk); 2019-171, s. 1 ; 2021 180,s. 19C.9(rrrr); 2022 74, s. 19A.1(i).)

1.2

NC Jail Health Administrative Rules

NC Administrative Code

TITLE 10A – DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHAPTER 14 – DIRECTOR, DIVISION OF HEALTH SERVICE REGULATION

SUBCHAPTER 14J – JAILS, LOCAL CONFINEMENT FACILITIES

SECTION .0200 - OPERATIONS MANUAL FOR JAILS

10A NCAC 14J .0201 REQUIREMENT FOR OPERATIONS MANUAL
The sheriff or the regional jail administrator shall develop an operations manual that meets the requirements of this Section.

History Note: Authority G.S. 153A-221; Eff. June 1, 1990; Amended Eff. June 1, 1991; Readopted Eff. September 4, 2020.

10A NCAC 14J .0202 PURPOSE OF OPERATIONS MANUAL
The purpose of the operations manual is to ensure the smooth and efficient operation of the jail, and therefore it shall be detailed enough to guide officers in completing their assigned duties. The operations manual shall be available to all officers, and each officer shall be familiar with the manual.

History Note: Authority G.S. 153A-221; Eff. June 1, 1990; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, 2016.

10A NCAC 14J .0203 CONTENTS OF OPERATIONS MANUAL
(a) The operations manual shall include written policies and procedures that address the following areas:
(1) administration and management of inmates;
(2) admissions, transportation, and release;
(3) classification for the placement and housing of inmates, as set forth in Rule .0301(a) of this Subchapter;
(4) security and supervision;
(5) inmate rules and discipline;
(6) management of special inmates;
(7) legal rights of inmates;
(8) health, mental health, developmental disability, intellectual disability, and substance use disorder services;
(9) food services;
(10) program services;
(11) work release;
(12) opportunities for exercise;
(13) access to legal assistance or legal materials;
(14) grievance procedures;
(15) visitation and mail policies;
(16) religious activities;
(17) sanitation procedures that comply with Rule .0701 of this Subchapter;
(18) emergency plans for a fire or an emergency situation that includes rioting, bomb threats, escapes, and the taking of hostages;
(19) a disaster plan as required by Rule .0403(d) of this Subchapter;
(20) a suicide prevention program that includes identifying suicidal inmates,

supervising suicidal inmates, and reviewing procedures and debriefing officers after an inmate suicide;
(21) waiving any medical fees for indigent inmates, as required by G.S. 153A-225;
(22) use of force; and
(23) use of restraints.

(b) In compliance with G.S. 153A-220(1), the Construction Section shall provide consultation and technical assistance to a jail upon request.

History Note: Authority G.S. 153A-221; Eff. June 1, 1990; Readopted Eff. September 4, 2020.

10A NCAC 14J .0204 REVIEW OF MANUAL

The sheriff or regional jail administrator shall review and approve the operations manual in writing annually beginning on January 1. If the operations manual has changed, it shall be updated during the review. The date of the most recent review and approval shall be stated in the operations manual. The operations manual and the written approval shall be made available to the Construction Section during an inspection upon request.

History Note: Authority G.S. 153A-221; Eff. June 1, 1990; Readopted Eff. September 4, 2020.

SECTION .0600 - SUPERVISION

10A NCAC 14J .0601 SUPERVISION

(a) A jail shall have an officer make supervision rounds and observe each inmate at least two times within a 60 minute time period on an irregular basis with not more than 40 minutes between rounds. Supervision rounds shall be conducted 24 hours a day, 7 days per week. The supervision rounds shall be documented and maintained as written or electronic records. These records shall be made available to the Construction Section during an inspection upon request. The supplemental methods of supervision specified in Paragraph (b) of this Rule shall not substitute for supervision rounds.

(b) A jail shall utilize one or more supplemental methods of supervision 24 hours a day, 7 days a week. The supplemental methods of supervision are:
(1) direct two-way voice communication;
(2) remote two-way voice communication;
(3) direct visual observation; and
(4) video surveillance.

(c) While an inmate is on special watch, as specified by this Paragraph, the jail shall have an officer conduct special watch rounds and observe the inmate not less than four times within a 60 minute period on an irregular basis with not more than 20 minutes between rounds. Special watch shall be conducted 24 hours a day, 7 days a week. The special watch rounds shall be documented. The jail shall maintain written or electronic records of the special watch rounds and shall make these records available to the Construction Section during an inspection upon request. The supplemental methods of supervision specified in Paragraph of this Rule shall not substitute for a special watch. Special watch shall be used for the following reasons:
(1) an inmate with a medical record maintained and preserved by the jail as required by Rule .1001(b)(7) of this Subchapter that indicates the inmate has attempted suicide at a previous time, unless the inmate is seen by a physician who determines a special watch is not needed;
(2) an inmate who reports a previous suicide attempt or threatens to commit suicide during their initial screening upon admission required by Rule .1001(b)(1) of this Subchapter, unless the inmate is seen by a physician who determines a special watch is not needed;

(3) an inmate who has been assigned to special watch by medical or mental health personnel of the jail or an officer;
(4) an inmate who displays any of the following behavior:
(A) physically hitting or trying to hit an officer;
(B) verbal abuse of other people;
(C) threatening other people, or threatening to or engaging in self-injury;
(D) screaming, crying, laughing uncontrollably, or refusing to talk; and
(5) an inmate who is intoxicated by alcohol or drug use as determined at intake by one of the following:
(A) a blood alcohol content level of .15 or greater as measured;
(B) use of slurred speech; or
(C) the inability to control body movement.

(d) A jail shall make sure that officers remain awake at all times while on duty.

(e) An officer or officers assigned to supervise inmates as required by Paragraph (a) and (c) of this Rule may be assigned other tasks if those tasks do not interfere with the completion of supervision and special watch rounds or are not performed at the same time as supervision and special watch rounds. These other tasks may include:
(1) delivering food to inmates;
(2) preparing inmates for and transporting inmates to court;
(3) escorting inmates to medical appointments;
(4) performing inmate booking and release functions;
(5) supervising inmates working in the jail; and
(6) exchanging inmate's soiled clothing, bed sheets, and blankets with clean clothing, bed sheets, and blankets.

(f) A jail shall have female officers on duty when female inmates are confined.

(g) The sheriff or the regional jail administrator shall develop contingency personnel plans for the supervision and control of inmates during a fire, an emergency event, or an emergency situation that includes rioting, bomb threats, escapes, and the taking of hostages. The contingency personnel plans shall provide for the availability of extra personnel. A contingency personnel plan shall be included in the emergency plans required by Rule .0203(18) of this Subchapter and the disaster plan required by Rule .0403(d) of this Subchapter.

(h) A jail shall not allow an inmate to supervise or assume control over other inmates.

History Note: Authority G.S. 153A-221; Eff. October 1, 1990; Amended Eff. June 1, 1992; Readopted Eff. September 4, 2020.

SECTION .0900 - FOOD

10A NCAC 14J .0903 FOOD AND NUTRIENT REQUIREMENTS

(a) The average nutrient content of weekly menus shall meet the Recommended Dietary Allowances of the National Academy of Sciences which are hereby adopted by reference pursuant to G.S. 150B-14(c).

(b) Daily menus shall include the following:
(1) Milk Group: Two servings;
(2) Fruit Group: Two servings, one of which shall be citrus;
(3) Vegetable Group: Three servings;
(4) Meat or Protein Group: Two servings;
(5) Cereal or Bread Group: Four servings of whole grain or enriched products; and
(6) Calories: 2,100 - 2,500.

(c) For all pregnant women and inmates under age 18, the milk group shall include four servings per day.

History Note: Authority G.S. 153A-221; Eff. June 1, 1990; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, 2016.

10A NCAC 14J .0905 MODIFIED DIETS

(a) Modified diets shall be provided if prescribed by appropriate medical or dental personnel.
(b) Modified diets shall be provided when reasonably possible to accommodate the sincerely held religious beliefs of an inmate.
(c) Written menus for modified diets shall be prepared in consultation with a registered dietitian.
(d) Modified diets shall be served as written. Any necessary substitutions shall be of comparable nutritional value, and a written record of substitutions shall be kept. Dated menus of modified diets and records of any substitutions shall be retained for three years.
(e) Each jail shall maintain a current list of inmates requiring modified diets, and it shall be posted for use by staff.
(f) Each jail shall record the number of modified diets served at each meal, along with the name of each inmate and the type of modified diet that he or she received.

History Note: Authority G.S. 153A-221; Eff. June 1, 1990; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, 2016.

SECTION .1000 - HEALTH CARE OF INMATES AND EXERCISE

10A NCAC 14J .1001 MEDICAL PLAN

(a) A governing body shall develop and adopt a written medical plan in compliance with G.S. 153A-225. The medical plan shall be available for reference by jail personnel. The medical plan shall include a description of the health services available to inmates.
(b) The written plan shall include policies and procedures that address the following areas:
    (1) screening of inmates upon admission as set forth in Rule .1002(a) of this Section;
    (2) handling routine medical care;
    (3) handling routine care for an inmate's needs related to:
        (A) mental health;
        (B) a developmental or intellectual disability; and
        (C) a substance use disorder;
    (4) the handling of inmates with chronic illnesses or communicable diseases or conditions;
    (5) administration, dispensing, and control of prescription and non-prescription medications;
    (6) handling emergency medical needs, including dental care, substance use disorder, pregnancy, and mental health;
    (7) maintenance, preservation, and confidentiality of medical records; and
    (8) privacy during medical examinations and conferences with medical or mental health personnel.
(c) Inmates shall be provided an opportunity each day to communicate their health complaints to medical personnel, mental health personnel, or an officer. Medical personnel or mental health personnel shall be available to evaluate the needs of inmates related to medical care, mental health care, a substance use disorder, and a developmental or intellectual disability. A jail shall maintain a written record of an inmate's health complaints and the action taken by the jail. The jail shall make these records available to the Construction Section during an inspection upon request.
(d) Inmates shall not render medical care or routine care for mental health, substance use disorders, and developmental or intellectual disabilities to anyone in the jail.
(e) The local or district health director shall review the medical plan to determine if it needs to be updated not less than once each year beginning on January 1. If so, he or she shall

update the medical plan in writing in accordance with G.S. 153A-225. The date of the most recent review shall be stated in the plan. The medical plan shall be maintained at the jail and shall be made available to the Construction Section during an inspection upon request.

History Note: Authority G.S. 153A-221; 153A-225; Eff. June 1, 1990; Amended Eff. December 1, 1991; Readopted Eff. September 4, 2020.

10A NCAC 14J .1002 SCREENING OF INMATES

(a) Medical personnel, mental health personnel, or an officer shall conduct and document screenings of each inmate upon admission for the following:
    (1) medical care needs;
    (2) mental health care needs;
    (3) developmental and intellectual disabilities;
    (4) substance use disorders; and
    (5) risk of suicide.

(b) Medical personnel or mental health personnel shall maintain a record of the screening in each inmate's medical record. In compliance with G.S. 153A-222, documentation of the screening shall be made available to the Construction Section during an inspection upon request.

(c) Officers may access or use information from the screening in accordance with the confidentiality policy and procedures for medical records that is required by Rule .1001(b)(7) of this Section.

History Note: Authority G.S. 153A-221; Eff. June 1, 1990; Amended Eff. December 1, 1991; Readopted Eff. September 4, 2020.

10A NCAC 14J .1003 MEDICAL ISOLATION

Each jail shall separate inmates who require medical isolation from other inmates, either by housing them in a separate area of the jail or by transferring them to another facility.

History Note: Authority G.S. 153A-221; Eff. June 1, 1990; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, 2016.

10A NCAC 14J .1004 EXERCISE

After the fourteenth consecutive day of confinement, each inmate shall be provided opportunities for physical exercise at least three days weekly for a period of one hour each of the days. Physical exercise shall take place either in the confinement unit if it provides adequate space or in a separate area of the jail that provides adequate space. The opportunity for physical exercise shall be documented.

History Note: Authority G.S. 153A-221; Eff. June 1, 1990; Amended Eff. December 1, 1991; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, 2016.

SECTION .1100 – REPORTS

10A NCAC 14J .1102 REPORT OF DEATH

The report of an inmate death required by G.S. 153A-225 shall be submitted to the Section within five days.

History Note: Authority G.S. 153A-221; Eff. June 1, 1990; Amended Eff. June 1, 1993; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, 2016.

TITLE 10A – DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHAPTER 41 - EPIDEMIOLOGY HEALTH

SUBCHAPTER 41A - COMMUNICABLE DISEASE CONTROL

10A NCAC 41A .0202 CONTROL MEASURES – HIV

The following are the control measures for the Human Immunodeficiency Virus (HIV) infection:

....

(8) The local health director shall ensure that the health plan for local jails include education of jail staff and prisoners about HIV, how it is transmitted, and how to avoid acquiring or transmitting this infection.

....

History Note: Authority G.S. 130A-135; 130A-144; 130A-145; 130A-148(h); Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988; Eff. March 1, 1988; Amended Eff. February 1, 1990; November 1, 1989; June 1, 1989; Temporary Amendment Eff. January 7, 1991 for a period of 180 days to expire on July 6, 1991; Amended Eff. May 1, 1991; Recodified from 15A NCAC 19A .0201 (d) and (e) Eff. June 11, 1991; Amended Eff. August 1, 1995; October 1, 1994; January 4, 1994; October 1, 1992; Temporary Amendment Eff. February 18, 2002; June 1, 2001; Amended Eff. January 1, 2018; November 1, 2007; April 1, 2005; April 1, 2003; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 9, 2018.

1.3

Jail Medical Plan Guide

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June 2024

This guide is only to be used as a resource and does not illustrate an actual medical plan. For assistance with the interpretation of the information presented or questions related to a specific facility plan email anita.wilson-merritt@dhhs.nc.gov

The statutes and rules referenced in this guide are the controlling regulatory provisions. The statutes and rules in this guide are current as of 5/10/2024 and may be subject to change. Individuals are responsible for ensuring the current statutes and regulations are followed.

Questions related to 10A NCAC 14J should be directed to the Jails & Detention Unit of the Division of Health Service Regulation NC DHSR: Jails and Detention Section (ncdhhs.gov).

What is the significance of a jail medical plan?

The medical plan itself is a document to detail a facility's approach to providing medical services for its residents. The document should provide staff with key information on what, when, and how services will be provided. The medical plan is also a significant connection to local health authorities. Local health directors have the responsibility of approving the jail medical plan annually. This important step should be used to ensure legal requirements are being met but to also ensure that the plan aligns with community resources and provide insight on opportunities for collaboration.

Medical Plan Guide Purpose

No two jails are the same. Detention centers' facility, population, funding, and culture vary widely making it impossible to create guidance that can apply to all. The most used approach is to create versatile guidance by outlining layers that can be added or withdrawn at the discretion of the detention center while providing some method to assist in selecting what guidance is appropriate for their circumstances.

We have modified this approach in creating this Medical Plan Guide. The guide is meant to be a resource for local health directors, jail administrators, and any other professional involved with the development and/or approval of their county's jail medical plan. Oftentimes administrators or public health officials are expected to review a medical plan without any experience with correctional healthcare delivery. There are very few resources that provide the contents of a medical plan. This resource aims to provide a detailed reference to explain the basics of such a plan.

Medical Plan Guide Overview

Medical plans are typically based upon or include some aspects of national correctional standards. The American Correctional Association (ACA; Standards Information - ACA Standards) and National Commission on Correctional Healthcare (NCCHC; Standards - National Commission on Correctional Health Care (ncchc.org)) both issue operational standards for healthcare delivery. The standards can be purchased from each organization and are utilized as a basis for accreditation from the issuing agency. The Federal Bureau of Prisons (BOP) also

has a set of policies they refer to as program statements which are similar to ACA and NCCHC standards and can be found on the BOP: Federal Bureau of Prisons Web Site.

This guide can be broken into 4 sections.

1. **Legal Requirements –** this section provides a summary of NC General Statutes and NC Administrative Code that applies to the Jail Medical Plan
2. **Sample Policy Template –** This section illustrates a basic policy template with definitions and example. Some medical plans utilize this format for their topics, while others utilize a more narrative approach.
3. **Medical Plan Section Topics –** This is a singular list of medical plan topics based on the National Commission on Correctional Healthcare (NCCHC) Jail Standards. The list highlights priority topics which are considered important within national standards or North Carolina law.
4. **Medical Plan Topic Specific Guidance –** Points to consider and facility specific information are provided for each topic. The points to consider are meant to provide general insight on the topic rather than define or specify language to be used in a medical plan. Facility specific information lists some details that are helpful to provide to staff involved in healthcare delivery. Sometimes this information can be found in medical plans, vendor contract, or an internal facility resource.

Contents

Legal Requirements

A jail medical plan is required. Every jail must have a plan for providing medical care for prisoners. The plan must be "adequate to protect the health and welfare of the prisoners." G.S. 153A-225(a). It shall be made available to the Construction Section during an inspection upon request. 10A NCAC 14J 1001 (e).

Development. The plan must be developed in consultation with appropriate local officials, including the sheriff, the county physician, the local or district health director, and the local medical society. G.S. 153A-225(a).

Approval. The operations manual shall be reviewed annually by the sheriff or jail administrator. The date of the most recent review shall be stated in the manual. The plan must then be approved by the local health director after consultation with the area mental health authority. G.S. 153A-225(a). The local health director shall review and update the plan at least once a year. The date of the most recent review shall be stated in the plan. 10A NCAC 14J .1001(e)

Board adoption. Upon a determination that the plan is adequate to protect the health and welfare of the prisoners, the plan must be adopted by the governing body. G.S. 153A-225(a).

Contents of the plan.

The jail medical plan must, at a minimum, cover the following topics:

1. A description of the health services available to inmates. 10A NCAC 14J .1001(a)
2. Screening upon admission. 10A NCAC 14J .1001(b).
3. Routine medical care, including the handling of inmates with chronic illnesses. 10A NCAC 14J .1001(b).
4. Routine care related to mental health, developmental or intellectual disability, and substance use disorder. 10A NCAC 14J .1001(b).
5. The handling of inmates with communicable diseases and the detection, examination, and treatment of prisoners who are infected with tuberculosis and sexually transmitted infections. G.S. 153A-225(a)(3); 10A NCAC 14J .1001(b).
6. Education of jail staff and prisoners about HIV, how it is transmitted, and how to avoid acquiring or transmitting this infection. 10A NCAC 41A .0202(8).
7. Administration, dispensing, and control of medications. 10A NCAC 14J .1001(b).
8. The handling of emergency medical needs, including emergencies involving dental care, substance use disorder, pregnancy, and mental health. G.S. 153A-225(a); 10A NCAC 14J .1001(b). An "emergency medical need" is a medical need "that requires medical treatment as soon as noticed and that may not be deferred until the next scheduled sick call or clinic." 10A NCAC 14J .0101(20).
9. Maintenance, preservation, and confidentiality of medical records. 10A NCAC 14J .1001(b). (Per G.S. 130A-143, all records that identify a person who has an HIV infection or other reportable condition must be held strictly confidential. See 10A NCAC 41A .0101 for a complete list of reportable conditions).
10. Privacy during medical examinations and conferences with medical or mental health personnel. 10A NCAC 14J .1001(b).

Sample Medical Policy Template

The purpose of this template is to illustrate and define the typical components of a correctional medical policy.

Section Title
Names each section (A section is defined as a collection of similar policies)

Policy Title

Objective
Provides the purpose and desired outcome of the policy

Policy
A facility's official position on an issue

Policies include those required by state or federal law and/or those optional and/or specific to their facility

Procedure (if applicable)
Details implementation of policy

Statutes, Administrative Code, or National Standards relating to policy
Links the policy to corresponding state laws/rules and national corrections standards (ACA and/or NCCHC)

SAMPLE POLICY

Policies are typically written in the below format, but some manuals may use a more narrative approach in which sections are not clearly separated but the information is still provided.

The information below should not be used as an actual policy.

Section I: Governance and Administration (*Section Title*).

Access to Care (*Policy Title*):

OBJECTIVE: To assure detainees of the Detention Facility (DF) have access to care to meet their medical and mental health needs.

POLICY: The responsible health authority (RHA) identifies and eliminates any barriers to detainees receiving health care. Access to care shall be in a timely manner, detainee can be seen by a clinician, be given a professional clinical judgment, and receive care that is ordered

PROCEDURE:

a. Access to health care information will be provided to detainees at intake
b. Signs providing instructions for access to health care will be posted in housing units
c. The responsible health authority will ensure that there are no unreasonable barriers (intentional or unintentional) to patients receiving health care

STANDARDS AND STATUTES:

a. State Statutes: G.S. 153A-225
b. State Rules: 10 NCAC 14J Section 1000
c. NCCHC Standards: J-A-01 (Essential)

Medical Plan Topics

Topics listed below in **green/bold** and with a ♦ are selected as priority for this guide as they can be linked to NC laws/rules, ACA standards, or NCCHC standards. These topics are included in most medical plans. Budget, staffing, community resources, and population details among other factors play a role in determining what medical services can be offered.

GOVERNANCE AND ADMINISTRATION

- ♦ **Access to Care [10 NCAC 14J .1000]**
- ♦ **Responsible Health Authority [10 NCAC 14J .1000]**
- ♦ **Policies and Procedures [10 NCAC 14J .1001]**
- ♦ **Communications for Special Needs Patients**
- ♦ **Procedure in the Event of Detainee Death [G.S. 153A-225; 10 NCAC 14J .1102]**
- Medical Autonomy
- Administrative Meetings & Reports
- Continuous Quality Improvement Program
- Emergency Plan
- Privacy of Care
- Grievance Mechanism
- Morbidity/Mortality

MANAGING A SAFE AND HEALTHY ENVIRONMENT

- ♦ **Infection Control and Prevention [G.S. 153A-225; 10NCAC 14J .1001 and .1003]**
- ♦ **Detainee Safety [G.S 153A-221]**
- ♦ **Suicide Prevention [10 NCAC 14J .0601 and .1002]**
- Staff Safety
- Response to Sexual Assault/Abuse
- Medical Surveillance of Detainee Workers
- Contraception
- Elder Abuse
- Management of Exposures

HEALTH PROMOTION

- ♦ **Use of Tobacco Products**
- Health Education and Promotion
- Clinical Preventive Services

PERSONNEL AND TRAINING

- **Credentialing**
- **Medication Administration Training**
- **Health Training for Detention Officers**
- **Detainee Workers [10 NCC 14J .1001]**

Clinical Performance Enhancement

Professional Development

Staffing

Health Care Liaison

Orientation for Health Staff

HEALTH CARE SERVICES SUPPORT

- **Pharmaceutical and Medication Operations [10 NCC 14J .1001]**
- **Clinic Space, Equipment and Supplies [10A NCAC 14J .1209]**
- **Diagnostic Services**
- **Hospital and Specialized Ambulatory Care**
- **Emergency Medical Response Plan [10 NCC 14J .1001]**
- **Medical Diets [10A NCAC 14J .0905]**

Telemedicine/Telepsychiatry

DETAINEE CARE AND TREATMENT

- **Information and Health Services [10 NCAC 14J .1001]**
- **Receiving Screening [10A NCAC 14J .1001 & .1002]**
- **Transfer Screening**
- **Initial Health Assessment**
- **Mental Health Evaluation**
- **Dental Care**
- **Handling of Non-Emergency Medical Request [10NCAC 14J .1001]**
- **Emergency Services [10 NCAC 14J .1001]**
- **Medical Isolation [10A NCAC 14J .1003]**
- **Medical Co-Pay [G.S. 153A-225]**

Hunger Strike

Health Evaluation of Detainees in Segregation

Patient Transport

Nursing Assessment Protocols

Written and Verbal Clinicians' Orders

Continuity of Care

Discharge Planning

SPECIAL NEEDS AND SERVICES

- **Chronic Disease Services [10 NCAC 14J .1001]**
- **Patients with Special Health Needs**
- **Care for the Terminally Ill**
- **Mental Health Services [G.S. 153A-221; 10 NCAC 14J .1001]**
- **Suicide Prevention Program [10 NCAC 14J .0601]**
- **Intoxication and Withdrawal [10 NCAC 14J .0601]**
- **Substance Use Services [G.S. 153A-221; 10 NCAC 14J .1001]**
- **Care of the Pregnant Detainee [G.S. 153A-221]**
- **Pregnancy Counseling**

Skilled Nursing and Infirmary Care

Orthosis, Prostheses and Other Aids to Impairment

Naloxone Use

Medications to Treat Opioid Use Disorder

Gender Dysphoria

HEALTH RECORDS

- **Health Record [10A NCAC 14J .1001]**
- **Confidentiality of Health Records [10A NCAC 14J .1001]**
- **Custody Access to Information [10A NCAC 14J .1002]**
- **Management of Health Records [10A NCAC 14J .1001]**

MEDICAL LEGAL ISSUES

- **Restraint and Seclusion**
- **Forensic Information**

Disciplinary Actions

Emergency Psychotropic Medication

End of Life Decision Making

Informed Consent/Right to Refuse Treatment

Medical and Other Research

Medical Plan Topics Detailed Guidance

Points to consider and facility specific information are provided for each topic in this section.

The **points to consider** are meant to provide general insight on the topic rather than define or specify language to be used in a medical plan.

Facility specific information lists some of the details that are helpful to provide to your staff involved in healthcare delivery. Sometimes this information can be found in medical plans, vendor contract, or an internal facility resource.

GOVERNANCE AND ADMINISTRATION

♦ ACCESS TO CARE

Points to Consider

- Simply acknowledges that those detained have a right to access to care for medical and mental health needs

Facility Specific Information

- A good place to list the primary medical provider for your facility.

♦ RESPONSIBLE HEALTH AUTHORITY

Points to Consider

- This person/entity is responsible for coordinating the health services offered for the facility and may or may not be a medical provider

Facility Specific Information

- Note title and contact information (ex. facility extension number) of facility's Responsible Health Authority in Plan (avoid specific names due to potential personnel changes)

♦ POLICIES AND PROCEDURES

Points to Consider

- Acknowledges need to establish site specific policies and procedures accessible to new and established staff

♦ COMMUNICATIONS FOR SPECIAL NEEDS PATIENTS

Points to Consider

- Details that healthcare staff communicate significant health needs of a detainee that may require accommodations

♦ PROCEDURE IN THE EVENT OF DETAINEE DEATH

Points to Consider

- Provides detailed instructions and checklist of procedures and notifications in the event of a detainee death

Facility Specific Information

- Identify facility first point of contact in the event of a death
- List of individuals and agencies to be notified
- List of required documentation

MEDICAL AUTONOMY

Points to Consider

- Acknowledges that healthcare decisions should be made by a qualified healthcare professional
- The delivery of healthcare is a joint effort of custody and health staff

Facility Specific Information

- Identify what healthcare decision makers service the facility

ADMINISTRATIVE MEETINGS & REPORTS

Points to Consider

- Supports collaboration and communication between custody and healthcare staff to address healthcare service delivery
- Often details frequency and purpose of various meetings/reports

Facility Specific Information

- List required reports
- List current meetings with their frequency and attendants (positions not individuals)

CONTINUOUS QUALITY IMPROVEMENT PROGRAM

Points to Consider

- Details continuous monitoring program to effect improvement in healthcare delivery and how the effectiveness is measured

EMERGENCY PLAN

Points to Consider

- Refers to the facility's emergency plan as it relates to healthcare in the event of a disaster as opposed to plans for individual healthcare emergencies.
- Typically includes information on how routine healthcare services will be handled during a disaster.

PRIVACY OF CARE

Points to Consider

- Acknowledges healthcare encounters are private and staff including custody are responsible for protecting health information

GRIEVANCE MECHANISM

Points to Consider

- Acknowledges detainee rights and establish procedures to address health related concerns identified Facility Specific Information
- Note responsible person/position for reviewing grievances within the facility

MORBIDITY/MORTALITY

Points to Consider

- Establishes procedures for reviewing critical incidents and deaths that occur for improvement purposes

MANAGING A SAFE AND HEALTHY ENVIRONMENT

♦ INFECTION CONTROL AND PREVENTION

Points to Consider

- Focuses on prevention, detection, and mitigation of infectious or communicable diseases within the facility
- Illnesses that require reporting should be identified and the reporting process should be included
- Include details for education of staff and detainees about HIV, how it is transmitted, and how to avoid acquiring or transmitting this infection

Facility Specific Information

- Note required intake testing and isolation areas for your facility

♦ DETAINEE SAFETY

Points to Consider

- Identifies measures and interventions implemented to reduce risk and adverse events for detainees

♦ SUICIDE PREVENTION

Points to Consider

- Identifies and details measures in place to aide in suicide prevention including screening and monitoring plans

Facility Specific Information

- List emergency contacts available for the facility

STAFF SAFETY

Points to Consider

- Identifies measures implemented to provide a safe working environment for all staff

RESPONSE TO SEXUAL ASSAULT/ABUSE

Points to Consider

- Details procedures regarding prevention, detection, and reduction of sexual abuse
- Identifies steps in evaluating, preserving evidence, and reporting an assault incident
- Describes how the facility complies with any applicable federal law of which PREA (Prison Rape Elimination Act) is most common

Facility Specific Information

- Note specifics of how and where a sexual assault kit collection for the facility occurs.

MEDICAL SURVEILLANCE OF DETAINEE WORKERS

Points to Consider

- Addresses health and safety of detainee workers through medical surveillance

Facility Specific Information

- Note restrictions or limitations associated with jobs offered by the facility

CONTRACEPTION

Points to Consider

- Identifies contraception options available while incarcerated
- States facility's policy on emergency contraception

ELDER ABUSE

Points to Consider

- Identifies measures in place to prevent and report incidents of potential elder abuse

MANAGEMENT OF EXPOSURES

Points to Consider

- Addresses how blood-borne pathogen or chemical exposures are handled
- Decontamination protocols may be listed

HEALTH PROMOTION

♦ USE OF TOBACCO PRODUCTS

Points to Consider

- States the prohibition of tobacco products as it relates to the grounds of the facility

HEALTH EDUCATION AND PROMOTION

Points to Consider

- Details awareness and efforts to provide education and training of self-care for detainees

Facility Specific Information

- Specific trainings offered within the facility

CLINICAL PREVENTIVE SERVICES

Points to Consider

- Identifies preventive and screening services available during incarceration (includes laboratory testing, immunizations, focused health assessments, etc.)

PERSONNEL AND TRAINING

♦ CREDENTIALING

Points to Consider

- To ensure that all health care personnel providing services to residents have verification of current credentials on file and legally eligible to perform their duties
- Initial and annual verification of credentials and licenses
- Maintaining healthcare employee files
- Identify procedure for security clearance
- Specific guidelines/recommendations can be found with N.C. Board of Medicine, N.C. Psychology Board, N.C. State Board of Nursing, N.C. Medical Board of Dieticians, etc.

♦ MEDICATION ADMINISTRATION TRAINING

Points to Consider

- All staff administering medication must be properly trained
- Healthcare workers should be trained on security issues during medication administration
- Consider detention officer training on side effects of common medications
- Training provided by qualified staff and approved by the RHA and Facility Administrator
- Review annually and maintain evidence of training in employee file

Facility Specific Information

- Detail medication administration and documentation when healthcare staff not available

♦ HEALTH TRAINING FOR DETENTION OFFICERS

Points to Consider

- Detention officers shall receive initial and in-service training that will enable them to recognize signs and symptoms of life-threatening situations of detainees and the reporting procedures for notifying medical staff.

Facility Specific Information

- Medical Emergency Code used in your facility
- Location of first aid kits & AED
- CPR training provider and schedule

♦ DETAINEE WORKERS

Points to Consider

- Detainees shall not render medical care or routine care for mental health, substance use disorders, and developmental or intellectual disabilities to anyone in the jail
- Detail detainee training and custody supervision while in the medical department

Facility Specific Information

- Clearly identify what duties the detainee may perform while in the medical unit if applicable

CLINICAL PERFORMANCE ENHANCEMENT

Points to Consider

- Evaluation of care being delivered and identify opportunities for improvement

Facility Specific Information

- Describe your Continuous Quality Improvement (CQI) program
- Identify CQI Committee(s) and reporting mechanism

PROFESSIONAL DEVELOPMENT

Points to Consider

- All qualified health care professionals participate annually in continuing education appropriate for their assigned position.
- Outline new hire orientation and annual trainings offered
- Remember CPR certification & recertifications

STAFFING

Points to Consider

- Adequate number of qualified health care staff members of varying types is available commensurate with the level of health services provided
- Detail number of days per week / how many hours per day will medical be staffed and by who
- Process when medical not staffed

Facility Specific Information

- Contact information i.e. who, when, & how
- Mental Health emergencies
- Medical Emergencies
- On-call staff & contact information
- Students / Interns

HEALTH CARE LIAISON

Points to Consider

- Identify a qualified individual who will be the designated person to coordinate healthcare services for detainees, when medical team is not on site for an extended period of time (i.e. weekends, holidays).

Facility Specific Information

- Contact information for on-call medical staff for medical, mental health, dental, ambulance, and other emergency service contacts

ORIENTATION FOR HEALTH STAFF

Points to Consider

- Orientation to facility and job responsibilities
- Orientation to Corrections to include but not limited to dress code, safety, security, deliberate indifference, detainee / staff relationships, boundaries & PREA

Facility Specific Information

- Orientation checklist and duration
- Emergency & Disaster Plan
- Policy & Procedures location

HEALTH CARE SERVICES SUPPORT

♦ PHARMACEUTICAL AND MEDICATION OPERATIONS

Points to Consider

- Ensure medication services are clinically appropriate and provided in timely, safe, and sufficient manner

Facility Specific Information

- Medication provider (Pharmacy) contact information and hours of service
- Pharmacist consultation availability
- Medication storage and disposal procedures
- Routine medication administration times
- Identification of detainee processes for handling of medication (i.e. keep on person (KOP) meds)

- Prescription refill procedures
- Controlled Substance policy

♦ CLINIC SPACE, EQUIPMENT AND SUPPLIES

Points to Consider

- Sufficient and suitable space, supplies, and equipment for medical, dental, and mental health services.
- Detail syringe, needles, and sharps procedure
- Privacy for detainee during assessments

♦ DIAGNOSTIC SERVICES

Points to Consider

- Provides the necessary diagnostic services for the diagnosis and treatment of residents confined in the facility either on site or referred
- Laboratory – Identify CLIA waived tests and other testing

Facility Specific Information

- List contracted vendors for Radiology, Mammography, etc
- Diagnostic procedures that will be performed at the facility and those performed at other medical facilities

♦ HOSPITAL AND SPECIALIZED AMBULATORY CARE

Points to Consider

- Hospitalization and specialty care is available to patients in need of these services
- Consider contracts with local hospitals and specialty providers to ensure all levels of care are available

Facility Specific Information

- List Hospitals, Ambulance Service, Specialty Providers, Specialty Facilities used

♦ EMERGENCY MEDICAL RESPONSE PLAN

Points to Consider

- Provide timely and orderly emergency medical services in the event of a natural or manmade disaster

Facility Specific Information

- Identify responsibilities and roles
- Detail Triage process
- Evacuation Plan
- Telephone numbers and procedures for calling healthcare staff and community emergency response system (i.e. hospitals, ambulance)

♦ MEDICAL DIETS

Points to Consider

- Modified diets shall be provided if prescribed by appropriate medical or dental personnel

Facility Specific Information

- Registered Dietician/Nutritionist contact information
- List of Medical Diets
- Process for medical diet consultations and orders

TELEMEDICINE/TELEPSYCHIATRY

Points to Consider

- Medical and Mental Health Services via electronic transmission; telemedicine, telepsychiatry, and tele-mental health

Facility Specific Information

- Identify services that can be delivered via telehealth

DETAINEE CARE AND TREATMENT

♦ INFORMATION AND HEALTH SERVICES

Points to Consider

- Upon arrival to the facility detainees are informed, verbally and in writing, of the availability of health care services and how to access them
- Signed acknowledgment by the detainee they received this education should be obtained
- Details and how to access for medical services offered

♦ RECEIVING SCREENING

Points to Consider

- Details process of screening all detainees upon arrival to ensure emergent and urgent health needs are met

Facility Specific Information

- Identify emergency care provider contacts and services available to facility

♦ TRANSFER SCREENING

Points to Consider

- Details process of medical information sharing to ensure continuity of care and identify medical needs

♦ INITIAL HEALTH ASSESSMENT

Points to Consider

- Ensures detainees receive needed health assessments either by “full population” or “assessment when clinically indicated” approaches

Facility Specific Information

- Detail method/frequency used to assess detainees within your facility

♦ MENTAL HEALTH EVALUATION

Points to Consider

- Ensures all detaining receive mental health screening to identify urgent and ongoing needs
- Performed by qualified healthcare professional
- Includes evaluation for mental health, intellectual functioning, and developmental disability

Facility Specific Information

- Outline mental health services and provider for your facility
- Identify timeframe for completing mental health evaluation
- List hours of availability of mental health staff

♦ EMERGENT DENTAL CARE

Points to Consider

- Outlines which oral health services and procedures to be provided

Facility Specific Information

- Detail dental provider and services offered
- Dental Emergency Response
- How to access care for Dental Services

♦ HANDLING OF NON-EMERGENCY MEDICAL REQUEST

Points to Consider

- Details procedure for detainees, regardless of housing assignment, to submit oral or written health care request daily.

♦ EMERGENCY SERVICES

Points to Consider

- 24-hr services for acute medical and psychiatric emergencies
- Provides facility procedure for emergency health situations

Facility Specific Information

- Contact / phone number for
  - Provider(s) on-call
  - Emergency transportation services
  - Emergency Providers i.e. hospital
- Note facility locations for AED, Naloxone, etc

♦ MEDICAL ISOLATION

Points to Consider

- Details policy and procedure relating to medical isolation.
- May be combined with Infection Control Policy

Facility Specific Information

- Identify areas for medical isolation

♦ MEDICAL CO-PAY

Points to Consider

- Details copay management and procedure for the facility
- Plan should specify how indigent detainees will maintain access to care

Facility Specific Information

- Define copay requirements for your facility

HUNGER STRIKE

Points to Consider

- Details management of detainees who have declared hunger strike
- Typically includes definition of what is considered a hunger strike and outlines monitoring requirements to ensure health and safety of detainee
- Defines when detainee should be transferred to higher level of care

HEALTH EVALUATION OF DETAINEES IN SEGREGATION

Points to Consider

- Outline procedures to provide all residents who are segregated from the general population with direct equal access to health care services and to provide for a regular schedule of documented health evaluations

Facility Specific Information

- Identify segregation locations of your facility

PATIENT TRANSPORT

Points to Consider

- Outlines process to transport safely and in a timely manner detainees for medical, mental health and dental clinic appointments both inside and outside the facility
- Includes the scheduling process, procedure in case of missed appointments, and escort requirements

NURSING ASSESSMENT PROTOCOLS

Points to Consider

- Details nursing assessment protocols appropriate to the level and skill of the nursing personnel who will carry them out.
- All protocols are to comply with all state nurse practice acts.
- Typically developed by the Medical Director and Nurse Supervisor or provided by contracted medical provider

WRITTEN AND VERBAL CLINICIANS' ORDERS

Points to Consider

- Declares written or verbal orders are to be signed by the responsible health provider that is licensed to practice medicine in the State of North Carolina
- Details process of verification, transcription and implementing verbal provider orders

Facility Specific Information

- Identify who has the authority to sign orders within the facility

CONTINUITY OF CARE

Points to Consider

- Outlines how medical, dental, and mental health care is coordinated and monitored from admission to discharge
- Specifies coordination with community care providers
- Outlines how medical information is shared at time of discharge or transfer

DISCHARGE PLANNING

Points to Consider

- Outlines how discharge planning is provided for detainees with serious health needs whose release is imminent

Facility Specific Information

- Provide list of community resources

SPECIAL NEEDS AND SERVICES

♦ CHRONIC DISEASE SERVICES

Points to Consider

- Detainees with chronic diseases should be managed in accordance with evidence-based standards.
- A list of all detainees with chronic diseases should be maintained so as to ensure proper care and follow-up.

♦ PATIENTS WITH SPECIAL HEALTH NEEDS

Points to Consider

- Individualized treatment plans should be developed for all detainees with special health care needs.
- Ensure the detainee understands and works cooperatively to understand medications, needed monitoring and environmental controls

Facility Specific Information

- Contact information for the facilities interpretation and other special needs resources can be listed

♦ CARE FOR THE TERMINALLY ILL

Points to Consider

- Identifies policies and procedures to declare a detainee as terminally ill
- Identifies available accommodations and treatments

Facility Specific Information

- Define facility specific procedure for early release if applicable

♦ MENTAL HEALTH SERVICES

Points to Consider

- Ensure that mental health services are available to all detainees either onsite or via outside provider

- Highlights that the Responsible Health Authority (RHA) work jointly with custodial staff to ensure mental health treatment goals can be met

Facility Specific Information

- Identify Mental Health Service provider for your facility and hours of availability

♦ SUICIDE PREVENTION PROGRAM

Points to Consider

- Ensure that all RHA staff and custody staff have training in suicide risks identification and response

Facility Specific Information

- Include an area of facility identified for close monitoring of suicidal detainees until they can be transferred to appropriate level of care to manage suicide risks or attempt

♦ INTOXICATION AND WITHDRAWAL

Points to Consider

- Written policy and procedures for the management of intoxicated detainees and those who may be experiencing withdrawal for drugs or alcohol.
- Acknowledges that all healthcare and custody staff should have training to identify signs of intoxication and withdrawal.

Facility Specific Information

- Identify local providers and medications used (if applicable) for treatment for your facility

♦ SUBSTANCE USE SERVICES

Points to Consider

- Acknowledges medical and custody staff should receive training in the recognition of substance use disorders
- Details methods to develop individualized treatment plans for detainees with substance use disorders

Facility Specific Information

- List substance use treatment options available to your facility

♦ CARE OF THE PREGNANT DETAINEE

Points to Consider

- Access to appropriate prenatal and post-partum care (consistent with national standards) by an Ob-Gyn specialist should be available to all pregnant detainees.

Facility Specific Information

- Identify Ob-Gyn provider to deliver prenatal and post-partum care.

♦ PREGNANCY COUNSELING

Points to Consider

- Ensure supportive counseling to help ensure healthy pregnancy outcomes
- Coercion relative to the expressed desire of the detainee should be avoided.

Facility Specific Information

- Detail resources available

SKILLED NURSING AND INFIRMARY CARE

Points to Consider

- Detail how appropriate level of skilled nursing or infirmary care for illnesses not appropriate for general population will be provided

Facility Specific Information

- If feasible, identify area of facility wherein skilled nursing or infirmary will be provided or list location where services are provided

ORTHOSIS, PROSTHESES AND OTHER AIDS TO IMPAIRMENT

Points to Consider

- Details how aids needed to maintain the health of the detainee should be determined and administered.
- Medical staff should work with custody staff ensure that needed equipment does not pose a custody risks; other options should be explored if custody risk is determined

Facility Specific Information

- Note specific common medical devices used within the facility

NALOXONE USE

Points to Consider

- Outlines procedures for use of Naloxone within the facility
- In accordance with state laws, Naloxone kits may be available in facility for use in the prevention of overdoses.
- Outlines training required for those administering Naloxone (both custody and medical staff)

MEDICATIONS TO TREAT OPIOID USE DISORDER PROGRAMS

Points to Consider

- Ensure that all detainees entering the facility are screened for substance use disorders
- Appropriate consultation and management of MOUD program will be clearly outlined in policy

Facility Specific Information

- Specific treatments and conditions should be listed
- List participating community partners

GENDER DYSPHORIA

Points to Consider

- Detainees with gender dysphoria should receive appropriate medical and mental health care services as done for all detainees.
- Education of medical staff and custody staff in gender dysphoria terminology along with medical and mental health issues associated with such should be clearly outlined in policy

- Issues of safety for gender dysphoric detainees must be clearly outlined (i.e. housing, showering, etc.)

HEALTH RECORDS

♦ HEALTH RECORD FORMAT AND CONTENT

Points to Consider

- Content of the Health record is confidential and should only be accessible to medical staff.
- Documentation in the health record should be in accordance with policies and procedures established by the responsible health authority

Facility Specific Information

- Note how medical records are maintained in your facility (electronic or paper).

♦ CONFIDENTIALITY OF HEALTH RECORDS

Points to Consider

- Highlights staff with access to confidential health records receive instruction relative to the importance of maintaining confidentiality
- If medical vendor is contracted for healthcare, the facility should maintain ownership of confidential health records; this should be in the contractual agreement with

♦ CUSTODY ACCESS TO INFORMATION

Points to Consider

- Custody does not routinely have access to detainee healthcare information.
- Policies outlining circumstance(s) wherein custody may access or receive confidential health information relative to a detainee should be developed

♦ MANAGEMENT OF HEALTH RECORDS

Points to Consider

- All medical records should be managed in a secure manner.
- Policy should include how records are stored, transferred, and released to other healthcare entities

MEDICAL LEGAL ISSUES

♦ RESTRAINT AND SECLUSION

Points to Consider

- Restraints should be utilized in a manner so as not to cause harm to the detainee.
- Ensure that policy development is very specific on the use of and monitoring when restraints are used and/or detainee is in seclusion

♦ FORENSIC INFORMATION

Points to Consider

- Medical staff should not be involved in the collections of forensic information
- Healthcare staff are to remain as advocates for the detainee
- Details of collection and documentation of forensic information should be provided

DISCIPLINARY ACTIONS

Points to Consider

- Disciplinary actions remain the responsibility of custody staff and should be noted that medical staff do not participate in disciplinary decisions

EMERGENCY PSYCHOTROPIC MEDICATION

Points to Consider

- Use of emergency psychotropic medications should be administered only in proper setting
- Policies and protocols clearly outline the transfer process of a detainee to an appropriate mental health facility or to the North Carolina Department of Adult Corrections (DAC) for safekeeping

END OF LIFE DECISION MAKING

Points to Consider

- Detainees are free to make end of life decisions.
- Outline procedures in policy for gathering end of life decisions and training medical and custody staff on specific information to be obtained and by whom

INFORMED CONSENT/RIGHT TO REFUSE TREATMENT

Points to Consider

- Detainees have a right to give informed consent and/or refuse treatment
- Have policy which clearly outlines procedures to follow for obtaining informed consent and refusals of treatment

MEDICAL AND OTHER RESEARCH

Points to Consider

- Research using detainees as subjects must be consistent with established ethical, medical, legal, and regulatory standards for human research.
- Outline policy and procedures that give clear guidance on when and how detainees may participate in research

1.4a

Intake Screening Information

Perhaps one of the most important processes of a correctional health system, this screening is meant to fulfill four purposes:

1. Identify and meet any urgent health needs of those being admitted
2. Identify and meet any known or easily identifiable health needs that require medical or mental health intervention
3. Identify and isolate inmates who may be potentially contagious
4. Obtain a medical clearance when necessary

STEP 1: MEDICAL CLEARANCE

a. Medical clearance should happen as soon as the individual arrives at the facility.
b. Reception personnel need to ensure that people who are **unconscious, semiconscious, bleeding, mentally unstable, severely intoxicated, exhibiting symptoms of alcohol or drug withdrawal**, or otherwise urgently in need of medical attention are referred immediately for care and a medical clearance into the facility.

STEP 2: THE ACTUAL SCREENING

a. In jails and juvenile facilities, the screening may be conducted by health-trained correctional personnel or qualified health care professionals.
b. Administrators should consider the risks of not knowing an inmate's medical condition (e.g., suicidal ideation, prescription medications, communicable illness symptoms, drug and alcohol use and/or withdrawal symptoms) when designing the intake and receiving screening process.
c. A good rule of thumb is that it should occur no more than two to four hours after admission.
d. Sometimes inmates arrive in large groups, making it impossible to conduct a receiving screening immediately. In such cases, a medical clearance to determine who may be too ill to wait for a screening or be admitted should be done.
e. Accommodations for people who have difficulty communicating (e.g., non-English speaking, intellectually or developmentally disabled, deaf, mentally ill, under the influence) should be made to ensure a thorough screening is conducted.
f. People with mental disorders are often unable to give complete or accurate information in response to health status inquiries. It would be helpful to have mental health staff assist in training staff who do the intake screening for these situations
g. Areas of Inquiry include
    i. current and past illnesses, health conditions or special requirements (e.g., hearing aids, visual aids, wheelchair, walker, sleep apnea machine);
    ii. past infectious disease; recent communicable illness symptoms (e.g., chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever);
    iii. current or past mental illness, including hospitalizations; current or past suicidal ideation;
    iv. dental problems (e.g., decay, gum disease, abscess); allergies;
    v. dietary needs;
    vi. prescription medications as well as legal and illegal drug use (type, amount, time of last use);
    vii. current or prior withdrawal symptoms;
    viii. possible, current or recent pregnancy;
    ix. other health problems as specified by your facility physician.
h. Observations to document include
    i. appearance (e.g., sweating, tremors, anxious, disheveled),
    ii. behavior (e.g., disorderly, inappropriate, insensible),

iii. state of consciousness (e.g., alert, responsive, lethargic),
iv. ease of movement (e.g., body deformities, gait),
v. breathing (e.g., persistent cough, hyperventilation)
vi. skin (including lesions, jaundice, infestations, bruises, scars, tattoo, needle marks or other indications of drug abuse)

i. Juveniles - consider

i. whether there are children under the juvenile's care;
ii. the type and time of the most recent sexual encounter and use of contraception and condoms in order to screen for emergency contraception eligibility;
iii. victimization by recent sexual assault in order to screen for emergency contraception eligibility.
iv. females should be offered a pregnancy test upon arrival and referred to health staff within 48 hours for testing
v. sexually transmitted disease testing should be offered to all juveniles upon arrival or at least within the first 24 to 48 hours

j. Females

i. should be asked about opioid history and those who report opioid use should immediately be offered a pregnancy test to avoid withdrawal risks to the fetus

STEP 3: DOCUMENTATION AND FOLLOW-UP

a. Based on the findings from the screening, the disposition of the inmate should be documented (e.g., referred to the appropriate health care service, placed in general population).
b. The forms should be dated and timed immediately upon completion and include the name, signature and title of the person completing the form.
c. If the screening revealed recent communicable illness symptoms, the potentially infectious patient should be isolated from the general inmate population.
d. All immediate health needs identified through the screening process should be properly addressed by qualified health care professionals.

ADDITIONAL SCREENING TIPS

a. Screeners should fully explore the potential for suicide for incoming inmates.
b. Screeners should also investigate the potential for individuals to exhibit symptoms of withdrawal from alcohol and other drugs.
c. Inmates arriving with signs of recent trauma should be referred immediately for medical observation and treatment.
d. Patients enrolled in a community substance abuse program should be considered for ongoing medication-assisted treatment.

CO'S PERFORMING RECEIVING SCREENING

The training given to correctional officers who conduct the receiving screening should include at a minimum,

a. how to take a medical history;
b. how to make the medical, dental and mental health observations;
c. how to determine the appropriate disposition based on responses to questions and observations;
d. how to document their findings on the receiving screening form.

10A NCAC 14J .1002 SCREENING OF INMATES

(a) Medical personnel, mental health personnel, or an officer shall conduct and document screenings of each inmate upon admission for the following:
    (1) medical care needs
    (2) mental health care needs
    (3) developmental and intellectual disabilities
    (4) substance use disorders
    (5) risk of suicide

(b) Medical personnel or mental health personnel shall maintain a record of the screening in each inmate's medical record. In compliance with G.S. 153A-222, documentation of the screening shall be made available to the Construction Section during an inspection upon request.

(c) Officers may access or use information from the screening in accordance with the confidentiality policy and procedures for medical records that is required by Rule .1001(b)(7) of this Section.

1.4b

Sample Universal Intake Screening Form

OFFENDER NAME:	DATE:
DATE OF BIRTH:	ID NUMBER:

ADMISSIONS/INTAKE

This screen does not replace or fulfill the requirement of a medical assessment by a qualified health professional.

INSTRUCTIONS: STAFF SHALL COMPLETE THIS SCREENING ON ALL OFFENDERS ARRIVING TO THE FACILITY.

INTAKE				
Prior Incarceration? ☐ No ☐ Yes When/Where?				
Translation Need? ☐ None ☐ Non-Verbal ☐ Spanish ☐ Other:				
Emergency Contact/Next of Kin	Name:			
	Phone:			
	Address:			
Cooperation with Screening ☐ Cooperative ☐ Partially Cooperative ☐ Refuse				
OBSERVATIONS				
LEVEL OF CONSCIOUSNESS	**MENTAL STATUS**	**BEHAVIOR**	**APPEARANCE**	**SKIN CONDITION**
Alert	Knows own name	Cooperative	Relaxed	No visible bruises
Drowsy	Knows location and date	Passive	Clean & neat	Tattoo
Confused	Normal emotional expression	Evasive	Disheveled/Dirty	Breaks in skin
Agitated	Lacks emotional expression	Demanding	Obvious injury	Yellowish/Jaundice
Semiconscious	Elated	Angry	Tremulous	Visible sweating
GAIT	Hypervigilant	Threatening	Deformity	Track marks
Normal	Hallucinating	Combative	Appears intoxicated	Scars
Unsteady	Delusional	Slurred speech	Odor of alcohol	Infestations
Limping	Incoherent	Tearful	Self-Inflicted injury	Skin infections
Other:	Other:	Other:	Other:	Other:
Serious injury/hospitalization in last 90 days? Yes ☐ No ☐ If yes, explain:				
Were you treated in an emergency department or urgent care within the last 30 days? Yes ☐ No ☐ If yes, explain:				

Medical History				
Do you have or have history of...	YES	NO	Describe:	Current Medications
Diabetes				
High Blood Pressure				
Heart Condition				
Asthma				
COPD				
Kidney Disease				
Seizure Disorder				
Cancer				
Other Chronic Illness				
Medications not previously listed (OTC or prescribed)				
Allergies? (medication or environmental)	None Known ☐			
	Medications ☐ List:			
	Environmental ☐ List:			
Are you on a specific diet prescribed by a physician? Yes ☐ No ☐ If yes, explain:				
Substance Use History				
Do you think you will have withdrawal symptoms from stopping the use of medications or other substances (including alcohol or drugs) while you are in jail? Yes ☐ No ☐ If yes, describe:				
Do you use drugs? Yes ☐ No ☐ If yes...	How often?			
	Last time?			
	What kind?			
	How much?			
Do you use alcohol? Yes ☐ No ☐ If yes...	How often?			
	Last time?			
	What kind?			
	How much?			
Have you ever been treated for drug and/or alcohol problems? Yes ☐ No ☐ If yes, when/where?				
Are you currently in a medication assisted treatment program for opioid use disorder? Yes ☐ No ☐ If yes, Medication: Last Dose:				
Mental Health				
Have you ever considered or attempted suicide? Yes ☐ No ☐ If yes explain:				
Are you currently thinking about killing or harming yourself? Yes ☐ No ☐ If yes, evaluate for suicide prevention and alert mental health/officers as applicable				
Does offender show signs of depression (sadness, irritability, emotional flatness)? Yes ☐ No ☐				
Are you extremely worried you will lose your job, position, spouse, significant other, custody of your children due to arrest? Yes ☐ No ☐				
Have you ever been in a hospital for emotional or mental health problems? Yes ☐ No ☐				
Do you have a current or past mental health diagnosis? Yes ☐ No ☐ If yes, please describe:				
Are you currently taking or been prescribed medication for an emotional or mental health problem? Yes ☐ No ☐ If yes, please list the medications:				

Special Considerations				
Are you gay/lesbian, bi-sexual, transgender, or gender non-conforming? What gender do you identify with?				
Have you ever been a victim of sexual assault? Yes ☐ No ☐ Molested as a child? Yes ☐ No ☐ Or been the perpetrator of a sexual assault? Yes ☐ No ☐ If yes, explain, note dates:				
Do you feel you are at risk for being attacked or harmed, either physically, emotionally, or sexually? Yes ☐ No ☐ If yes, explain:				
Have you ever had a traumatic brain injury, concussion, or loss of consciousness? Yes ☐ No ☐ If yes, describe:				
Have you fainted or had a head injury in the past? Yes ☐ No ☐				
Do you experience any of these problems in your daily life since you hit your head?	Headache	Anxiety	Difficulty remembering or concentrating	
	Easily upset or agitated	Seizure	Difficulty talking	
	Blurry vision	Dizziness	Sensitivity to loud noise or light	
Do you have a caregiver that assists you with daily activities or living skills? Yes ☐ No ☐ If yes, explain:				
Do you have a history of developmental disability? Yes ☐ No ☐ If yes explain:				
Do you have... Learning difficulty ☐ Reading difficulty ☐ Writing difficulty ☐ Legal Guardian ☐ Description:				
Any assistive devices?	Glasses	Contacts	Braces	Hearing Aid
	Prosthesis	Crutches	Cane	Wheelchair
	Walker	Other:		
Dental				
Do you have a painful dental condition or complaint? Yes ☐ No ☐ If so, explain:				
Do you wear dentures? Yes ☐ No ☐				
Female Specific Screening				
Urine pregnancy test: Negative ☐ Positive ☐ Not completed ☐			LMP:	
Are you pregnant? Yes ☐ No ☐	Recent Opiate Use		Fetal Movement	
	Headache		Blurred Vision	
	Nausea/Vomiting		Swelling	
	Prenatal Care? Yes ☐ No ☐ Last Exam: Physician/Clinic:			
Have you recently delivered within the last year? Yes ☐ No ☐ If yes: Are you breastfeeding? Yes ☐ No ☐				
Have you recently had a miscarriage or abortion? Yes ☐ No ☐ If yes, provide date/location:				
Are you currently on birth control? Yes ☐ No ☐ If yes, list type:				

Infectious Disease/TB			
Have you ever had a positive blood test, skin test, or PPD test for tuberculosis? Yes ☐ No ☐			
Do you currently have a cough that's lasted for more than three weeks? Yes ☐ No ☐			
Are you coughing up blood? Yes ☐ No ☐			
Do you have fever, chills, or night sweats? Yes ☐ No ☐			
Have you had unintentional weight loss? Yes ☐ No ☐			
Have you had any recent exposure to someone with an infectious disease? Yes ☐ No ☐ If yes, explain:			
Do you currently have diarrhea or have you had it in the past few days? Yes ☐ No ☐			
Do you have pus or liquid draining from any part of your body? Do you have a rash? Yes ☐ No ☐			
Have you been diagnosed with HIV? Yes ☐ No ☐			
COVID-19			
Rapid Antigen Test: Negative ☐ Positive ☐ Test not completed ☐			
Do you have any of these signs or symptoms?	Shortness of breath	Unexplained tiredness	Muscle/Body aches
	Headache	New loss of taste or smell	Sore throat
	Congestion or runny nose	Nausea/Vomiting/Diarrhea	Fever/Chills
Have you been tested for COVID in the last 10 days? Yes ☐ No ☐ If yes, the results are... Negative ☐ Positive ☐ Still Pending ☐			
Have you received a COVID vaccine? If yes... Single Dose ☐ 2-Dose ☐ Have you received a Booster? Yes ☐ No ☐			
Have you been exposed to someone with COVID-19 in the past 14 days? Yes ☐ No ☐			
Have you tested positive for COVID-19 in the past 90 days? Yes ☐ No ☐ If yes, provide date:			
Hepatitis Risk Screen			
Have you ever:			
Used I/V drugs Yes ☐ No ☐ If yes, Drug of choice: Last used:			
Snorted drugs Yes ☐ No ☐			
Shared needles Yes ☐ No ☐			
Have you been diagnosed with Hepatitis C? Yes ☐ No ☐			
Do you have a history of liver disease or Hepatitis B? Yes ☐ No ☐			
Do you want to be tested for hepatitis or HIV? Yes ☐ No ☐			
Disposition			
No Housing Restrictions due to Medical Issues			
Suicide Observation			
Medical Observation			
Medical Isolation due to potential infectious condition			

Safe and Proper Use of Disinfectants in Correctional Facilities

WORKPLACE SOLUTIONS

From the National Institute for Occupational Safety and Health

Safe and Proper Use of Disinfectants to Reduce Viral Surface Contamination in Correctional Facilities

Summary

Workers in correctional facilities, as well as incarcerated persons who are assigned to work details, may be exposed to viral pathogens if communal, high-touch surfaces are not properly cleaned and disinfected [CDC 2020d]. The National Institute for Occupational Safety and Health (NIOSH) recommends steps to reduce viral surface contamination through safe and proper use of disinfectants.

Introduction

According to the Bureau of Labor Statistics, approximately 442,000 correctional officers and jailers work inside correctional facilities in the United States [BLS 2019]. These employees frequently use disinfectants to disinfect their workspaces, offices, gear, and equipment, in addition to supervising the use of disinfectants by incarcerated persons. The total number of people working in these facilities is much higher because correctional facilities may also employ chaplains, healthcare providers, teachers, vocational instructors, drug treatment specialists, food service personnel, and construction and maintenance personnel.

In addition to employees, incarcerated persons also perform work assignments. For example, in federal prisons, each physically and mentally able incarcerated person is assigned to perform a work activity that contributes to the orderly operation of the institution [BOP 2008]. According to the Occupational Safety and Health Administration (OSHA), all staff and inmates who receive a wage for tasks performed are considered "workers." They maintain institution operations and services in numerous departments such as food service, laundry, facilities, etc. Incarcerated persons are also largely responsible for conducting daily sanitation tasks in areas such as food service, medical facilities, and inmate housing units.*

Correctional employees are assigned to work in areas where incarcerated persons are tasked with the responsibility of cleaning effectively. Work injuries among incarcerated persons are reported to OSHA in the same manner as employee injuries are reported.

The Incarcerated Population

Approximately 2 million persons are incarcerated in the United States: 1.3 million are in state or federal prisons and 700,000 are in county jails [Doleac et al. 2020]. Incarcerated persons are often required to share small cells or large dormitory-style barracks and communal bathrooms. These congregate settings and conditions make effective social distancing difficult, especially in small cells. Incarcerated persons frequently have higher rates of chronic conditions compared with the general population [Healthy People 2020]. These factors, combined with the complexities of employees and incarcerated

*Institution operations and services are completed through work by incarcerated persons, and correctional employees are frequently assigned to work inside inmate housing units. The term inmate housing unit is used throughout this document to describe the designated quarters where the inmates sleep and conduct daily personal hygiene tasks. Other terminologies for housing units may include cells, cell blocks, dormitories, pods, etc. Inmate housing units frequently have staff offices inside the unit, as well as, phones, computers, bathrooms, showers, and television viewing areas with game tables and chairs.

Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health

persons working in shared spaces, heighten the importance of enhanced cleaning and disinfecting practices through the safe and proper use of chemical disinfectants.

Viral Pathogens

Potential viral pathogens within the correctional environment include but are not limited to the following:

- Common cold viruses (coronavirus, parainfluenza, respiratory syncytial virus, and rhinovirus)
- Hepatitis viruses
- Human immunodeficiency virus (HIV)
- Influenza
- Norovirus
- Severe acute respiratory syndrome coronavirus 2 (SARS–CoV–2)

Hepatitis A is transmitted through fecal-oral routes. Hepatitis viruses B and C (HBV and HCV), and HIV are bloodborne pathogens and could be transmitted through shared items such as razors, needles, and syringes. If there are bodily fluids from a person infected with any type of hepatitis on a surface in a correctional facility, the area is disinfected. [CDC 2020f; NIOSH 2016].

Other viruses, like influenza, norovirus, parainfluenza, respiratory syncytial virus, and rhinoviruses, are more likely to be transmitted by contact with contaminated surfaces (compared with HBV, HCV, HIV, and coronaviruses). Certain coronaviruses have the potential to spread from contaminated surfaces, but they spread more often via respiratory droplets [CDC 2018, 2019 b,c, 2020a,c,d,f,g]. SARS–CoV–2, the virus that causes coronavirus disease 2019 (COVID–19), is not thought to be commonly spread through surface transmission [CDC 2020c, 2021a,c]. Hard, non-porous surfaces may facilitate virus transmission, especially if they are "high-touch" surfaces, as described below.

Inside the Correctional Work Environment

Correctional employees are required to share and exchange equipment with other employees such as paracentric keys, two-way radios, and handcuffs. Correctional employees also share workspaces (with other employees) inside inmate housing units or direct supervision pods, as well as desks, computers, and phones. Employees and incarcerated persons may also work in shared workspaces (e.g., cubicles).

Congregate settings can present unique challenges. Incarcerated persons' use of communal areas contributes to the potential for viral transmission onto surfaces such as game tables, desks, door handles, stair rails, light switches, sink fixtures, shower fixtures, toilets, phones, and computer keyboards. Some surfaces are frequently touched by both the employees and the incarcerated persons (door handles, stair rails, etc.). Surface contamination of viral pathogens can be reduced with effective cleaning and disinfecting protocols [CDC 2021b].

Health Effects of Disinfectants

Asthma and reactive airway disease can occur in persons exposed to certain airborne chemicals, including some disinfectants. Clinically important asthma can occur at exposure concentrations below occupational exposure limits regulated by OSHA or recommended by NIOSH [CDC 2016]. Dermatologic diseases are also associated with exposure to cleaning agents [Charles et al. 2009; NIOSH 2013]. In addition, because occupational diseases among cleaning personnel are associated with the use of several disinfectants (e.g., glutaraldehyde and chlorine), precautions should be used to minimize exposure (e.g., gloves and proper ventilation) [CDC 2019a; NIOSH 2020].

Controlling Exposure to Disinfectants

Neutral pH, quaternary disinfectants are very commonly used within the correctional environment. Detergent disinfectants (quaternary ammonium compounds) are generally used for housekeeping purposes.

The most effective method of reducing exposure to a disinfectant is to eliminate the hazard or substitute a less hazardous substance [Quinn et al. 2015, NIOSH 2015]. If this is not possible, engineering controls such as ventilation should be considered. An example of an administrative control would be to reassign a worker to reduce exposure to a substance. Personal protective equipment (PPE) can be used if the hazard cannot be controlled by other means (elimination, substitution, engineering, or administrative controls) and should be provided by the employer [**29 CFR†1910.132**; CDC 2019a; NIOSH 2015].

Recommendations for Employers

Employers should take the following steps to ensure the safe use of disinfectants and reduce exposures to viral contaminants among employees and incarcerated persons assigned to work details.

†Code of Federal Regulations. See CFR in References

- Purchase and provide appropriate Environmental Protection Agency (EPA)-registered disinfectants for cleaning and disinfection of environmental surfaces and equipment. Ensure the product (chemical) appears on the **EPA-registered disinfectant list** (A–O). The product registration number is used to verify the product's effectiveness for specific viral pathogens listed on the registered disinfectant list [EPA 2020; CDC 2021a].
  - Lists E and N are for bloodborne pathogens.
  - List N is for COVID–19.
  - List G is for norovirus.
  - Detergent disinfectants (quaternary ammonium compounds) are generally used for housekeeping purposes.[‡]
- Provide and document training and instructions for correctional employees and incarcerated persons to ensure that they read labels carefully and that the correct EPA-registered disinfectant is used for each purpose (the correct product for the correct viral pathogen).
- Ensure that indoor ventilation is adequate when using disinfectants, especially in small, enclosed spaces[§] [NIOSH 2012, 2018]. Open inner doors if the security level allows, or open windows in low-security settings, if the physical plant permits such options.
- Maintain consistent, scheduled housekeeping practices to include the frequent cleaning and disinfection of surfaces and work equipment [CDC 2003, 2021a,b].
- Provide appropriate PPE as recommended by the product's safety data sheet (SDS) at no cost to the worker [**29 CFR 1910.132**]. Ensure that correctional employees and incarcerated persons are aware of possible latex allergies [NIOSH 1997].
- Train employees in the use, care, and disposal of PPE.
- Ensure that the SDSs are readily available in the general area where the product is used and stored in accordance with the Hazard Communication Standard [**29 CFR 1910.1200**].
- Provide access to soap and water stations for handwashing for employees and incarcerated persons.
- Provide appropriate levels of supervision to ensure chemicals aren't ingested or used in a manner intended to cause harm to employees or other incarcerated persons.
- Provide facility-specific cleaning instructions where needed for facility furnishings (game tables, bathroom fixtures, beds, mattresses, etc.).

Recommendations for Correctional Workers and Incarcerated Persons

Workers within correctional facilities, as well as incarcerated persons who are assigned to work details, should take the following steps during cleaning and disinfection processes to protect themselves from exposure to disinfectants and prevent or reduce surface viral contamination within the correctional setting:

Use Safe Work Practices

- Ensure that indoor ventilation is adequate when using disinfectants, especially in small, enclosed spaces [NIOSH 2012, 2018]. Open inner doors if the security level allows, or open windows in low-security settings, if the physical plant provides such options.
- Maintain consistent, scheduled housekeeping practices to include the frequent cleaning and disinfection of surfaces and work equipment [CDC 2003, 2021a,b].
- If surfaces are visibly dirty, use cleaning products or soap and water before disinfecting.
- Wear appropriate PPE, as recommended by the product's SDS when applying disinfectants to surfaces. Ensure that workers are aware when latex gloves are being used, so those with a latex allergy can avoid contact. For more information about latex gloves and allergies, see [NIOSH 1997].
- Clean and disinfect the duty belt and gear (before re-use) using a disinfectant spray or wipe, according to the product label.
- Wash hands with soap and water after using cleaning products or after touching surfaces that may be contaminated.

[‡]Products may appear on multiple lists and may be cross referenced

[§]For more information about ventilation, see https://www.cdc.gov/niosh/topics/indoorenv/buildingventilation.html and https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html

Choose the Correct Product

- Select an appropriate EPA-registered disinfectant for cleaning and disinfection of environmental surfaces and equipment. Check the equipment manufacturer's instructions for cleaning to ensure the product will not damage the equipment. For example, some chemicals may corrode two-way radios, paracentric keys, etc.
- Ensure the product (chemical) appears on the **EPA-registered disinfectant list** (A–O).
- Use EPA-registered disinfectants to disinfect high-touch surfaces [EPA 2020]. Surfaces include tables, chairs, desks, door handles, stair rails, light switches, sink fixtures, showers and fixtures, toilets, phones, and keyboards. Disinfect surfaces at the frequency determined by the facility's infection-control personnel.
- Note that not all disinfectants are effective against every organism or virus found in correctional facilities. Workers (including employees who obtain or dispense disinfectants, medical personnel, or infection prevention and control personnel) should ensure that the correct EPA-registered disinfectant is being used for the intended purpose or a specific viral pathogen.

Follow Product Instructions

- Review the specific product's SDS in its entirety. SDSs contain 16 sections of information about a specific chemical/product, including instructions for use, hazards, and spill-handling procedures [**29 CFR 1910.1200**; NIOSH 2012].
  - In correctional facilities, SDSs may be stored electronically or in common areas in a yellow binder [affixed on the wall, in a wire basket], or they can be requested from correctional management.
- Review the product label instructions, paying careful attention to the sections that detail the specific uses, surface types, contact/wet time, and shelf life (if applicable). In most instances, a product is designed for a specific purpose and for use in a specific manner [CDC 2019a; NIOSH 2020]. Also review the precautionary statements associated with product use.

Photo by © Boston Globe/Getty Images

- Follow the manufacturer's instructions for all disinfection products/chemicals:
  - **Concentration/dilution ratio:** Some disinfectants are shipped in concentrated form and must be diluted and/or activated with water (per the Chemical Formulary) before use in a correctional facility. Likewise, these disinfectants may have a shorter shelf life once the disinfectant is activated/diluted with water.
  - **Application method:** Products may contain specific directions for general cleaning. For example, the "directions for use" may list what to use to apply the product (mop, sponge, trigger sprayer, etc.). Products may also have a separate set of directions for disinfecting the surfaces and what to use to apply the product (brush, cloth, etc.).
  - **Contact time:** Some disinfectants may have a longer contact/wet time.
  - **Personal protective equipment (PPE):** Use recommended PPE and follow training guidelines for maintenance and disposal of PPE.
  - **Mixing:** NEVER mix disinfectants with cleaners, other disinfectants, or other chemicals. Mixing some chemical disinfectants with other chemical substances could be hazardous. For example, the toxic gas chlorine can be released if you mix sodium hypochlorite (bleaching solutions) and acidic cleaning agents [NIOSH 2020]. In addition, mixing a disinfectant with anything else could change its properties and it may no longer be effective [NIOSH 2020].

- Follow all facility-specific cleaning instructions for facility furnishings (game tables, bathroom fixtures, beds, mattresses, etc.).

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For More Information about Safe Cleaning Practices, Visit

Cleaning and Custodial Services | NIOSH | CDC

For More Information about COVID-19 Cleaning and Disinfecting, Visit

COVID-19 Guidance: Businesses and Employers | CDC

https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html

EPA Resources

Six Steps for Safe & Effective Disinfectant Use (epa.gov)

OSHA-NIOSH Infosheet: DHHS (NIOSH) 2012126; OSHA 351202 (cdc.gov)

For More Information about Bloodborne Infectious Diseases, Visit

CDC - Bloodborne Infectious Diseases - HIV/AIDS, Hepatitis B Virus, and Hepatitis C Virus - NIOSH Workplace Safety and Health Topic

For More Information

Find NIOSH products and get answers to workplace safety and health questions:

1-800-CDC-INFO (1-800-232-4636)

TTY: 1-888-232-6348

CDC/NIOSH INFO: **cdc.gov/info | cdc.gov/niosh**

Monthly *NIOSH eNews*: **https://www.cdc.gov/niosh/enews/**

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As part of the Centers for Disease Control and Prevention, NIOSH is the Federal agency responsible for conducting research and making recommendations to prevent work-related illnesses and injuries. All ***Workplace Solutions*** are based on research studies that show how worker exposures to hazardous agents or activities can be significantly reduced.

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DHHS (NIOSH) Publication No. 2021-121

July 2021

Guidelines Regarding Women in NC Jails Handout

Incarcerated WOMEN'S HEALTH
IncarceratedWomensHealth.org

Dignity for Women Who are Incarcerated Act (SL 2021-143)

Requirements During Pregnancy through Six Weeks Postpartum:

- Prohibits use of restraints starting 2nd trimester*
- Prohibits body cavity searches*
- Prohibits restrictive housing*
- Provide sufficient prenatal food and dietary supplements
- Beds no more than 3 feet from the floor
- Prenatal, labor, and delivery care at no cost
- Newborn permitted to remain with mom while in hospital
- Nutritional and hygiene products provided at no cost

Guidelines that apply to all incarcerated females:

- Free menstrual products must be provided
- When possible, male employees shall not perform inspections of undressed females*

***Exceptions may be made by corrections staff for reasonable safety and security concerns.**

Written report to sheriff or administrator is required within 5 days documenting instance leading to exception, and a monthly summary of all exceptions must be documented. See the full text for more detail on all provisions of the act.

Women Who are Pregnant or Have Been Pregnant in the Past Year

Call for immediate medical help and/or 911 for any of the below symptoms. These could be signs of very serious complications.

- Headache that won't go away or gets worse over time
- Dizziness or fainting
- Changes in vision
- Fever of 100.4° F or higher
- Extreme swelling of hands or face
- Thoughts of harming self or baby
- Trouble breathing
- Chest pain or fast beating heart
- Severe nausea and throwing up
- Severe belly pain that doesn't go away
- Baby's movement stopping or slowing during pregnancy
- Severe swelling, redness or pain in leg or arm
- Vaginal bleeding or fluid leaking during pregnancy
- Heavy vaginal bleeding or discharge after pregnancy
- Overwhelming tiredness

Substance Use During Pregnancy

Call for immediate medical help and/or 911 if a pregnant woman who uses substances shows signs of withdrawal.

Including: nausea, vomiting, sweating, muscle aches, agitation, or tremors.
It is very dangerous for the mother and fetus to experience sudden withdrawal.

For guidance on pregnant women who use substances, call:

The UNC Horizons Substance Use Disorder Program (919-903-0591)
Alcohol and Drug Council of NC: Visit or call alcoholdrughelp.org (1-800-688-4232) and ask for perinatal resources.

UNC SCHOOL OF MEDICINE Pediatrics, Obstetrics and Gynecology
Collaborative for Maternal and Infant Health

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

4.1

Assessing for Intellectual/ Developmental Disability (including Autism Spectrum Disorder)

Purpose: Screen for a better understanding of an individual's difficulties, limitations in understanding, and associated vulnerability.

Someone with an intellectual/developmental disability (IDD) was born with or developed limitations in intellectual and social abilities at birth or very early in life. IDD is pervasive and lifelong; there is no cure. A person with IDD cannot be identified by appearance and persons with IDD may try to hide their condition due to fear of being labelled. Generally, people with IDD have:

1. A limited mental capacity (scores below 70 on an IQ test);
2. Difficulty with social interactions and daily activities (personal care, managing money, schedules and routines);
3. Challenges with major life activities (vocational skills, written or spoken language, mobility, academic activities, self-help, and independent living).

Autism Spectrum Disorder is a diagnosis which may or may not come with intellectual impairment, but the individual is likely to have significant social and communication impairments. The individual may react to stressful situations with extreme anxiety. This could include pacing, flapping or twirling hands, self-harming, screaming, groaning, shouting, and loss of control. People with autism could invade the personal space of others or may need more personal space for themselves than the average person. They could speak in a monotone voice and/or with unusual pronunciation.

Knowing a person has IDD or Autism Spectrum Disorder is essential to their safety while incarcerated.

Note: *Persons who have previously been referred to as having a diagnosis of mental retardation are now referred to as having a diagnosis of intellectual disability (ID), as this has been identified as a more respectful and preferred term by community advocates; it is also embraced by the medical and legal community.*

People with IDD may be reluctant to discuss their disability and may even seek to hide it. This screening is important so officers will understand that the person:

- may not understand commands or instructions but pretend that they do;
- may get frustrated;
- may be vulnerable to victimization (having their items stolen, be sexually assaulted, be targeted for physical/verbal abuse, harassment, or used by other inmates for acts that violate jail rules);
- may suffer from anxiety or depression or also have a diagnosed mental illness in addition to IDD.

People with IDD may have trouble following jail rules, but they also may not know how to best ask for help.

- Many people with IDD have legal guardians as appointed by their local Clerk of Court to assist and make some decisions for the person. Guardians can coordinate needed medications, connect for needed services, and help with discharge planning.

Inmate Housing- inmates with IDD must be appropriately housed according to their risk and needs:

a. Housed in an area that reduces risk of victimization;
b. Housed in an area based on their individual challenges.

TIPS FOR COMMUNICATION

1. Speak directly to the person, make eye contact if possible, and say his/her name often.
    - Keep sentences short, concise; speak slowly and clearly using plain language.
    - Break complicated instructions/info into smaller parts (2-3 steps).
    - Be patient; take time with information.
    - If you are unsure if the person really understood what you are saying, ask them to repeat it in their own words, or rephrase it and ask another way.

2. Ask specific questions; give specific requests:
    - "Where do you live?"..."Who do you live with?"..."Where do/did you go to school?"
    - "I need you to sit here." or "I need you to stand over here."

3. Try to use open-ended questions when possible (recognizing this is impossible in a formalized assessment). Often people with IDD will respond with the answer they think you want to hear, or the word you said last.

4. Use plain, friendly language:
    - "Can you tell/show me what happened?"..."I am here to help you."..."You are safe."

This resource was developed in partnership with
The Arc of North Carolina & Disability Rights North Carolina.

The Arc North Carolina

The Arc of North Carolina has been providing advocacy and services to people with intellectual and developmental disabilities since 1953.

353 East Six Forks Road, Suite 300
Raleigh, NC 27609
800.662.8706
www.arcnc.org

DISABILITY RIGHTS NORTH CAROLINA

Disability Rights North Carolina is NC's federally mandated protection and advocacy agency, committed to promoting and preserving disability rights.

3724 National Drive, Suite 100
Raleigh, NC 27612
919.856.2195
www.disabilityrightsnc.org

4.2

Screening Tool for Intellectual/ Developmental Disability (including Autism Spectrum Disorder)

1. As a child or teenager, did you:

a. have delays in learning to speak, walk, or to take care of your personal needs?

Yes No I don't know

b. receive a diagnosis of autism, ADHD, dyslexia, intellectual disability, learning disability, or something else?

Yes No I don't know

c. receive support services from a caregiver who would come to your home or take you out into the community?

Yes No I don't know

d. have a lot of problems being sensitive to sounds, people touching you, eating, or the way clothes felt on your body?

Yes No I don't know

e. have unusual body movements (like flapping your hands)?

Yes No I don't know

2. When you were in school, did you:

a. need or receive extra help with reading, writing, or math?

Yes No I don't know

b. have a special plan (IEP or 504) that required regular meetings with your parent?

Yes No I don't know

c. have help from a classroom assistant or did you learn in a separate classroom?

Yes No I don't know

d. go to a specialized school?

Yes No I don't know

e. have a hard time understanding social situations?

Yes No I don't know

f. have a hard time knowing what was expected of you?

Yes No I don't know

3. At this time, do you:

a. need help filling out forms?

Yes No I don't know

b. need help managing money?

Yes No I don't know

c. need help with household tasks?

Yes No I don't know

d. have trouble understanding what is going on around you?

Yes No I don't know

e. have trouble understanding what is expected of you?

Yes No I don't know

f. have trouble living by yourself?

Yes No I don't know

g. have unusual body movements (like flapping your hands)?

Yes No I don't know

4. Does anyone help you make decisions (like a legal guardian)?

a. Yes No I don't know

(if so, please provide name and contact information below)

_____

Three or more "yes" responses may be evidence of an IDD diagnosis.

This resource was developed in partnership with
The Arc of North Carolina & Disability Rights North Carolina.

The Arc North Carolina

5.1

Prescreening for Lifetime History of TBI (from the OSU TBI-ID) and other Acquired Brain Injuries

1. Please think about injuries you have had during your entire lifetime, especially those that affected your head or neck. It might help to remember times you went to the hospital or Emergency room. Think about injuries you may have received from a car or motorcycle wreck, bicycle crash, being hit by something, falling down, being hit by someone, playing sports or an injury during military service.
    a. Thinking about any injuries you have had in your lifetime, were you ever knocked out or did you lose consciousness?
        _____ Yes
        _____ No (IF NO, GO TO QUESTION 2)
    b. What was the longest time you were knocked out or unconscious? (Choose just one; if you are not sure please make your best guess.)
        _____ knocked out or lost consciousness for *less than 30 min*
        _____ knocked out or lost consciousness *between 30 min and 24 hours*
        _____ knocked out or lost consciousness for *24 hours or longer*
    c. How old were you the first time you were knocked out or lost consciousness?
        _____ years old

2. Have you ever lost consciousness from a drug overdose or being strangled or choked?
        _____ Yes
        _____ No (IF NO, GO TO QUESTION 3)
    a. How many times from a drug overdose? _____# overdose
    b. How many time from being strangled or choked? _____# choked

3. Have you EVER been told by a doctor or other health professional that you had any of the following?
        _____ epilepsy or seizures?
        _____ a stroke or a transient ischemic attack?
        _____ cerebral palsy?
        _____ brain cancer?
        _____ a brain infection like meningitis or encephalitis?
        _____toxic exposure, like to lead or pesticides?
        _____ dementia, like Alzheimer's Disease?
        _____ a progressive disease like AIDS, multiple sclerosis, Parkinson's Disease or Huntington's Disease? (if yes, which one _____)

NOTES: Question 1 allows 3 indicators of lifetime history of TBI to be computed:

1. Positive for a lifetime history for TBI with loss of consciousness (yes/no)
2. Worst TBI with loss of consciousness (LOC) was mild, moderate or severe (no TBI with LOC, mild TBI with LOC, moderate TBI, severe TBI)
3. Age at first TBI with loss of consciousness (in years)

Name: _____ Current Age: _____ Interviewer Initials: _____ Date: _____

Ohio State University TBI Identification Method — Interview Form

Step 1

Ask questions 1-5 below. Record the cause of each reported injury and any details provided spontaneously in the chart at the bottom of this page. You do not need to ask further about loss of consciousness or other injury details during this step.

I am going to ask you about injuries to your head or neck that you may have had anytime in your life.

1. In your lifetime, have you ever been hospitalized or treated in an emergency room following an injury to your head or neck? Think about any childhood injuries you remember or were told about.
   ☐ No ☐ Yes—Record cause in chart
2. In your lifetime, have you ever injured your head or neck in a car accident or from crashing some other moving vehicle like a bicycle, motorcycle or ATV?
   ☐ No ☐ Yes—Record cause in chart
3. In your lifetime, have you ever injured your head or neck in a fall or from being hit by something (for example, falling from a bike or horse, rollerblading, falling on ice, being hit by a rock)? Have you ever injured your head or neck playing sports or on the playground?
   ☐ No ☐ Yes—Record cause in chart
4. In your lifetime, have you ever injured your head or neck in a fight, from being hit by someone, or from being shaken violently? Have you ever been shot in the head?
   ☐ No ☐ Yes—Record cause in chart
5. In your lifetime, have you ever been nearby when an explosion or a blast occurred? If you served in the military, think about any combat- or training-related incidents.
   ☐ No ☐ Yes—Record cause in chart

Interviewer instruction:
If the answers to any of the above questions are "yes," go to Step 2. If the answers to all of the above questions are "no," then proceed to Step 3.

Step 2

Interviewer instruction: If the answer is "yes" to any of the questions in Step 1 ask the following additional questions about each reported injury and add details to the chart below.

Were you knocked out or did you lose consciousness (LOC)?

If yes, how long?

If no, were you dazed or did you have a gap in your memory from the injury?

How old were you?

Step 3

Interviewer instruction: Ask the following questions to help identify a history that may include multiple mild TBIs and complete the chart below.

Have you ever had a period of time in which you experienced multiple, repeated impacts to your head (e.g. history of abuse, contact sports, military duty)?

If yes, what was the typical or usual effect—were you knocked out (Loss of Consciousness - LOC)?

If no, were you dazed or did you have a gap in your memory from the injury?

What was the most severe effect from one of the times you had an impact to the head?

How old were you when these repeated injuries began? Ended?

Step 1	Step 2						
	Loss of consciousness (LOC)/knocked out				Dazed/Mem Gap		Age
Cause	No LOC	< 30 min	30 min-24 hrs	> 24 hrs	Yes	No	

If more injuries with LOC: How many?_____ Longest knocked out?_____ How many ≥ 30 mins.?_____ Youngest age? _____

Step 3	Typical Effect		Most Severe Effect				Age	
Cause of repeated injury	Dazed/ memory gap, no LOC	LOC	Dazed/ memory gap, no LOC	LOC < 30 min	LOC 30 min - 24 hrs.	LOC > 24 hrs.	Began	Ended

Adapted with permission from the Ohio State University TBI Identification Method (Corrigan, J.D., Bogner, J.A. (2007). Initial reliability and validity of the OSU TBI Identification Method. J Head Trauma Rehabil, 22(6):318-329.

(Continuation from reverse side, if needed)

Name: _____ **Current Age:** _____ **Interviewer Initials:** _____ **Date:** _____

Step 1	Step 2						
	Loss of consciousness (LOC)/knocked out				Dazed/Mem Gap		Age
Cause	No LOC	< 30 min	30 min-24 hrs	> 24 hrs	Yes	No	

If more injuries with LOC: How many?_____ Longest knocked out?_____ How many ≥ 30 mins.?_____ Youngest age? _____

Step 3	Typical Effect		Most Severe Effect				Age	
Cause of repeated injury	Dazed/ memory gap, no LOC	LOC	Dazed/ memory gap, no LOC	LOC < 30 min	LOC 30 min - 24 hrs.	LOC > 24 hrs.	Began	Ended

Interpreting Findings

A person may be more likely to have ongoing problems if they have any of the following:

- **WORST**
  One moderate or severe TBI
- **FIRST**
  TBI with loss of consciousness before age 20
- **MULTIPLE**
  2 or more TBIs close together, including a period of time when they experienced multiple blows to the head
- **RECENT**
  A mild TBI in the last weeks or a more severe TBI in the last months
- **OTHER SOURCES**
  Any TBI combined with another way that their brain function has been impaired

For more information about TBI or the OSU TBI Identification Method visit:

- Ohio Valley Center at OSU
  www.ohiovalley.org/informationeducation
- BrainLine.org
  www.brainline.org

(Updated July 2013)

7.1

Sample Arrest / Booking Report Identifying Suicide Risk

(Arrestee Name) Last:	First:	Middle:		
Address:	City:	State:	Zip:	
DOB:	SS#:	OLN/ID#:	State:	
Arresting Agency:	Arresting Officer:	Assisting Officer:		
Date / Time of Arrest:	Place of Arrest:			
Type of Arrest: ☐ On Sight ☐ Criminal Summons/Non Custody ☐ OFA ☐ Citation				
During the arrest or while in your custody, has the individual made any statements, displayed any emotions, or taken any actions that would be considered suicidal in nature? If yes, explain:				
During the arrest or while in your custody, has this individual been violent or assaultive? If yes, explain:				
During the arrest or while in your custody, has this individual made statements about mental illness, had emotional outburst(s), or displayed any signs of mental illness? If yes, explain:				
During the arrest or while in your custody, has this individual displayed or show signs of the use of narcotics? If yes, explain:				
During the arrest or while in your custody, does the individual have any medical conditions that the Detention Staff need to be aware of? If yes, explain:				
Additional Comments:				
Officer Signature:	Date/Time Submitted:			

7.2

Sample Suicide Inmate Observation Form

Date:

Inmate Last Name:	**First Name:**	**Middle:**
Time Initiated:	**Initiated by:** (signature & title)	
Time Ordered:	**Ordered by:** (signature & title)	

Reason for Isolation:	**Room Contains:**	**Inmate Wearing:**
☐ **Harmful to others**	☐ **Bed with mattress**	☐ **Underwear**
☐ **Harmful to self**	☐ **Mattress**	☐ **Own clothing**
☐ **Destructive to property**	☐ **Blanket**	☐ **Detention attire**
☐ **Other (explain below):**	☐ **Sheet**	☐ **Other (specify below):**
	☐ **Room stripped (explain reason below):**	

7.3a

Sample Suicide Prevention Screening Form

Name	Sex	DOB	Most serious charge(s)	Date	Time
Facility	Screened by		Show serious psychiatric problems during prior incarceration (circle) Yes No		

CHECK APPROPRIATE COLUMN FOR EACH QUESTION

	COLUMN A YES	COLUMN B NO	COMMENTS
1. Arresting or transporting officer believes subject may be suicide risk. If yes, notify shift commander.			
2. Lacks close family/friends in community.	No family, friends		
3. Experienced a significant loss within last six months (loss of job, relationship, death of close family member).			
4. Worried about major problems other than legal situation (terminal illness).			
5. Family member or significant other has attempted or committed suicide (spouse, parent, sibling, close friend, lover).			
6. Has psychiatric history (note current psychotropic medication and name of most recent treatment agency).			
7. Holds position of respect in community (i.e. professional, public official) and/or alleged crime is shocking in nature. If yes, notify shift commander.			
8. Is thinking about killing self. If yes, notify shift commander.			
9. If yes to 8, has a suicide plan and/or suicide instrument in possession.			
10. Has previous suicide attempt. (Check wrists and note method)			
11. Feels there is nothing to look forward to in the future (expresses feelings of helplessness and hopelessness). If yes to 10 and 11, notify shift commander.			
12. Shows signs of depression (crying, emotional flatness).			
13. Appears overly anxious, afraid or angry.			
14. Appears to feel unusually embarrassed or ashamed.			
15. Is acting and/or talking in a strange manner. (Cannot focus attention, hearing or seeing things that are not there).			
16. Is apparently under the influence of alcohol or drugs.			
17. If yes to 16, is individual incoherent or showing signs of withdrawal or mental illness. If yes to both 16 and 17, call shift commander.			
Total Column A Actions: If total checks in Column A are eight or more, notify shift commander.			

Shift Commander notified Yes _____ No _____
Supervision instituted Routine _____ Active _____ Constant _____

Referred to Medical/Mental Health:	
Yes _____ No _____ If yes:	Emergency _____ Non-Emergency _____
Yes _____ No _____	Medical _____ Medical _____
	Mental Health _____ Mental Health _____

Medical/Mental Health Personnel Actions (to be completed by Medical/Mental Health Personnel).

Suicide Prevention Screening Form Reference Guide

Suicide Prevention Screening Form Reference Guide
Suicide Screening Questions

QUESTION #1 - Observation of Transporting Officer

Booking officers and intake staff may not routinely record the observations and recommendations of the arresting officer. These officers can frequently provide information about the detainee's behavior and emotional state as well as the circumstances of the arrest. This information can be extremely relevant and valuable to the screening process especially when the detainee refuses to answer questions. Your screening form should require officers to solicit input from arresting officers.

If arresting/transporting officer reports that detainee may be a suicide risk or if the lock-up screening form indicates suicide risk, you should have procedural guidelines to follow.

Personal Data

QUESTION #2 - Detainee Lacks Close Family or Friends

People without close friends or family are isolated from important sources of emotional, social and even financial support. If emotional support or a sense of responsibility toward others is lacking, an attitude of hopelessness and uselessness may arise.

These feelings may overwhelm the detainee causing him to feel isolated and alone. Without these important emotional connections, suicide becomes a greater risk. Research has shown these facts to be true in numerous situations.

When asking this question, you must be sure that a "close friend or family member" is indeed close. For the purpose of this guideline, we will define a "close" person in the following way:

- Someone other than a lawyer or bondsman who will be willing to post detainees bail
- Someone who would visit the detainee while he is incarcerated
- Someone who would be willing to accept a collect call from the detainee

In fact, you might want to ask the above as questions.

If you determine that a detainee lacks close family or friends, this is an affirmative answer and check mark should be placed in Column A (yes).

QUESTION #3 - Detainee Has Experienced a Significant Loss

It is important to understand the concept of loss when assessing suicide risk. The death of an important person or the end of a relationship can leave the inmate without necessary emotional support. As mentioned in the previous questions, this lack of

support may precipitate depression and possibly suicide. The loss of a job can be a devastating experience, creating both financial problems as well as destroying self-esteem.

Content

The best way to explore the issue of loss is to ask:

- Have you lost your job in the last six months?
- Has your marriage or relationship broken up in the last six months?
- Has a close friend or family member died in the last six months?

For the purpose of the Intake Guidelines loss reported by an inmate should be scored as a "yes" response in Column A.

QUESTION #4 - Detainee Is Worried About Major Problem

While all inmates probably experience some stress following their arrest, for those who are already very worried about other problems, this arrest might constitute the proverbial "last straw."

This question is intended to focus on the detainee's current state of mind. The best way to explore this issue is to ask the detainee if he is currently worried about any major problems other than his legal situation. For instance:

- Do you have any serious financial or family problems?
- Do you or anyone close to you have serious medical problems?
- Do you fear losing your job?

Posing these questions may also enable officers to obtain valuable information about the kinds of developments that are likely to have a significant impact on the detainee's behavior in the weeks and months following booking. A detainee may indicate, for example, that his/her spouse has recently threatened to file for divorce. Intake staff would be well advised to note this fact in the log and/or in the comment column so that security officers can be particularly watchful following visits or mail deliveries that may bring the inmate upsetting news.

QUESTION #5 - Detainee's Family or Significant Other Has Attempted/Committed Suicide

Psychiatric literature has shown that a person is more likely to attempt or complete suicide if another person close to them has already done so. In this question "significant other" is defined as someone who has an important emotional relationship with the detainee. It is easy to understand that this significant person can serve as a role model for the detainee. For example, if a detainee has experienced the suicide of a parent, he is likely to view suicide as an acceptable solution.

QUESTION #6 - Detainee Has Psychiatric History

Recently, the New York State Commission of Correction reported that 50% of all locally incarcerated inmates who commit suicide have prior psychiatric in-patient histories.

In these questions, psychiatric history is defined as any one of the following:

- Any psychiatric hospitalization
- Any current psychotropic medication
- Outpatient psychotherapy within past six months

Remember minimum standards require these people to be seen four times per hour. People who are viewed as "high risk" should be observed constantly.

QUESTION #7 - Detainee Has History of Drug or Alcohol Abuse

Persons dependent on alcohol or drugs are predisposed to depression. Since depression is an indicator of suicide, pay particular attention to persons with a past history of alcohol or drug abuse.

Drug abuse or alcohol history does not mean that a person is an addict or alcoholic. It means that a person has abused drugs or alcohol to the extent that it has impacted their life, such as a DWI, disorderly conduct or drug-related arrest, or difficulties with a job or relationship.

The best way to obtain this is to ask one or two of these questions?

- Have you ever been charged with DWI or drug-related offenses?
- Have you ever received any counseling for a drug or alcohol problem?
- Has alcohol or drugs ever caused problems in your life like losing a job, causing fights with a girlfriend/boyfriend or wife/husband or damaging your health?
- Has anyone ever been upset by or complained about your alcohol or drug abuse?

QUESTION #8 - Detainee Holds Position of Respect or Alleged Crime Is Shocking

This is not a question which has been designed to be asked directly. First, you need to know the nature of the detainee's employment and if he holds any elected office. Certain people who are in the public eye or whose professions hold public respect (e.g., public officials, doctors, lawyers, police officers, executives, etc.) may be more prone to attempt suicide when arrested. An arrest is likely to damage their image and jeopardize their job or position.

For the purpose of this question, a shocking crime is defined as one which disgusts and upsets the community. Crimes such as rape, child molestation and murder fall into this category.

When scoring this question, be sure to put a check in the "yes" column if either part of this question receives a "yes" response.

QUESTION #9 - Detainee Thinking about Killing Himself

The best way to determine if the detainee is thinking about killing himself is to directly ask, "Are you thinking about killing yourself?" Although you may be uncomfortable asking this question, research has indicated that the most accurate way of differentiating a suicidal from a non-suicidal person is by simply asking the person about his suicidal thoughts.

Even if the person does not make direct suicide statements such as "I am thinking of killing myself" or "I want to kill myself," you should be alert to indirect suicide statements such as "I won't be a burden anymore," "I have nothing to live for," or "No one will miss me when I'm gone." Often these indirect statements prompt feelings or uneasiness, apprehension or doubt on your part. If you feel this, use the communication skills we will be learning in the next chapter to explore the issue further. Any direct or indirect suicide statement should be scored a "yes."

QUESTION #10 - Detainee Has Previous Suicide Attempt

It is a documented fact that people who have attempted suicide are more likely to do so again. Approximately 80 percent of persons who commit suicide have made at least one previous suicide attempt. A previous attempt is an excellent indication for subsequent attempts.

The best way to obtain this information is to ask, "Have you ever attempted suicide?" If the detainee answers "yes," you should explore the method and note it in the Comment Column. This information can enable you to provide better supervision.

The screening form also indicates that you should check the detainee's wrists. Looking for scars will only take a few seconds, and may help you identify some detainees who have made prior attempts but have not admitted it.

Remember minimum standards requires people in this category to be seen four times per hour. Previous attempts of suicide should be taken seriously.

QUESTION #11 - Detainee Feels There Is Nothing to Look Forward to

This question is designed to assess the degree to which the detainee is feeling hopeless and helpless. Assessing hopelessness can be a subtle process. You want to determine if the detainee is experiencing intolerable, unbearable psychological pain and if he feels there is any way to relieve this pain. One concrete indication is whether the detainee feels there is nothing to look forward to. This can be a direct question, "Do you feel there is nothing to look forward to?" as well as "Do you feel like giving up trying to make things better for yourself?"

There may be a tendency to phrase your question, "Do you feel you have anything to look forward to?" In this case, a "yes" response would be scored a "no" on the form.

Behavior Appearance

You can learn about a person's state of mind by observing his behavior and appearance in addition to what he directly says. This is especially important when you are interviewing someone who is reluctant to speak. Throughout the booking process, be alert to statements and behaviors which will help you answer the following questions. People give verbal cries for help; always hear what they say.

QUESTION #12 - Signs of Depression

In this question, you will put to use what you've already learned about the signs of depression. Most important, you need to be tuned in to the detainee's nonverbal expressions and behaviors to identify signs of depression (e.g., crying, posture, lethargy).

QUESTION #13 - Detainee Appears Anxious, Afraid or Angry

Research indicates that a person who is overly anxious, afraid or angry is a high risk for suicide (Los Angeles Suicide Prevention Center).

Anxiety and fear can be observed in behaviors such as hand-wringing, pacing, profuse sweating, excessive fidgeting, and shallow breathing.

People who are arrested and detained often appear anxious, afraid or angry. What we are identifying in these questions are the extreme and inappropriate expression of these emotions.

QUESTION #14 - Detainee Feels Embarrassed or Ashamed

To score this item you need to assure the detainee's emotional response to being arrested and detained. You might be alert for statements such as "I'll never be able to face my boss/family/friends again," "This will kill my mother/father/wife if she/he finds out," "Is this going to be in the newspapers?" We repeat, this is not a question to be asked. If the detainee is feeling ashamed, it will be evident.

QUESTION #15 - Detainee Is Acting or Talking in a Strange Manner

This item requires you to note any signs of psychosis or other mental illness. Be alert for signs such as hallucinations, abrupt changes in mood or behavior, disorientation, and withdrawal from the outside world. Any unusual behaviors or verbalization should be scored a "yes."

QUESTION #16A - Detainee Under the Influence of Alcohol or Drugs

When someone is high on drugs or alcohol, he is a very serious suicide risk. Approximately 65-86 percent of suicides in a detention facility are by persons who are intoxicated. Sometimes it is difficult to be certain that a person is intoxicated, especially on drugs. If you think someone is high, follow your intuition. Remember the minimum standards require inmates in this category be seen four times per hour and they are at risk for suicide.

QUESTION #16B - Detainee Is Incoherent or Showing Signs of Withdrawal or Mental Illness

Many detainees are intoxicated at the time of booking. It is unrealistic to refer all of these inmates to the shift commander. Part B of this question helps identify those intoxicated inmates who have a greater likelihood of attempting suicide. Withdrawal in this question refers to physiological withdrawal from the substance and not emotional withdrawal.

QUESTION #17 - No Prior Arrests

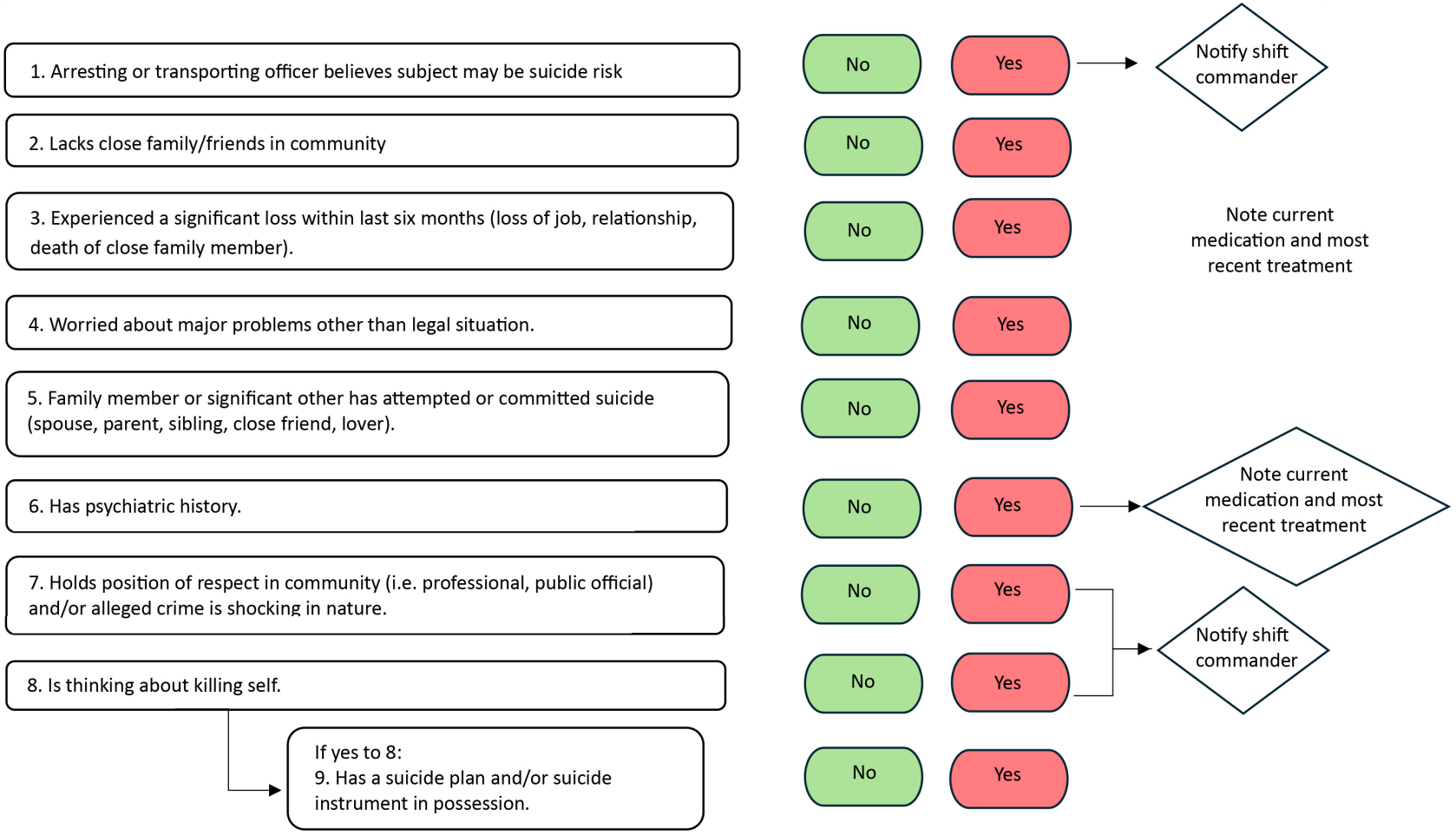
Those detainees without a significant criminal history are most likely to kill themselves shortly after confinement due to the disgrace and embarrassment stemming from their arrest.

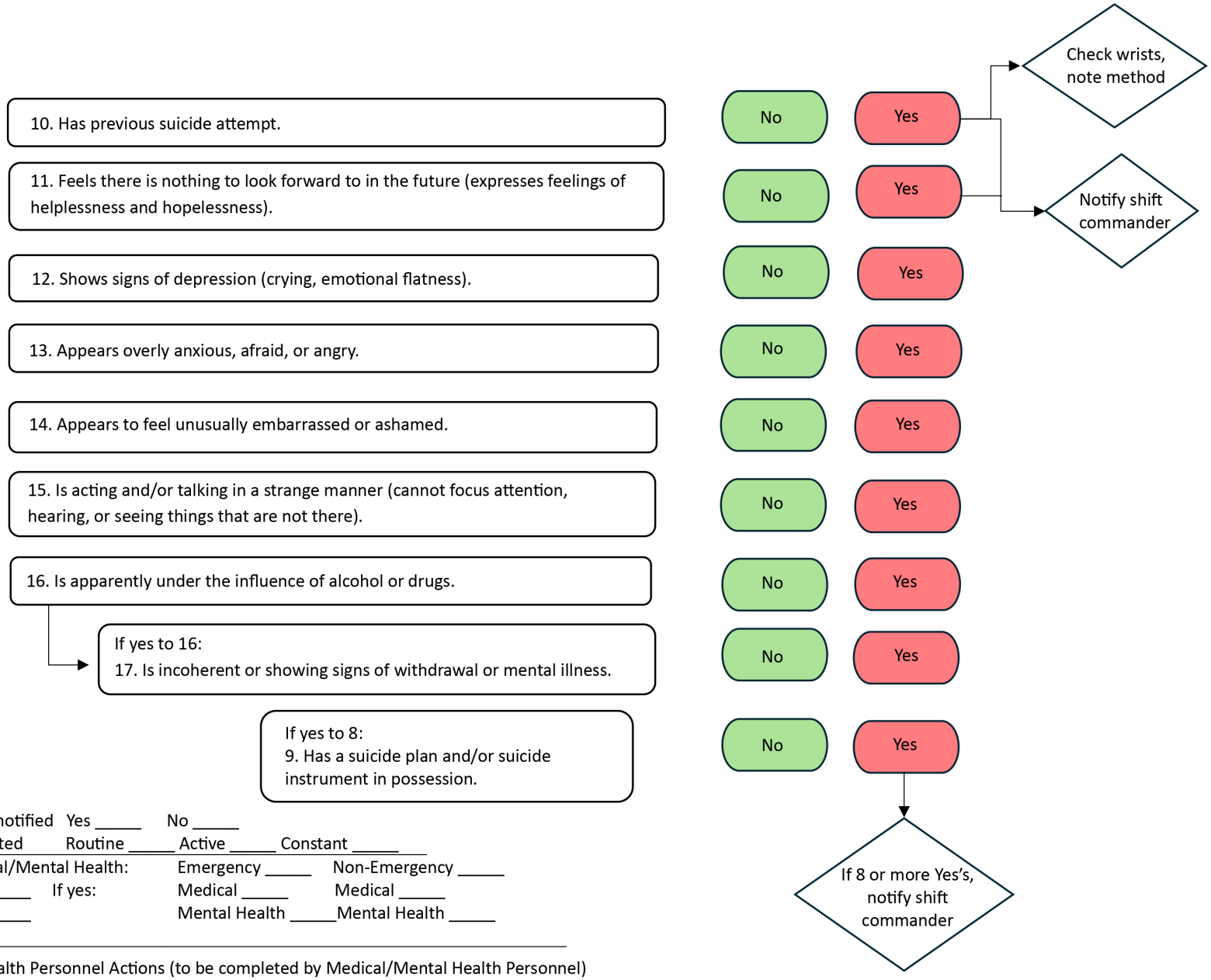
A first offender is an especially high risk because the initial entry into a correctional facility is frightening. He may feel extremely ashamed, upset, fearful, helpless and uncertain. It must be emphasized that those with no prior arrests tend to attempt suicide within the first twenty-four hours.

It is also important to note that there is another group of detainees with an extensive criminal record who are more likely to attempt suicide after several weeks or months in confinement during which time they become increasingly despondent about their future.

SUICIDE PREVENTION SCREENING

NAME	SEX	DOB	MOST SERIOUS CHARGE(S)	DATE	TIME
FACILITY	SCREENED BY		SHOW SERIOUS PSYCHIATRIC PROBLEMS DURING PRIOR INCARCERATION (CIRCLE) YES NO		




10. Has previous suicide attempt.
No
Yes
11. Feels there is nothing to look forward to in the future (expresses feelings of helplessness and hopelessness).
No
Yes
Check wrists, note method
Notify shift commander
12. Shows signs of depression (crying, emotional flatness).
No
Yes
13. Appears overly anxious, afraid, or angry.
No
Yes
14. Appears to feel unusually embarrassed or ashamed.
No
Yes
15. Is acting and/or talking in a strange manner (cannot focus attention, hearing, or seeing things that are not there).
No
Yes
16. Is apparently under the influence of alcohol or drugs.
No
Yes
If yes to 16:
17. Is incoherent or showing signs of withdrawal or mental illness.
No
Yes
If yes to 8:
9. Has a suicide plan and/or suicide instrument in possession.
No
Yes
If 8 or more Yes's, notify shift commander
Shift Commander notified Yes _____ No _____
Supervision instituted Routine _____ Active _____ Constant _____
Referred to Medical/Mental Health: Emergency _____ Non-Emergency _____
Yes _____ No _____ If yes: Medical _____ Medical _____
Yes _____ No _____ Mental Health _____ Mental Health _____
Medical/Mental Health Personnel Actions (to be completed by Medical/Mental Health Personnel)

7.4

Checklist for the "Suicide-Resistant" Design of Correctional Facilities

CHECKLIST FOR THE "SUICIDE-RESISTANT" DESIGN OF CORRECTIONAL FACILITIES

Lindsay M. Hayes

The safe housing of suicidal inmates and juveniles is an important component to a correctional facility's comprehensive suicide prevention policy. At the outset, suicidal individuals should be placed in housing units designed as single-story units versus units with a mezzanine or secondary floor configuration to prevent suicide attempts by jumping. Although impossible to create a "suicide-proof" cell environment within any correctional facility, given the fact that almost all inmate and juvenile suicides occur by hanging, it is certainly reasonable to ensure that all cells utilized to house potentially suicidal inmates and juveniles are free of all obvious protrusions. And while it is more common for ligatures to be affixed to air vents and window bars (or grates), all cell fixtures should be scrutinized, since bed frames/holes, shelves with clothing hooks, sprinkler heads, door hinge/knobs, towel racks, water faucet lips, and light fixtures have been used as anchoring devices in hanging attempts. As such, to ensure that inmates and juveniles placed on suicide precautions are housed in "suicide-resistant" cells, facility officials are strongly encouraged to address the following architectural and environmental issues:

1. Cell doors should have large-vision panels of Lexan (or low-abrasion polycarbonate) to allow for unobstructed view of the entire cell interior at all times. These windows should never be covered (even for reasons of privacy, discipline, etc.) If door sliders are not used, door interiors should not have handles/knobs; rather they should have recessed door pulls. Any door containing a food pass should be closed and locked.

   Interior door hinges should bevel down so as not to permit being used as an anchoring device. Door frames should be rounded and smooth on the top edges. The frame should be grouted into the wall with as little edge exposed as possible.

   In older, antiquated facilities with cell fronts, walls and/or cell doors made of steel bars, Lexan paneling (or low-abrasion polycarbonate) should be installed from the interior of the cell.

   Solid cell fronts must be modified to include large-vision Lexan panels or security screens with small mesh;

2. Vents, ducts, grilles, and light fixtures should be protrusion-free and covered with screening that has holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

3. If cells have floor drains, they should also have holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch (inmates have been known to weave one end of a ligature through the floor drain with the other end tied around their neck, then lay on the floor and spin in a circular motion as the ligature tightens);

4. Wall-mounted corded telephones should not be placed inside cells. Telephone cords of varying length have been utilized in hanging attempts;

5. Cells should not contain any clothing hooks. The traditional, pull-down or collapsible hook can be easily jammed and/or its side supports utilized as an anchor;

6. A stainless-steel combo toilet-sink (with concealed plumbing and outside control valve) should be used. The fixture should not contain an anti-squirt slit faucet, toothbrush holder, toilet paper rod, and/or towel bar;

7. ADA-compliant grab bars that are located around the sink and/or toilet areas should be designed with a closed bottom (i.e., no open space) that prevents attachment of a ligature.

8. Beds should ideally be either heavy molded plastic or solid concrete slab with rounded edges, totally enclosed underneath.

   If metal bunks are utilized, they should be bolted flush to the wall with the frame constructed to prevent its use as an anchoring device. Bunk holes should be covered; ladders should be removed. (Traditional metal beds with holes in the bottom, not built flush to the wall and open underneath, have often been used to attach suicide nooses. Lying flat on the floor, the individual attaches the noose from above, runs it under his neck, turns over on their stomach and asphyxiates themselves within minutes.);

9. Electricity should be turned off from wall outlets outside of the cell;

10. Light fixtures should be recessed into the ceiling and tamper-proof. Some fixtures can be securely anchored into ceiling or wall corners when remodeling prohibits recessed lighting. All fixtures should be caulked or grouted with tamper-resistant security grade caulking or grout.

    Ample light for reading (at least 20 foot-candles at desk level) should be provided. Low-wattage night light bulbs should be used (except in special, high-risk housing units where sufficient lighting 24 hours per day should be provided to allow closed-circuit television (CCTV) cameras to identify movements and forms).

    An alternative is to install an infrared filter over the ceiling light to produce total darkness, allowing inmates to sleep at night. Various cameras are then able to have total observation as if it were daylight. This filter should be used only at night because sensitivity can otherwise develop and produce aftereffects;

11. CCTV monitoring does not prevent a suicide, it only identifies a suicide attempt in progress. If utilized, CCTV monitoring should only supplement the physical observation by staff. The camera should obviously be enclosed in a box that is tamper-proof and does not contain anchoring points. It should be placed in a high corner location of the cell and all edges around the housing should be caulked or grouted.

    Cells containing CCTV monitoring should be painted in pastel colors to allow for better visibility. To reduce camera glare and provide a contrast in monitoring, the headers above cell doors should be painted black or some other dark color.

    CCTV cameras should provide a clear and unobstructed view of the entire cell interior, including all four corners of the room. Camera lens should have the capacity for both night or low light level vision;

12. Cells should have a smoke detector mounted flush in the ceiling, with an audible alarm at the control desk. Some cells have a security screening mesh to protect the smoke detector from vandalism. The protective coverings should be high enough to be outside the reach

of an individual and far enough away from the toilet so that the fixture could not be used as a ladder to access the smoke detector and screen. Ceiling height for new construction should be 10 feet to make such a reasonable accommodation. Existing facilities with lower ceilings should carefully select the protective device to make sure it cannot be tampered with, or have mesh openings large enough to thread a noose through.

Water sprinkler heads should not be exposed. Some have protective cones; others are flush with the ceiling and drop down when set off; some are the breakaway type;

13. Cells should have an audio monitoring intercom for listening to calls of distress (only as a supplement to physical observation by staff). While the individual is on suicide precautions, intercoms should be turned up high (as hanging victims can often be heard to be gurgling, gasping for air, their body hitting the wall/floor, etc.);

14. Cells utilized for suicide precautions should be located as close as possible to a control desk to allow for additional audio and visual monitoring;

15. If modesty walls or shields are utilized, they should have triangular, rounded or sloping tops to prevent anchoring. The walls should allow visibility of both the head and feet;

16. Some individuals hang themselves under desks, benches, tables or stools/pull-out seats. Potential suicide-resistant remedies are: (a) Extending the bed slab for use as a seat; (b) Cylinder-shaped concrete seat anchored to floor, with rounded edges; (c) Triangular corner desk top anchored to the two walls; and (d) Rectangular desk top, with triangular end plates, anchored to the wall. Towel racks should also be removed from any desk area;

17. All shelf tops and exposed hinges should have solid, triangular end-plates which preclude a ligature being applied;

18. Cells should have security windows with an outside view. The ability to identify time of day via sunlight helps re-establish perception and natural thinking, while minimizing disorientation.

    If cell windows contain security bars that are not completely flush with window panel (thus allowing a gap between the glass and bar for use as an anchoring device), they should be covered with Lexan (or low-abrasion polycarbonate) paneling to prevent access to the bars, or the gap, should be closed with caulking, glazing tape, etc.

    If window screening or grating is used, covering should have holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

19. A mattress should always be issued to an individual on suicide precautions unless the individual is observed to be utilizing it in ways in which it was not intended (i.e., attempting to tamper with/destroy, utilizes to obstruct visibility into the cell, etc.). The mattress should be fire retardant and not produce toxic smoke. The seam should be tear-resistant so that it cannot be used as a ligature;

20. Given the fact that the risk of self-harm utilizing a laundry bag string outweighs its usefulness for holding dirty clothes off the floor, laundry bag strings should be removed from the cell;

21. Mirrors should be of brushed, polished metal, attached with tamper-proof screws;

22. Padding of cell walls is prohibited in many states. Check with your fire marshal. If permitted, padded walls must be of fire-retardant materials that are not combustible and

do not produce toxic gasses. Because padded cells do not contain a sink or toilet, they should not be primarily utilized for suicidal inmates, but, if utilized, the duration should be limited to a few hours; and

23. Ceiling and wall joints should be sealed with neoprene rubber gasket or sealed with tamper-resistant security grade caulking or grout for preventing the attachment of an anchoring device through the joints.

NOTE: A portion of this checklist was originally derived from R. Atlas (1989), "Reducing the Opportunity for Inmate Suicide: A Design Guide," Psychiatric Quarterly, 60 (2): 161-171. Additions and modifications were made by Lindsay M. Hayes, and updated by Randall Atlas, Ph.D., a registered architect. Last revised Lindsay M. Hayes in January 2022.

Lindsay M. Hayes is nationally recognized as an expert in the field of suicide prevention within jails, prisons and juvenile facilities. He has been appointed as a federal court monitor (and expert to special masters/monitors) in the monitoring of suicide prevention practices in several adult and juvenile correctional systems under court jurisdiction. Mr. Hayes also serves as an expert witness/consultant in inmate suicide litigation cases, as well as consultant in assessing suicide prevention practices in various state and local jurisdictions throughout the country.

8.1

Opioid Treatment Program Chain-of-Custody Record Example

Source: Substance Abuse and Mental Health Services Administration. (2015). https://store.samhsa.gov/sites/default/files/d7/priv/pep15-fedguideotp.pdf.

FEDERAL GUIDELINES FOR OPIOID TREATMENT PROGRAMS

EXAMPLE OF MEDICATION CHAIN-OF-CUSTODY RECORD

Date: _____

Name of Treatment Program: _____

Name of Treatment Program Dispensing Nurse: _____

Medication To Be Delivered (Methadone/Buprenorphine/Buprenorphine +Naloxone):

_____

Number of Doses To Be Delivered: _____

Medication Provided From _____ (Date) to _____ (Date)

Name of Person Transporting Medication: _____

License Number of Person Transporting Medication: _____

Date Medication Received: _____ Number of Doses Received_____

Medication Received Covering_____ (Date) to _____ (Date)

COMMENTS: _____

_____ Signature of person receiving medication

_____ Signature of person transporting medication

Date of Administration and Initials of Patient Receiving Medication

DATE	Pt. Initials	DATE	Pt. Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Stop the Stigma Handout

STOP THE STIGMA

Negative language and stigma regarding substance use disorder and addiction have shown to be a key barrier to seeking and receiving treatment for people who use drugs. Stigmatizing words such as "addict" reduce a person to only their drug use. Talking about substance use disorder in a more accurate and humanizing way can reduce stigma and help people receive appropriate treatment and support.

Instead of these words...Try using these!

DRUG ABUSE SUBSTANCE ABUSE	"SUBSTANCE USE DISORDER" "DRUG MISUSE" "SUBSTANCE MISUSE"	Although the term "substance abuse" is widely used—including in the names of federal and state agencies—use of the term "abuse" in the context of substance use is no longer favored in the mental health community. The word "abuse" connotes violence and criminality and does not fit with a view of substance use disorder as a health condition. Substance use disorder is a diagnosable condition that refers to drug use that has become significantly problematic in a person's life.
ADDICT ABUSER JUNKIE DRUGGIE	"PERSON WHO USES DRUGS" "PERSON WITH A SUBSTANCE USE DISORDER" "PERSON USING DRUGS PROBLEMATICALLY/CHAOTICALLY"	Person-first language affirms people's individuality and dignity. It promotes the message that a person is more than just their addiction. NOTE: How a person chooses to self-identify is up to them, and they should not be corrected or admonished if they choose not to use person-first language.
CLEAN/ DIRTY	"STERILE/USED SYRINGES" "POSITIVE/NEGATIVE DRUG TEST" "PERSON IN RECOVERY/ PERSON WITH PROBLEMATIC DRUG USE"	The term "dirty" is often used to describe syringes that have been used or to describe positive drug screens. People who are no longer using drugs are often referred to as "clean." However, the clean/dirty dichotomy creates a false narrative that people who use drugs are inherently unclean.

If you're providing a service or resource – support, don't stigmatize.

People may use or identify with stigmatizing language based on their own history, and that's their prerogative. Do not correct people with lived experience on their preferred way to refer to themselves. Use non-stigmatizing language to show people who use drugs that you respect them with your words.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

8.3

Substance Use Effects, Signs, Symptoms, and Points to Consider

Adapted from NC DOJ Justice Academy

Substance	Signs/Symptoms	Considerations
Alcohol can damage the brain and most body organs. Areas of the brain especially vulnerable to alcohol-related damage are responsible for problem solving, decision making, memory, learning, and coordination.	Slurred speech, stumbling, inappropriate laughing or crying, uncoordinated movement, belligerence, repeating themselves, alcohol smell	Physical dependence requires medical detoxification; Serious potential for violence in persons who are intoxicated
Marijuana is the most commonly used illicit substance. This drug impairs short term memory and learning, the ability to focus, and coordination.	Bloodshot eyes, slow movement, preoccupied with unimportant details, sluggish, inappropriate laughing or giggling	It can increase the risk of psychosis in persons with an underlying vulnerability
Inhalants are volatile substances found in household products, such as oven cleaner, gasoline, spray paint, and other aerosols, that induce mind-altering (hallucinogenic) effects.	Loss of contact with reality, psychotic type behavior	Potentially violent if approached too rapidly or with heavy initial confrontation
Cocaine is a stimulant, which can lead users to "binge" (take the drug many times in a single session). **Amphetamines** including **Methamphetamines**, are stimulants that can produce feelings of euphoria and alertness. Methamphetamine's effects are particularly long-lasting and harmful to the brain.	Excessive energy/ hyperactivity, rapid speech, disorganized thoughts & statements, hyper-sexuality, agitation, irritability, anxiety, panic, paranoia	May be impulsive or over stimulated - introduction of further stimulation may produce violence; Severe depression and suicidal thinking can follow use or binges.
Ecstasy, **Rohypnol** & **GHB**, "club drugs," produce mind-altering and sedating effects. Rohypnol & GHB are associated with sexual assaults.	Ecstasy: Mild hallucinogenic effects, increased sensitivity to touch, chills, sweating Rohypnol: sedation, confusion, impaired coordination GHB: drowsiness, loss of coordination, memory loss	People in this condition are not responding to the same external stimulus as others present who are not under the influence

LSD is one of the most potent hallucinogenic drugs. Its effects are unpredictable. Users may have traumatic experiences and emotions that can last for many hours.	Distortions in perception of reality; seeing images, hearing sounds & feeling sensations that seem real but are not; impulsive behavior; rapid & intense emotional swings; sweating; tremors	People in this condition are not responding to the same external stimulus as others present who are not under the influence
Barbiturates & Benzodiazepines are depressants used to treat anxiety, panic attacks and sleep disorders.	Drunken appearance, drowsy, slurred speech, uncoordinated movement, sluggish, dizziness, unresponsive	Physical dependence requires medical detoxification; Potentially violent though persons are slowed down
Heroin & Other Opioids are powerful drugs that produce euphoria and feelings of relaxation. Other opioid drugs include **morphine**, **OxyContin**, and **Vicodin**, which have legitimate medical uses; however, their nonmedical use can result in the same harmful consequences as heroin.	Sluggish, dreamy behavior, drowsiness, continuously scratching, extreme detachment	Physical dependence requires medical detoxification
Anabolic Steroids are used nonmedically to increase muscle mass and to improve athletic performance or physical appearance.	No intoxication effects. Consequences of abuse can include severe acne, infectious diseases, depression, and suicide	Potentially hostile and aggressive
Drug combinations. A particularly dangerous and common practice is the combining of two or more drugs. The practice ranges from the dangerous random mixing of prescription drugs to the deadly combination of heroin or cocaine with fentanyl (an opioid pain medication). It is critical to realize that because of drug-to-drug interactions, these practices are more dangerous than the already harmful effects of any single drug.		

Sources:
Sonya Brown, M.A., NC Division of Mental Health Developmental Disabilities and Substance Abuse Services.

U.S. Department of Health and Human Services, "Commonly Used Drugs." National Institute on Drug Abuse, 2011. [On-line]. Available at: http://www.drugabuse.gov/drugpages/drugsofabuse.html [October 2011].

9.1

Naloxone Distribution Standing Order Sample

Template Standing Order for Distribution of Naloxone by Organizations

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***This page is information for the signing physician only and should be removed from the order before use. ***

- This document is a template to be customized by each practitioner wishing to authorize the distribution of naloxone by an organization as allowed by NCGS 90-12.7.
  - This template does not authorize the dispensing of naloxone to an organization. A separate standing order must be executed to authorize the dispensing of naloxone to the organization..
  - This template is intended to authorize the distribution of the naloxone by the organization after it has been properly dispensed to the organization.
- The attached template requires edits before signing and use.
- Review all areas highlighted in yellow.
  - Fill in the requested information
  - Remove the yellow highlighting
- Review the area highlighted in green.
  - Ensure you want all formulations included and that you agree with the provided instructions.
  - Make any edits you feel necessary
  - Remove the green highlighting
- Complete the row for Record Keeping highlighted in orange with any information the distributing agency should log and where logs should be submitted. While it is not required to maintain logs of individuals receiving naloxone, it is a best practice to log basic information on kit distribution to collect data to support and track distribution efforts. Consider recoding the following information:
  - Date, number of kits distributed, name of distributor, zip code where distribution occurred, confirmation that education was provided.
  - Also include frequency with which logs should be returned and to whom they should be returned.
- Remove the "Template" watermark once you have completed the previous steps.

- If you have questions, please contact Amanda Moore – Amanda.fullermoore@dhhs.nc.gov

Distribution Order for Naloxone

I hereby authorize (INSERT AUTHORIZED AGENCY/GOUP/ORGANIZATION NAME(s) HERE) to distribute naloxone in the state of North Carolina to persons as directed below.

<table>
<tr><th colspan="4">Distribution Protocol for Naloxone HCl</th></tr>
<tr><td>Eligible Candidates</td><td colspan="3">
▪ Persons who voluntarily request Naloxone and are at risk of experiencing an opiate-related overdose, including, but not limited to:
– Current illicit or non-medical opioid users or persons with a history of such use
– Persons with a history of opioid intoxication or overdose and/or recipients of emergency medical care for acute opioid poisoning
– Persons with a high dose opioid prescription (>50 morphine mg equivalents per day)
– Persons with an opioid prescription and known or suspected concurrent alcohol use
– Persons from opioid detoxification and mandatory abstinence programs
– Persons entering methadone maintenance treatment programs (for addiction or pain)
– Persons with opioid prescription and smoking/COPD or other respiratory illness or obstruction
– Persons with an opioid prescription who also suffer from renal dysfunction, hepatic disease, cardiac disease, HIV/AIDS
– Persons who may have difficulty accessing emergency medical services
– Persons enrolled in prescription lock in programs
▪ Persons who voluntarily request Naloxone and are the family member or friend of a person at risk of experiencing an opiate-related overdose.
▪ Persons who voluntarily request Naloxone and are in the position to assist a person at risk of experiencing an opiate-related overdose.
</td></tr>
<tr><td>Route(s) of Administration</td><td colspan="2">Intranasal (IN)
Preferred method</td><td>Intramuscular (IM)
Inject into shoulder or thigh</td></tr>
<tr><td>Medication and Required Device for Administration</td><td>Naloxone HCl 1 mg/mL Inj.
2 x 2 mL as pre-filled Luer-Lock syringes
▪ Distribute 2 (two) doses
2 (two) x Intranasal Mucosal Atomizing Devices (MAD 300) Available from: Teleflex (866-246-6990) or Safety Works, Inc. (800-723-3892)</td><td>Narcan ® 4 mg/0.1 mL Nasal Spray
▪ Distribute 1 x two-pack</td><td>Naloxone HCl 0.4mg/mL Inj.
▪ 2 x 1mL single dose vials (SDV)
▪ 2 (two) 3 mL syringe
▪ 2 (two) 25 G, 1-inch needle

Naloxone HCl 2 mg/2mL Inj.
▪ Distribute 2 (two) pre-filled syringes
▪ 2 (two) 25 G, 1-inch needle</td></tr>
<tr><td>Directions for Use</td><td>Call 911. Spray 1 mL in each nostril. Repeat every 3 minutes as needed if no or minimal response.</td><td>Call 911. Administer a single spray of NARCAN® in one nostril. Repeat every 3 minutes as needed if no or minimal response.</td><td>Call 911. Inject the entire solution of the vial or pre-filled syringe IM in shoulder or thigh. Repeat every 3 minutes as needed if no or minimal response.</td></tr>
<tr><td>Contraindications</td><td colspan="3">A history of known hypersensitivity to Naloxone or any of its components</td></tr>
<tr><td>Patient Education</td><td colspan="3">Every person provided Naloxone under this distribution order shall receive education regarding the risk factors of overdose, signs of an overdose, overdose response steps, and the use of Naloxone. Examples of educational materials that incorporate the above information may be found at http://www.naloxonesaves.org.</td></tr>
<tr><td>Storage</td><td colspan="3">• Maintain kits in a secured location that limits access to authorized staff.
• Store at controlled room temperature 59°F to 77°F (15°C to 25°C). Excursions permitted between 4°C to 40°C (39°F to 104°F). Do not freeze. Protect from light.
• Inventory stored kits monthly to ensure expiration dates have not passed.</td></tr>
<tr><td>Record Keeping</td><td colspan="3"></td></tr>
</table>

INSERT SIGNING PHYSICIAN NAME AND CREDENTIALS

Date Signed

INSERT PHYSICIAN TITLE

INSERT PHYSICIAN EMPLOYER

National Provider ID: INSERT NUMBER

(Insert date 1 year from date of signing)

Date Expires

This order is effective immediately upon signing and may be revised or revoked by (INSERT PHYSICIAN TITLE) according to his/her discretion. A copy should be maintained by the authorizing physician and the authorized agency(s).

9.2

Overdose Prevention Education Program Implementation Questionnaire for Jail Administrators

Source: North Carolina Harm Reduction Coalition

Existing Jail Resources/Info

- Describe other social/health programs available in the jail
- Describe the technology used for education in the jail (e.g. iPad).
- What is the average daily jail count?
- What percent is male/female?

Partnerships/Staff

1. Do you have restrictions on who you allow to come into the jail to deliver programs (e.g. people who might have a criminal history?).
2. How can we facilitate entry into the jail with ease on the training days? Is there a professional visitor ID card that can be applied for?
3. This project will need a point person to serve as the primary liaison for our program manager. Who will this person be?

Program Implementation Details

1. What will work best for advertising the education within the jail? Options could include posting a flyer, using digital screens or kiosks if available, detention staff identification, medical staff identification, detention staff announcing.
2. What should we know about program implementation (e.g. are there certain times that wouldn't work here because of shift change, etc.)
3. What is the easiest way for us to access inmate names so we can match to death records to get a sense of what the baseline overdose rate for jail detainees might be?
4. Where in your facility will be the best place for this education to take place? What can our staff expect regarding supervision?
5. What are the rules on materials that can be brought into the facility/training room? For examples, should we laminate pictures of naloxone instead of bringing trainer models...no staples. etc.
6. During the training session, we will review educational materials. Will inmates be allowed to take these with them or should they be reserved for distribution at exit (to be placed in their personal belongings).

Identification of Potential Participants

1. Do you currently have a substance use or opioid use screening process in place?
2. What specific forms are used to screen for opioid dependence?
3. When are these forms used? (Booking process, during medical)

10.1

Sample Request for Proposal Outline (RFP)

Disclaimer

This document is meant to be used only as a guide in the development of an RFP and is not intended to provide instructions. The outline is NOT all-inclusive of topics to be covered. It cannot be used in place of consultation with appropriate administrators and medical personnel OR override any facility or government laws and regulations.

Invitation/RFP Announcement

This brief section provides notice that the Facility/County is seeking proposals for inmate medical services.

Submission Procedures, Requirements

This section provides the details including key dates, how proposals are to be submitted, and who should be contacted for questions/additional information. The bullets below are typical areas to be included with appropriate details provided.

1. Inquiries and Questions
2. Pre-Proposal Conference
3. Prime Contractor Responsibly
4. Service Provider Qualifications
5. Facility and Population

The below outline provides a list of sections to be considered in the development of the RFP.

I. Purpose

II. Scope of Services

A. Onsite Inmate Medical Services

1. Intake Screening
2. Transfer Screening
3. Health Assessment
4. Inmate Requests for Health Care Services
5. Assessment Protocols
6. Segregation Rounds
7. Women's Preventive Health Care
8. Infirmary Care
9. Infectious Disease
10. Chronic Illness and Special Needs
11. Onsite Specialty Services
12. Emergency Services
13. Emergency Response Plan
14. Medication Management
15. Laboratory Services
16. Radiological Services
17. Mental Health Services
18. Health Records Management
19. Nutritional Services
20. Inmate Complaint/Grievance Procedure
21. Inmate Co-Payment Processing Procedures
22. Dental Care

23. Orthoses, Prostheses and Other Aids to Impairment
24. Discharge Planning
25. Quality Improvement

B. Offsite Medical Services
1. Provider Network
2. Provider Agreements
3. Coordination of Services
4. Utilization Management
5. Offsite Statistical Reports

III. Staffing and Human Resources

A. Staff and Schedule
B. Recruitment
C. Hiring and Credentials
D. New Employee Orientation
E. Ongoing In-Service Training
F. Position Descriptions
G. Performance Appraisals
H. Administrative Procedures
I. Security
J. Training and Information for Detention Staff

IV. Contract Administration

A. Management Plan
B. Clinical Program Implementation
C. Cost Containment
D. Statistical and Management Reporting
E. Hazardous Waste Management
F. Insurance
G. Other Terms and Conditions
1. Contract Period
2. Termination of Contract
3. Penalties
4. Non-Discrimination

V. Contractor Qualifications and Experience

A. Minimum Qualifications
B. Summary of Experience
C. Key Medical Services Staff
D. Litigation History
E. Subcontractors

VI. Price

VII. Evaluation of Proposals Submitted

10.2 RFP Planning Example

Provided by Forsyth County Detention Center

The Forsyth County Law Enforcement and Detention Center engaged in an RFP process between 2020-2021 to determine how health services would be provided within their facility. This RFP process was conducted by a multidisciplinary team to select the best medical provider possible to meet their needs.

How did they get started?

An initial piece of the RFP development process in Forsyth County included building a multidisciplinary team with diverse backgrounds, as well as identifying vendors and beginning to communicate with them. To develop the RFP, the team gathered information about the jail and the population that their health services would reach. The team set priorities using this information and created an assessment tool for evaluating vendors. Categories for assessment included: mandatory requirements, cost, past performance, and technical and management.

Who is involved?

The multidisciplinary team included representatives from the County Manager's Office, the Sheriff's Office, and the County Budget and Management Department, as well as clinical and administrative advisors from the Forsyth County Department of Public Health and two representatives from a local health system. Through this RFP process, the team also created procedures related to Continuous Quality Improvement (CQI) and accreditation, including the involvement of an external public health professional. The county uses a public health nurse, as well as reporting from the health service vendor, to monitor the CQIs.

1. Preparing for and informing the RFP (3 months)
    a. Built a multidisciplinary team
    b. Identified potential vendors and opened communications
    c. Gathered information about the population, including Average Daily Population (ADP), clinical needs, and past services provided
        - Identified developing a Behavioral Health Unit to be amongst their priorities
    d. Gathered information about the jail's operations, including space and equipment available, staffing, facility capacity, and past invoices
        - Reviewed cost reporting – evaluated costs associated with providing health services outside of the jail
    e. Developed a tool for assessing applicants – the following table is adapted from Forsyth County's assessment tool as an example of categories and criteria that can be used for evaluating potential medical vendors

2. Reviewing proposals and selecting a vendor and services (6-7 months)
    a. Held a conference to present to vendors and give tour about one month after releasing the RFP, accepted questions from vendors for a few weeks after
    b. Shared addendum with question responses about 2 weeks after receiving questions
    c. Accepted applications for one month after responding to questions
    d. Evaluated applications over 3-4 month period using assessment tool
    e. Held interviews and engaged in the negotiation process, identified start date

3. Quality improvement and assessment (Continuous)
    a. Monitors performance and health outcomes through Continuous Quality Improvement (CQI) procedures included in contract

4. For their CQI measuring and monitoring process, the Forsyth County Law Enforcement and Detention Center engages both with the team providing health services within the jail as well as with an external public health nurse

Assessment Category	Description	Scoring Method	Example Criteria
Mandatory Requirements	The criteria a vendor must meet in order to be considered further.	Yes/No	1. Is the vendor authorized to work in your state and county? 2. Is the vendor able to comply with NCCHC standards? 3. Did the vendor attend the pre-proposal conference?
Cost	What is the on-site, off-site, and total cost proposed by each vendor?	Side-by-side comparison	1. Is the combined fixed cost within your budget? 2. Are there costs that could be negotiated (e.g., cost of third-party administrators)?
Past Performance and Experience	Does the vendor have the demonstrated ability to perform services for a jail of this size and a population with these clinical needs?	Weighted scale	1. Relative size and complexity of prior contracts. 2. Client feedback on vendor's performance on similar contracts.
Technical Support and Management	What management, clinical, and reporting services does the vendor propose?	Grading scale	1. Staffing plan (e.g., proposed staff, coverage, schedule) 2. Staff quality (e.g., hiring practices, training plan, performance reviews) 3. Clinical performance measurement: a. Which clinical indicators will the vendor collect data on? b. How often will they report data to the jail? c. What consequences will the contractor face if they fail to meet clinical performance standards?

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