Re: Your request for access to information under Part II of the Access to Information and Protection of Privacy Act [JPS/57/2017]

Dear [Redacted],

On May 8, 2017, the Department of Justice and Public Safety received your request for access to the following records:

s.40(1) and we are researching provincial health care policies across Canada. We are comparing them against the Mandela rules in an effort to determine the role of mental health professionals in the solitary confinement of inmates. To this end, we would like the Newfoundland & Labrador health care policy and, if health care is provided through a health authority as opposed to corrections, then the health authority policy as well.

I am pleased to inform you that a decision has been made by the Deputy Minister for the Department of Justice and Public Safety to provide access to the requested records. As per your request responsive records are enclosed. Please note in addition to the enclosed records a provincial All-Party Committee on Mental Health and Addictions released a report and recommendations on March 24, 2017. For your convenience a copy of the report can be found at the following location:

http://www.releases.gov.nl.ca/releases/2017/health/0324n01.aspx

Please be advised that you may ask the Information and Privacy Commissioner to review the processing of your access request as set out in section 42 of the Act (a copy of this section of the Act has been enclosed for your reference). A request to the Commissioner must be made in writing within 15 business days of the date of this letter or within a longer period that may be allowed by the Commissioner.

The appeal may be addressed to the Information and Privacy Commissioner as follows:
Office of the Information and Privacy Commissioner
2 Canada Drive
P. O. Box 13004, Stn. A
St. John’s, NL A1B 3V8

Telephone: (709) 729-6309
Toll-Free: 1-877-729-6309
Facsimile: (709) 729-6500

You may also appeal directly to the Supreme Court Trial Division within 15 business days after you receive the decision of the public body, pursuant to section 52 of the Act (a copy of this section of the Act has been enclosed for your reference).

Please be advised that responsive records will be published following a 72 hour period after the response is sent electronically to you or five business days in the case where records are mailed to you. It is the goal to have the responsive records posted to the Office of Public Engagement's website within one business day following the applicable period of time.

If you have any questions, please feel free to contact me by telephone at 709-729-7906, or by email at ncroke@gov.nl.ca.

Sincerely,

[Signature]
Neil Croke
ATIPP Coordinator

Encls.(1)
Access or correction complaint

42. (1) A person who makes a request under this Act for access to a record or for correction of personal information may file a complaint with the commissioner respecting a decision, act or failure to act of the head of the public body that relates to the request.

(2) A complaint under subsection (1) shall be filed in writing not later than 15 business days after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16 (2).

(3) A third party informed under section 19 of a decision of the head of a public body to grant access to a record or part of a record in response to a request may file a complaint with the commissioner respecting that decision.

(4) A complaint under subsection (3) shall be filed in writing not later than 15 business days after the third party is informed of the decision of the head of the public body.

(5) The commissioner may allow a longer time period for the filing of a complaint under this section.

(6) A person or third party who has appealed directly to the Trial Division under subsection 52 (1) or 53 (1) shall not file a complaint with the commissioner.

(7) The commissioner shall refuse to investigate a complaint where an appeal has been commenced in the Trial Division.

(8) A complaint shall not be filed under this section with respect to

(a) a request that is disregarded under section 21;

(b) a decision respecting an extension of time under section 23;

(c) a variation of a procedure under section 24; or

(d) an estimate of costs or a decision not to waive a cost under section 26.
(9) The commissioner shall provide a copy of the complaint to the head of the public body concerned.

Direct appeal to Trial Division by an applicant

52. (1) Where an applicant has made a request to a public body for access to a record or correction of personal information and has not filed a complaint with the commissioner under section 42, the applicant may appeal the decision, act or failure to act of the head of the public body that relates to the request directly to the Trial Division.

(2) An appeal shall be commenced under subsection (1) not later than 15 business days after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16 (2).

(3) Where an applicant has filed a complaint with the commissioner under section 42 and the commissioner has refused to investigate the complaint, the applicant may commence an appeal in the Trial Division of the decision, act or failure to act of the head of the public body that relates to the request for access to a record or for correction of personal information.

(4) An appeal shall be commenced under subsection (3) not later than 15 business days after the applicant is notified of the commissioner's refusal under subsection 45 (2).
SECTION 10  HEALTH CARE SERVICES

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Section 10: Health Care Services

Sub-Section: Health Care Services – General Statement

Policy

To ensure that all offenders in custody have access to quality health care services. This includes psychiatric and other mental health care programs where there is a demonstrated need for such intervention. These services will be governed by standards comparable to those applied in the community.
Section 10: Health Care Services

Sub-Section: Health Care Administration – Health Services

Policy

To ensure that inmates have access to essential medical, dental and mental health services in keeping with generally accepted community practices.

Responsibilities

The Institutional Head must ensure that:

- all staff have ready access to necessary protective and first aid equipment in all work locations.
- all Correctional Officers are issued, have access to or carry on their person and use approved protective equipment (e.g. protective masks, gloves) when administering cardiopulmonary resuscitation (CPR) or first aid.

Inmates shall have reasonable access to health services which may be provided in keeping with community practice.

Health services shall only be provided by health care professionals who are registered or licensed in Canada, preferably in the province of Newfoundland and Labrador.

Access by inmates to health services shall be available on a 24-hour basis. Access can be provided through on-site coverage or other community services.

All staff are responsible to inform a health care professional of the condition of any inmate who appears to be ill, whether he or she complains or not.

A process shall be in place to allow inmates to submit, in confidence, a request for health care services, indicating the reason for the request.

An inmate’s request for health services must be relayed to a health care professional without delay.

Inmate requests for routine health services shall be screened by a Nurse or other health care professional.
As soon as possible following initial arrival to any institution, every offender must undergo a nursing assessment. This nursing assessment must, at a minimum, screen for:

- communicable conditions;
- acute medical, mental or dental conditions;
- conditions requiring continuing treatment; and
- activity limitations.
Section 10: Health Care Services

Sub-Section: Health Care Administration – Health Services

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- acute medical, mental or dental conditions;
- conditions requiring continuing treatment; and
- activity limitations.
Section 10: Health Care Services

Sub-Section: Health Care Administration – Inmate Access

Policy

To ensure that all inmates in custody have access to a comprehensive health care service equivalent in quality to the health care available in the community.

Directives

Inmates will have access to medical services/physical examinations upon request.

Comprehensive health care service includes those services designed for:
  - the promotion and improvement of health;
  - the prevention of disease and disability;
  - the cure and mitigation of disease;
  - the medical rehabilitation of the inmate.

Inmates who need health care beyond the resources available in an institution, as determined by the responsible medical practitioner, will be transferred under appropriate security provisions, to a facility where such care is available.

While the Branch endeavors to provide comprehensive medical services, an inmate may occasionally request treatment by his/her own medical practitioner. An inmate may be examined by a doctor of his/her choice provided that:
  - the medical practitioner of the inmate’s choice will carry out the examination in the institution;
  - all inmate-requested services deemed non-essential by the institutional physician will be at the inmate’s complete expense including any consultation fees and, at the discretion of the Institutional Head, any associated escort costs. Health Services shall be responsible for the coordination of arrangements for all inmate requested services.
Section 10: Health Care Services

Sub-Section: Health Care Administration – Health Service Staff

Policy

Health care services shall be provided by competent health care professionals registered in good standing and legally licensed to practice in the province.

Directives

Appropriate provincial licensure, certification or registration requirements and restrictions shall apply to all personnel who provide health care services to inmates.

Appropriate current credentials will be verified by the Manager of Institutional Programs and included in a personnel file.

The duties and responsibilities of health care personnel will be governed by written contract or written job description.

All new health care personnel shall be given a period of orientation designed to familiarize them with the special complexities of providing health care in a correctional environment.
Section 10: Health Care Services

Sub-Section: Health Care Administration – Nursing Functions

Policy

It shall be the function of nursing staff to provide direct nursing care to inmates for implementation of preventive, diagnostic, therapeutic and rehabilitative measures in accordance with inmate health care plans, medical and dental prescriptions and policy directives.

Directives

Specifically, the staff nurse or Nurse Practitioner will:
- provide emergency nursing treatment to inmates;
- arrange for admission, discharge and transfer of patients;
- provide basic diagnostic clinical tests;
- carry out delegated medical acts, if so authorized in writing in accordance with the nursing-medical transfer functions as approved by the Association of Registered Nurses of Newfoundland and Labrador (ARNNL);
- undertake health counselling and teaching;
- maintain medical records system;
- manage the medication distribution system;
- advise the Officer-in-Charge of conditions in the institution which may be detrimental to good hygiene and sanitation;
- promote a climate conducive to effective relationships between patients, institutional personnel, medical officers and community health services;
Section 10: Health Care Services

Sub-Section: Health Care Administration – Staff Responsibilities

Policy

The relationship between medical and correctional personnel as it pertains to medical services must be functional and efficient.

Directives

Medical judgments are solely the responsibility of the health professional who will make the final judgment in determining the medical needs of the inmate(s).

Security orientation applicable to correctional personnel will also apply to health personnel.

Medical Services Personnel will be consulted when developing and revising policies and procedures governing medical services for inmates.

The Institutional Health Care staff will advise the Officer-in-Charge of any insufficiency in the resources or facilities related to health care services as the occasion demands.

The Manager of Institutional Programs will ensure that the Institutional Heads convene regular meetings with contracted medical officials. The Superintendent will be advised of any issues that cannot be resolved.
Section 10: Health Care Services

Sub-Section: Health Care Administration – Examination Room

Policy

Each institution, where structurally possible, will maintain an adequately equipped medical examination room that ensures privacy and dignity for the physician and the patient.

Directives

Each correctional facility, where possible, will designate a specific area as a medical examination room.

While the examination room ideally should not be utilized for other purposes, such a practice is acceptable where the physical plant dictates multiple use of the area and the area serves other purposes which are not incongruent with fundamental medical procedures.

Each examination room should be equipped in accordance with the respective medical personnel request and Institutional Procedures.
Section 10: Health Care Services

Sub-Section: Health Care Administration – First Aid Kits

Policy

Each Correctional and Detention Facility will ensure easy access to First Aid Kits dispersed in strategic locations throughout the facility.

Directives

Procedures and regulations governing the mandatory existence of First Aid Kits are outlined in the Life Safety Policy Directive 6.30.02 and the Occupational Health and Safety First Aid Regulations.

Each Institutional Head is responsible for ensuring that the contents of the First Aid Kits comply with the Occupational Health and Safety First Aid Regulations Sections 16, 17 and 18.

http://www.assembly.nl.ca/Legislation/sr/Regulations/rc961148.htm
Section 10: Health Care Services

Sub-Section: Health Care Administration – Medical Clinics – Inmate Access

Policy

All inmates shall have access to medical consideration and the right to address individual medical problems through a regularly scheduled series of medical clinics to be held within each correctional facility.

Directives

Every correctional facility will ensure that medical clinics are convened at the facility on a regularly scheduled basis.

The purpose of the clinic will be to:
- examine all new inmate admissions;
- examine other inmates with a medical complaint;
- provide appropriate treatment and specialist referrals;
- complete any medical transfer forms, programming entrance forms, etc.;
- to visually inspect all inmates confined in segregation and address complaints and/or applicable treatments, if necessary.

Appropriate records of the medical interview will be included in the inmate file and the PCOMS segregation register if applicable.
Section 10: Health Care Services

Sub-Section: Health Care Administration – Consent to Health Service Assessment and Treatment

Policy

To balance the need to protect the public with the need to safeguard an inmate’s rights, by ensuring that an offender’s right to accept or refuse any health care or mental health care is protected and that the release of relevant information is disseminated in accordance with professional and community standards and legal requirements.

Directives

The consent of the offender must be obtained for:

1. all medical procedures;
2. all mental health procedures, including psychiatric and psychological assessment and treatment;
3. involvement or participation in any form of research and
4. the sharing of health care information, except as provided for in this policy and in relevant legislation.

Notwithstanding number 2 above, even if an offender refuses to consent to an assessment, in the interest of public safety, a risk assessment will be done based on available information.

Consent shall be voluntary, informed and specific to the assessment, treatment or procedure.

Correctional Officers may not provide consent on behalf of any inmate.

Consent is considered to be informed when the offender has the capacity to understand the nature of the procedure and is fully apprised of:

- the possible results and the risks associated with the procedure;
- the likely effects of refusal to agree to the procedure; and
- the fact that he or she has the right to withdraw from the procedure at any time.

Consent may be expressed or implied, and shall be documented or witnessed in accordance with accepted professional standards.

In the event the offender does not have the capacity to give an informed consent, consent to treatment shall be governed by the relevant provincial law. Where the offender meets the criteria for involuntary treatment under the relevant provincial legislation, treatment shall be administered accordingly.
If a physician determines that an inmate is not competent, the inmate’s medical file shall indicate that the inmate does not have the capacity to give or withhold a valid consent.

Where an inmate is illiterate, consent may be signified by an “X” or other suitable mark witnessed by at least two persons present. Both witnesses are to be present during the full explanation of the medical treatment to be administered and both should make notes of what transpires during the interview in the event of future litigation.

An offender may refuse to consent to any procedure, even if such refusal may endanger his or her life. In the event of a refusal of consent, the offender shall sign a statement that outlines the recommended treatment and the offender’s refusal to consent to that treatment.

When an offender refuses to consent to a specific treatment or procedure, no punitive action shall be taken and alternative treatment shall, if possible, be made available.

When an offender refuses mental health care, the clinician shall advise the offender of the potential consequences of such a refusal.

Informed consent may be waived if:
- there is an emergency which requires immediate medical intervention for the safety of the inmate, or
- the emergency involves an inmate who does not have the capacity or ability to understand the information given.

In emergency situations, where practicable, the attending clinician shall determine if the offender has given previous competent direction as to the treatment to be provided or withheld in the event that he or she became incapable of providing informed consent. If such a direction exists, and there is no reason to believe that it had been revoked, it shall be considered binding. If no such direction appears to exist, consent shall be deemed to be implied and treatment shall be administered in accordance with professionally accepted standards.

In the case of young offenders, the informed consent of the minor as well as the parent or guardian shall be required in accordance with prevailing statutes. Such consent must be sought directly by the treating licensed practitioner or dentist.

Inmates diagnosed as having a communicable disease and who refuse appropriate treatment may be subject to medical quarantine as authorized by the treating medical personnel. A court order for treatment will be sought to ensure that an inmate(s) get the necessary medical attention for diagnosed communicable disease.
Section 10: Health Care Services

Sub-Section: Health Care Administration – Staff Development

Policy

All correctional officers will receive instruction in basic First Aid procedures and Mental Health Awareness procedures and will be required to maintain a minimum standard of proficiency in applying emergency techniques.

Directives

All correctional officer recruit training will include instruction pertaining to basic health care procedures.

All staff shall participate in training pertaining to fundamental health care procedures as determined by the Staff Training and Development Officer and in accordance with policy.
Section 10: Health Care Services

Sub-Section: Health Care Administration – Student Affiliations

Policy

Medical students and/or interns may be utilized for health care delivery to inmates subject to specific conditions. All student/interns shall have a security clearance completed.

Directives

Medical student affiliations shall be governed by a Memorandum of Agreement between the medical school and the Division of Corrections and Community Services.

All student affiliations must meet the following criteria:
  ▪ the objectives of the clinical training correspond to those of the health care system administered by the Division;
  ▪ the clinical training is an integral part of a recognized educational program;
  ▪ the medical school shall retain responsibility for, and supervision of, the student during the clinical training.

The Division shall provide appropriate facilities and information necessary for successful implementation of the program, however, reserves the right to intervene in clinical activities judged to be contrary to the policies and regulations of the Division.
Section 10: Health Care Services

Sub-Section: Health Care Administration – Fiscal Management

Policy

The health care services program administered by the Division of Correctional and Community Services will be managed in a fiscally responsible manner consistent with the provisions of the provincial Medical Care Plan (MCP) and internal Divisional funding mechanisms to support programs not covered by MCP.

Directives

Health services provided to prisoners, regardless of where the prisoner is detained, is a provincial government responsibility.

In most instances, health services to prisoners in provincial and federal (RCMP) detention facilities and provincial correctional facilities will be financially covered under the MCP plan, whether such services are provided on a fee-for-service basis or through fee per session clinic arrangement.

If applicable, it is the responsibility of the contracted physician to arrange billing and mode of fee structure with the applicable governing body, MCP.

All medical services provided to prisoners in RCMP detention facilities are invoiced directly to MCP through the submission of the individual MCP Claim Form.

Where a private physician is not ordinarily available in the community, the Officer-in-Charge of the RCMP Detachment should obtain prior approval from the Superintendent of Prisons or designate before entering into a special arrangement with a physician who is employed by government or a Hospital Board.

Psychiatric Services

Wherever appropriate, psychiatric referrals should be processed through a General Practitioner (G.P.) so that the services rendered by the psychiatrist are covered under MCP.

Prescription Drugs

All prescription medications for prisoners detained anywhere in the province are the financial responsibility of the Division of Corrections and Community Services.
Emergency Dental Services

Where the health of the prisoners would be otherwise jeopardized, emergency dental services are to be provided to such prisoners and the costs borne by the Adult Custody Branch as outlined in policy directive 10.35.02.

MCP Numbers Not Available

By virtue of the provisions of an inter-provincial agreement, prisoners from out-of-province or who are non-residents may be covered by the Newfoundland MCP program.

In circumstances where an MCP card is not available, a designated Correctional Officer or medical personnel will assist the inmate in locating his/her MCP card/number, if at all possible.

In both circumstances, a designate of the institution shall contact MCP with the required information pertaining to the inmate so as a temporary MCP number can be issued to cover medical costs for the duration of the inmate’s incarceration.

Witness Fees

Medical, psychiatric or psychological services provided to the court will not be the financial responsibility of the Division of Corrections and Community Services. Such services will be paid from the “Witness Fee” account. These services include:

- expert psychiatric testimony pertaining to fitness to stand trial, a Not Criminally Responsible (NCR) defense or other assessments of the mental health of the accused person;
- psychiatric assessments required by the court as part of the pre-sentence investigations;
- general medical reports required by the court before sentence;
- psychological assessments required by the court at the pre-sentence stage.

Psychological Testing

Psychological assessments and tests administered by a trained psychologist are the financial responsibility of the Division of Corrections and Community Services if conducted at the request of the Division.
Section 10: Health Care Services

Sub-Section: Physical Examinations – Nurse’s Pre-Medical

Policy

Where possible, a staff nurse shall conduct a pre-medical clinical history on behalf of each new inmate admission to a correctional centre.

Directives

The staff nurse will complete a pre-medical clinical history as soon as possible after the admission of a new inmate.

The pre-medical history will include a description of the inmate’s:
- personal medical history;
- family history;
- height, weight, etc.;
- pulse and blood pressure.

If required, following the pre-medical inmates will be seen as soon as possible by the institutional physician.

Specialist consultations will be arranged where necessary by the institutional physician.
Section 10: Health Care Services

Sub-Section: Physical Examinations – Inmate Transfer

Policy

All inmates will be physically examined by a physician or nurse prior to transfer to another institution or before being admitted in the case of transfers from other jurisdictions.

Directives

- Inmates being transferred to another provincial institution will be physically examined by a physician or nurse prior to transfer to ensure continuity of care and fitness for program placement at the receiving institution.
- Inmates being transferred to a federal penitentiary will be medically examined by a qualified physician or nurse and the required documentation forwarded to the receiving institution with such inmates.
- In a case where an inmate is being transferred from the custody of another jurisdiction, whether federal or provincial, all medical records relative to that inmate must be transferred simultaneously and presented to the host institution at the time of admission.
- The Province has an Agreement with the Correctional Service of Canada concerning the provision of offender information which was signed in 2004. This Agreement permits the exchange of personal information of offenders for the purpose of enforcing the Prisons Act or the federal Corrections and Conditional Release Act in order to ensure the effective custody of offenders and their safe reintegration into the community.
Section 10: Health Care Services

Sub-Section: Mental Health Care - Philosophy

Policy

The Adult Custody Branch is responsible for the care, custody, management and treatment of all inmates under its jurisdiction, and must provide access to psychiatric and other mental health care programs where there is a demonstrated need for such intervention.

Directives

Inmates will be referred for assessment when there is reason to believe that a mental health illness may be present.

The Division contracts psychiatrist(s) that services all Correctional and Detention Facilities.

In addition, the Division will utilize existing community resources for mental health care where appropriate and if an identified need exists. Inmates shall have access, if deemed necessary, to a mental health team consisting of a psychologist, psychiatrist, nurse and/or nurse practitioner, Classification Officer and ad hoc members as required. This team will advise on needs, mental health services and case monitoring.

If suitable resources are not available in the community or the respective Correctional or Detention Facility for providing the mental health care needs of inmates, the Division may consider transferring an inmate to another facility in an effort to ensure access to specialized treatment services.

Mental health practitioners shall provide mental health services and programs in accordance with professional standards and shall provide leadership and guidance in the provision of programs by other professionals.
Section 10: Health Care Services

Sub-Section: Mental Health Care – Remand or Detained Persons

Policy

To ensure that inmates admitted to a lockup or remanded in custody and who are apparently in need of special mental health care services are referred as soon as possible for assessment and/or treatment.

Directives

Persons remanded in custody or admitted to an institution often display acute signs of anxiety and stress, thus they are of particular concern for corrections staff.

If an inmate does display signs of severe stress, anxiety or mental illness a medical referral shall be initiated as soon as possible given that early intervention may be particularly critical in such circumstances.

Inmates admitted to a lock-up and who are apparently in need of special mental health care services will be prioritized in being transferred to a facility with a medical unit and team.
Section 10: Health Care Services

Sub-Section: Mental Health Care – Needs Identification

Policy

Any information identifying inmates as having mental health issues must be communicated as soon as possible to those professionals responsible for providing mental health care services.

Directives

Information relating to the identification of offenders with mental health issues may be obtained from the following sources:

- police observation at the time of arrest;
- reports from detention facilities;
- family members;
- pre-sentence reports;
- mental health agency records;
- reception interviews;
- psychological assessments;
- observations by other inmates;
- self referrals.

It is critical that all such information be recorded and communicated to the institutional medical staff and appropriate mental health professional.

Prompt and appropriate intervention must occur in every identified case if proper diagnosis and treatment is to occur. Intervention may take a number of forms:

- referral to nursing staff;
- referral to medical clinic, either within the institution or in the community, contingent on the urgency of the situation and/or availability of services;
- referral to psychiatric specialists;
- referral for psychological assessment;
- transfer to a treatment facility.

Inmates reported to have mental health issues but who are not hospitalized will require special attention to prevent potentially disruptive or self-destructive behavior resulting in the deterioration of the inmate’s mental health. Inmates in this category will be assessed by a mental health professional and a case management plan designed to be implemented by correctional personnel.
Re: Inmate Transfer to Mental Health Facility

I am sending you herewith documents for committal of ______________________,
(name)
born ______________________ a resident of ______________________
(date of birth) (address)
He was admitted to ______________________ on ______________________
(institution) (date)
due to being remanded/sentenced on the following charges:

a Breach of

His tentative release date/scheduled court appearance is set for ______________________.
(date)

Would you please have the necessary order issued authorizing the removal of this person to the

________________________ as soon as possible.
(facility)

Superintendent of Prisons
FORM A

ORDER OF MINISTER OF JUSTICE

TO: The Superintendent of Her Majesty’s Penitentiary
    at St. John’s, Newfoundland

AND

The Clinical Chief of the Waterford Hospital
at St. John’s, Newfoundland

WHEREAS the prisoner

(name)

was charged with (or convicted of the offence) a Breach of

AND WHEREAS the prisoner appears to be ill and requires treatment pursuant to Section 19 of the Prisons Act /Section 78 of the Mental Health Care and Treatment Act.
NOW THEREFORE pursuant to the powers conferred on me by Section 19 of the *Prisons Act* / Section 78 of the *Mental Health Care and Treatment Act* you are hereby ordered to convey the prisoner to the Waterford Hospital at St. John's together with the following precept: You, the Clinical Chief of the Waterford Hospital are hereby ordered to receive the accused into custody for treatment until his/her recovery and until further ordered and for so doing this is sufficient authority.

DATED AT ST. John's day of , A.D.
2010

Minister of Justice
ORDER OF MINISTER OF JUSTICE

TO: The Superintendent of Her Majesty’s Penitentiary
   at St. John’s, Newfoundland

AND

The Clinical Chief of the Waterford Hospital
at St. John’s, Newfoundland

WHEREAS hereinafter called the
prisoner (name)

was charged with (or convicted of the offence) that

AND WHEREAS the prisoner was conveyed to the Waterford Hospital for treatment pursuant
to Section 19 of the Prisons Act /Section 78 of the Mental Health Care and Treatment
Act.
AND WHEREAS in the opinion of the medical authorities and staff of the Waterford Hospital, the accused has recovered sufficiently to be returned to Her Majesty's Penitentiary,

NOW THEREFORE pursuant to the powers conferred on me by Section 19 of the Prisons Act/Section 78 of the Mental Health Care and Treatment Act you are hereby ordered to deliver the prisoner into the custody of the Superintendent of Her Majesty's Penitentiary together with the following precept: You, the Superintendent of Her Majesty's Penitentiary, are hereby ordered to receive the prisoner into your custody to be further dealt with according to law and for so doing this is sufficient authority.

DATED AT ST. John's _________ day of ______________, A.D., 20__

________________________

Minister of Justice
Re: **Inmate Transfer From Mental Health Facility**

I am sending you herewith documents for transfer of custody of

born ___________________________ a resident of ___________________________

(name) (date of birth)

_____________________________ He was transferred to ___________________________

(address) (mental health facility)

on ___________________________ and is now deemed medically fit for transfer to

(date)

_____________________________

(name of custody facility)

Would you please have the necessary order issued authorizing the transfer of this

person to ___________________________ as soon as possible.

(adult custody facility)

_____________________________

Superintendent of Prisons
Section 10: Health Care Services

Sub-Section: Mental Health Care – Mental Health Facility Transfers

Policy

The transfer of prisoners suffering from a mental disorder shall be conducted in a manner that is consistent with the *Mental Health Care and Treatment Act* as well as with the mental health needs of the prisoners concerned.

Directives

An inmate shall be transferred to a psychiatric unit upon receipt of:
- two completed and signed certificates of involuntary admission; and
- an Order of the Minister or Deputy Minister of Justice.

Upon transfer, the administrator of the psychiatric unit named in the Order shall be provided with the two certificates of involuntary admission, a copy of the Order (Form A), a Letter of Conveyance (Form B) and a copy of the Warrant of Committal.

Employees are to ensure that:
- the first certificate of involuntary admission is completed and signed by a physician or nurse practitioner; and
- the second certificate of involuntary admission is completed and signed by a psychiatrist or, where a psychiatrist is not readily available, by a physician who did not sign the first certificate.

Upon receipt of an Order of the Minister or Deputy Minister of Justice (Form C) and the Letter of Conveyance (Form D) to return the inmate to a correctional institution, an employee shall accept the inmate into custody.
Section 10: Health Care Services

Sub-Section: Mental Health Care – Psychiatric Emergencies

Policy

Psychiatric or psychological evaluations shall be performed on any inmate who exhibits behavior which may be suicidal, homicidal or otherwise extremely inappropriate.

Directives

Signs and symptoms of possible mental illness may include:
- delusions of persecution and/or grandeur;
- intense anxiety, fear or panic in the absence of any real danger;
- bizarre delusions, inappropriate laughing;
- hallucinations;
- exaggerated mood swings;
- extreme depression, withdrawal, neglect of appearance or hygiene;
- refusal to eat or leave cell for long periods, uncontrollable crying.

Signs and symptoms of potential suicide cases may include:
- loss of interest in activities or social interests previously enjoyed;
- depression, withdrawal, crying, insomnia, lethargy;
- extreme restlessness;
- past history of suicide attempts;
- active discussion of suicide plans;
- sudden drastic change in eating or sleeping habits.

Response Procedure

Upon identifying an inmate as requiring immediate attention for a mental illness or suicidal ideation, the following response shall be initiated:
- place the inmate in a suitable unit under a continuous observation;
- remove potentially harmful items;
- personal clothing will be removed and a suicide gown provided;
- where this is not possible (i.e. double bunking) the inmate may remain in his/her personal clothing;
- ensure that any self-inflicted or other injuries are treated;
- advise the medical officer;
- allow the inmate time to regain his/her composure;
- in an honest, non-threatening manner, reassure the inmate of a desire to help him/her;
- remain calm and kind, but firm.
### APPENDIX "B"
CORRECTIONS AND COMMUNITY SERVICES DIVISION
NEWFOUNDLAND AND LABRADOR
SUICIDE RISK ASSESSMENT AND REFERRAL

<table>
<thead>
<tr>
<th>SEX</th>
<th>AGE</th>
<th>SENTENCE</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>F</td>
<td></td>
<td>Completed by:</td>
</tr>
</tbody>
</table>

#### CIRCUMSTANCES:
- New Admission
- Repeat Admission
- Remand
- Other

#### Check Appropriate Column for Each Question

**OBSERVATIONS FROM SENDING INSTITUTION/AGENCY:**
1. Remand facility/Probation Officer/Arresting Officer or significant other (e.g. spouse advises that inmate may be suicidal)
2. Inmate has previous suicide attempt(s)
   - Note: frequency and method of attempt(s)
   - most recent attempt
   - history of drug overdose (elicit circumstances and motivation)
   - any scarring
3. Inmate has had psychiatric/psychological interventions

**STRESSORS:**
4. Inmate reportedly has experienced significant loss within the last 6 months (e.g. loss of relationship, death of close family member) or has a feeling of being alone (few if any resources)
5. Inmate appears very worried about major problems (e.g. legal situation, serious family problems, medical condition)
6. Inmate is apparently under the influence of drugs or showing signs of withdrawal

**IDEATION:**
7. Inmate shows signs of depression (e.g. crying, emotional flatness)
8. Inmate is thinking about or has expressed the intention of committing suicide

**PLANS:**
9. Inmate has a plan for suicide. Comment on:
   - The lethality and viability of plan
   - where-when-how
10. Inmate is experiencing mental pain that at times feels unbearable (ask inmate to rate pain on scale of 1 to 10)

**Action:** if any checks in Column A

**TOTAL COLUMN**
make necessary referral

**Supervisor Notified:**
- Yes
- No

**Mental Health Referral**
- Yes
- No

**Seen By:**
- Yes
- No

#### MENTAL HEALTH COMMENTS AND RECOMMENDATIONS:

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55
Section 10: Health Care Services

Sub-Section: Mental Health Care – Suicide Intervention

Policy

To implement a comprehensive strategy for the prevention of suicide, based on the fundamental principle that the ultimate sanctity of life must be safeguarded by all reasonable means available.

Directives

Identification

All correctional staff have a collective responsibility to ensure that the Officer-in-Charge is advised whenever there is reason to believe that an inmate is a potential suicide risk.

Suicide Incident Report

When an inmate has been identified as being at risk, an Officer Statement Observation Report (OSOR) is to be completed immediately by the Correctional Officer or other staff member who receives such information or observes behaviour regarded as being potentially at risk.

The OSOR is to be submitted at the earliest possible opportunity to the Officer-in-Charge who will verify the information, complete a Suicide Incident Report and refer a copy of the OSOR to the medical officer and/or nurse as soon as possible. The Suicide Incident Report is automatically recorded for a permanent record on PCOMS.

The Reports will specifically indicate, where appropriate, whether or not:
- the injury appears to be self-inflicted
- the wounds are superficial/serious
- a drug overdose is apparently involved and/or the medication suspected
- the specific clues and risk factors observed
- any other related information deemed warranted.

In the event that an inmate is identified as “At Risk”, the psychiatrist or nurse is to be contacted immediately and the situation treated as an emergency.

Suicide Risk Assessment on Admission
A Suicide Risk Assessment form will be completed by a designated officer on behalf of each inmate at the time of the admission interview with the exception of Lock-ups (where short term detainees are universally regarded as potentially at risk and under camera surveillance).

The Suicide Risk Assessment must be completed within four (4) hours of admission.

In the event that the interview reveals certain Risk Factors or other designated stressors are apparent, the admitting officer is to notify the Shift Supervisor who will alert the medical officer or nurse.

**Suicide Risk Classification**

Inmates will be classified in one of two categories:
- At Risk – presence of suicidal ideation requiring constant observation
- Not at Risk – no suicidal ideation indicated during interview.

If the Risk Factors indicate that certain needs and concerns of the inmate should be addressed, but no suicidal ideation is indicated, the Officer-in-Charge has the authority to override the classification level of “At Risk” for the safety of the inmate.

The presiding licensed practitioner has the authority to designate the suicide risk classification level to be assigned to an inmate. In his/her absence, the nurse retains such authority. If neither the psychiatrist nor the nurse is available, the authority is delegated to the Officer-in-Charge.

Only the psychiatrist has the authority to change the inmate’s status from a higher to a lower risk classification level.

**Case Management**

**Institutional Placement and Supervision Level**

The suicide risk classification level assigned to an inmate will determine institutional placement.

**Transfers**

Inmates considered suicidal or self injurious shall not be transferred to an institution other than a treatment facility unless the psychiatrist managing the case, in consultation with other health service professionals, deems that the transfer would reduce or eliminate the inmate’s potential for suicide or self injury.

It may be necessary to transfer an inmate to a higher security institution for suicide watch or other interventions.
The psychiatrist of the sending institution shall advise the psychiatrist of the receiving institution prior to the transfer and provide written notification of the inmate’s suicidal state to ensure continuity of care with respect to treatment and monitoring.

At Risk inmates are to be isolated in an area that affords constant observation by means of CCTV or otherwise direct visual observation. However, exclusive reliance on CCTV surveillance is not a good practice and should be supplemented by regular direct visual checks.

The inmate is to be strip-searched, potentially harmful elements removed from the cell, including plastic, metal or glass items.

Personal items are to be restricted to a minimum and all items used for hygiene purposes are to be used under continuous supervision and retrieved after use.

Increased vigilance must be taken to ensure that suicidal inmates are not given the opportunity to hoard medications.

Inmates should be dressed in suicide gowns and given suicide blankets.

A daily diary will be maintained to record all activities or events.

Not at Risk inmates or an inmate taken off the At Risk level, will normally remain in the general population.

There may be certain incidents where the medical plan to return the inmate from At Risk to Not at Risk may include a request from the psychiatrist to have staff conduct thirty (30) minute checks on the inmate to see how they are coping in the Living Unit with the general population, or have the inmate return under surveillance during the night time, and return to the Unit the following day.

The offender’s behaviour will be noted by correctional staff on Offender Unit Notes daily and reviewed regularly by the officer or nurse.

**Self-Mutilation Restraints**

Three (3) types of “soft restraints” may be used to augment or substitute the hard restraints which are sometimes applied to an inmate engaging in self-mutilation. All uniformed staff will be trained in the proper application of these restraints.

The “HOBBLE” is used to restrain the ankles, knees and elbows while the officer changes from hard to soft restraints, or to gain control over an offender who is kicking or punching.

The ‘TUBE” will work with handcuffs and transportation belts to help prevent the inmate smuggle contraband/weapons or bite hands/pick at stitches, etc.
The "TRANSPORTATION BELT" for the transportation of inmates or used with the "TUBE" when inmate is trying to self-mutilate or obtain contraband.

These restraints will only be applied by trained staff under the direction and permission of the Officer-in-Charge.

Social Interaction/Support

It is important that inmates who have been identified as suicidal be afforded continuing opportunities for social interaction rather than be subjected to continued isolation.

Correctional Officers and other institutional staff should adopt a practice of maintaining rapport with the inmate, providing positive support and encouraging social interaction whenever possible.

Counseling will be provided by the psychiatrist and psychologist where available and appropriate.

A handbook on Suicide Prevention will be distributed to all staff at the time of their training and maintained for continuing reference.

Staff will receive an initial two (2) day training session and all staff will receive training of one half day duration every three years.

Suicide Prevention Committee

A Suicide Prevention Committee will operate on a permanent basis.

The Committee will have a mandate to review Divisional policy directives, operational procedures, the training curriculum as well as any other matter related to suicide prevention.

Recommendations regarding needed improvements or adjustments will be submitted to the Superintendent.

The Committee will meet at least semi-annually and copies of minutes forwarded to the Superintendent and Director.

Determination of Death

Under no circumstances may any individual other than a medical officer make a decision as to whether or not there is presence of life.

Any inmate who has apparently attempted suicide, even if primary life functions are not in evidence, will be considered as living and the appropriate first aid measures applied continuously until a medical officer determines that the patient is officially deceased.
Strangulation

If an inmate if found hanging by the neck, the following procedure is to be employed:
- alert other staff as assistance is essential;
- act as quickly as possible since speed of action is critical if the patient's life is to be saved;
- with assistance, relieve the weight, cut the body down and remove the ligature;
- if the ligature cannot be removed, it may be cut but do not untie any knots since these may be used as evidence;
- check breathing and carotid pulse;
- if necessary, immediately commence mouth to mouth resuscitation and heart massage and maintain until the applicable medical equipment is available.

Wounds

In the case of apparent suicide with a cutting instrument, every effort is to be made to stop the bleeding by applying pressure and enlist medical aid as soon as possible.

Toxic Fluids

Where toxic fluids have been ingested, the appropriate first aid measures are to be implemented while awaiting medical attention.

Each institution's OH&S Officer will ensure that WHMIS Information Sheets are present at every Control Post for access and referral in an emergency.
APPENDIX “A”
CORRECTIONS AND COMMUNITY SERVICES DIVISION
NEWFOUNDLAND AND LABRADOR
SUICIDE INCIDENT REPORT FORM

INSTITUTION: ____________________________

NAME OF INMATE: _______________________

UNIT/CELL: _____________________________

DATE AND TIME OF INCIDENT: ______________

APPARENT INJURY: ________ ________

YES NO

EXACT DESCRIPTION OF INCIDENT:

_______________________________
_______________________________
_______________________________
_______________________________

_______________________________

CORRECTIONAL OFFICER

_______________________________

OFFICER IN CHARGE

_______________________________

RECOMMENDED PLACEMENT OF INMATE: EXPLANATION OF PLACEMENT:

_______________________________
_______________________________
_______________________________
_______________________________

_______________________________

_______________________________
Section 10: Health Care Services

Sub-Section: Mental Health Care – Inmate Release

Policy

To facilitate continuity of care in the community for inmates who have been released from custody and who are suffering from mental illness.

Directives

An inmate’s assigned Classification Officer, in consultation with the Manager of Institutional Programs or the Institutional Head, shall ensure that release planning and follow-up is arranged for inmates who were treated for a mental illness while in custody.

Contacts will be made with appropriate community resources to ensure that proper aftercare services are in place.

In the event that a period of parole or probation is in force following release from custody, the probation or parole officer will be apprised, prior to the inmate’s release, of the following:
- the offender’s mental health history;
- the treatment administered;
- release plans for continued treatment;
- an assessment of the offender’s risk to himself/herself and others.
Section 10: Health Care Services

Sub-Section: Mental Health Care – Admission and Discharge Under the Mental Health Care and Treatment Act

Policy

The admission and release of a person allegedly suffering from mental illness to and from a correctional facility shall be conducted in a manner that is consistent with appropriate legislation as well as the mental health needs of the inmates concerned.

Directives

Admission

Persons alleged to be suffering from a mental illness may be admitted to an institution under the following circumstances:

- by warrant issued under Section 19 of the Mental Health Care and Treatment Act;
- by a police officer who has 'reasonable cause for believing that a person is suffering from a mental disorder' and it is impracticable to obtain a warrant, as specified in Section 20 of the Mental Health Care and Treatment Act.

Any admission should be limited to circumstances where there are no other reasonable alternatives to the psychiatric assessment taking place at a correctional facility. The Peace Officer admitting the person is required to provide a copy of the warrant issued under Section 19 or a written statement in accordance with Sections 20 and 21 containing:

- the name of the person conveyed, if known;
- and the date, time and place at which the person was apprehended;
- and the grounds on which the Peace Officer formed his or her belief and any other information relating to the circumstances which led to the taking of the person into custody.

Medical Assessment

When a person has been admitted to an institution by virtue of Section 19 or Section 20 of the Mental Health Care and Treatment Act, the Officer-in-Charge shall immediately contact the appropriate physician designated in these circumstances to conduct a psychiatric assessment of the person.

The Peace Officer who effected the apprehension shall remain at the facility where possible and retain custody of the person until the assessment is completed unless advised by a commissioned officer that continuing custody is not required.
The psychiatric assessment shall be conducted as soon as practicable and in any event within seventy-two (72) hours of the arrival of the person at the facility. The person detained may be treated without his or her consent during the period of detention.

Release

Any person admitted to an institution under Section 20 or Section 19 of the Mental Health Care and Treatment Act may only be released on the written authority of the examining physician. If the person is to be transferred to a psychiatric facility on an involuntary basis, two certificates of involuntary admission must be completed. The first certificate is to be completed by a physician or nurse practitioner and the second certificate should be completed by a psychiatrist. A person who is subject to two completed certificates of involuntary admission shall be immediately transported to a psychiatric unit. Where it is not practical to immediately transfer a person to a psychiatric unit, the person may be transferred to an appropriate place as defined in the Mental Health Care and Treatment Regulations.

If the transfer is voluntary, only one medical practitioner is needed to authorize the admission.

If the person is deemed mentally competent on the written authority of the attending medical practitioner, the person must be advised of his/her right to leave the facility. The Officer-in-Charge must arrange for the return of the person to the place where the person was when taken into custody or to another appropriate place. It is also incumbent on the Officer-in-Charge of the institution to ensure that the detainee is properly clothed and fed and has access to suitable shelter.

If there is reason to believe that the detainee may not be properly clothed or does not have access to proper shelter, the appropriate government department or service is to be engaged in the case to ensure that the necessities of life are made available.
Section 10: Health Care Services

Sub-Section: Psychological Services

Policy

To ensure the provision of psychological services to inmates in order to assist them with the resolution of mental health issues or behavioral disorders.

Directives

Psychological services shall strive to assist inmates in learning and adopting socially acceptable behavioral patterns as well as preventing or attenuating their relapse following an intervention.

The Manager of Institutional Programs shall ensure that psychological services are available to all inmates.

All psychological services shall focus on the needs of the offender, specifically the behavior that contributed to criminal activity, on the assessment risk posed by the offender and on strategies to reduce and/or manage risk.

The psychologist is one member of the multi-disciplinary team responsible for the management of the offender’s case.

Interventions shall be both culturally and gender sensitive.

Intervention shall be provided to higher risk/higher need offenders receiving more intensive treatment. Problem behavior directly related to criminality and essential mental health needs shall be primary treatment targets.

Psychologists will identify treatment targets (e.g. sexual deviation, substance abuse, anger/aggressive behavior, criminal attitudes, values and beliefs).

The delivery of treatment should be matched to methods proven to be effective with offenders, subject to ongoing program development and innovation.

Treatment shall be aimed at symptom reduction, skill acquisition, the identification of high risk situations, viable coping strategies for offenders and relapse prevention.

Documentation must be maintained relating to treatment activities.
Information Sharing

Personal psychological information cannot be disclosed without the consent of the individual to whom it relates.

Personal information may be disclosed where authorized by law under ATIPPA and the Personal Health Information Act. However, the Personal Health Information Act recognizes a number of exemptions to this general rule.

Newly appointed psychologists, including contract psychologists, shall be provided with orientation training focusing on psychological services within Adult Custody as well issues pertaining to the safety and security of the institution, the staff, inmates and the general public.
Section 10: Health Care Services

Sub-Section: Special Health Care Services – Plan Development

Policy

Individual treatment plans shall be developed for each inmate who has special health care needs requiring close medical supervision.

Directives

Inmates may require specialized health care services for a number of health-related conditions:
- chronic care – health care provided to patients over a long period of time;
- convalescent care – services provided to patients recovering from illness or injury;
- detoxification – gradual withdrawal from alcohol or other drug dependency;
- disabilities – physical or mental deficits that restrict daily functioning;
- psychiatric/psychological disorders – emotional, personality or other mental disorders which are environmentally or biologically induced and which represent a potential threat to self or others.

Where any of the foregoing conditions prevail, it is the responsibility of the medical unit to develop a health care plan detailing:
- recommended placement within the institution;
- work assignment restrictions;
- medication prescribed;
- treatment procedures;
- referrals to community resources.
Section 10: Health Care Services

Sub-Section: Special Health Care Services – Response to Medical Emergencies

Policy

In responding to a medical emergency, the primary goal is the preservation of life and all staff must act to preserve life.

Directives

Non-health services staff arriving on the scene of a possible medical emergency must immediately call for assistance, secure the area and initiate CPR/first aid without delay.

Non-health services staff must initiate CPR/first aid where physically feasible even in cases where signs of life are not apparent.

Non-health services staff must continue to perform CPR/first aid until relieved by health services staff or the ambulance service.

The decision to discontinue CPR/first aid can be made only by authorized health service staff or the ambulance service.

Initiation of CPR by non-health services staff is not required in the following situations:
- Decapitation (i.e. the complete severing of the head from the remainder of the body);
- Decomposition (i.e. condition of decay, deterioration, disintegration of the body);
- When non-health services staff are advised by the medical staff that a valid DO NOT RESUSCITATE (DNR) order exists;

The existence of a DNR order does not preclude the use of other forms of treatment or care (i.e. treatment for a non-life threatening injury).

Non-health services staff must use approved protective equipment when administering CPR/first aid.

As soon as a possible medical emergency is identified, the Officer-in-Charge must notify health services and the ambulance service in accordance with the Institutional Contingency Plan, Standing Orders or Post Orders.
The Officer-in-Charge must immediately establish appropriate security for responding staff and the ambulance service.

Once on the scene, health services or the ambulance service shall be responsible for determining the medical response to the situation.

Correctional staff on the scene will continue to provide assistance as directed by health services or the ambulance services.

The Institutional Head shall ensure that debriefings occur immediately following a medical emergency to inform Managers of the details related to the medical emergency and offer Critical Incident Stress Management Services to all staff and inmates involved in or witness to the incident.
Policy Manual

Policy 10.20.03

Section 10: Health Care Services

Sub-Section: Special Health Care Services – Code 9 – Medical Emergency

Policy

Each correctional centre and lock-up will ensure that each employee is familiar with the standard CODE 9 (Medical Emergency) Contingency Plan and is able to implement CODE 9 stages consistently and in the proper sequence.

Directives

To ensure that medical attention is provided with all due haste in the event of an emergency, CODE 9 Contingency Plan shall be adopted at all correctional centres and lock-ups.

When an inmate is found in need of immediate emergency medical treatment, the employee who discovers the casualty shall:

- immediately render the necessary First Aid;
- summon assistance by the most expeditious method available only after the immediate First Aid requirements have been satisfied;
- continue First Aid as necessary;

On receipt of notification of a medical emergency the Control Centre or Guardroom will:

- announce a CODE 9 on the P.A. system twice in a clear concise manner;
- identify the exact location of the emergency;
- Ensure that resuscitating equipment is conveyed to the CODE 9 location whether it has been requested or not.

The Shift Supervisor is responsible for:

- coordinating the conveyance of emergency resuscitating equipment as expeditiously as possible;
- ensuring that medical support services are contacted;
- ensuring that necessary First Aid procedures are applied and maintained as long as necessary or until medical assistance arrives.

Under no circumstances may an employee make a decision to discontinue administering First Aid on the basis that life is not present. Emergency medical treatment and life support equipment will be maintained until the arrival of ambulance attendants and/or the physician.
Policy

This policy in accordance with Health Canada will provide guidelines for infectious disease prevention and detection, and treatment of inmates and correctional employees who face exposure to infectious diseases in correctional institutions.

Directive(s)

Infection control refers to practices to prevent the acquisition or transmission of infection during the provision of service within our correctional facilities.

Universal precautions are to be practiced at all times.

It will help to ensure that staff and inmates are working and living in a safe environment in accordance with Health and Safety Regulations and staff recognize the potential/actual risk of infection and by their action, minimize the spread by cross infection.

Each correctional facility will establish its own infectious disease protocol as it relates to their institution.

The infectious disease protocol will be part of each institution’s Occupational Health and Safety Program and hard copies will be accessible to staff in their work stations.
Section: Health Care Services

Sub-Section: Special Health Care - Management of Infectious Diseases

Policy

To contribute to a safe and healthy institutional environment through a comprehensive infectious disease program.

Definitions

Infectious diseases are those which can be transmitted from one person to another and include:
- those contracted through exposure to blood and body fluids of an infected person;
- sexually transmitted diseases; and
- those contracted through exposure to airborne droplets (e.g. tuberculosis and influenza A)

Harmful reduction is a policy, a program or a measure aimed at reducing the negative health, social and economic consequences of harmful behaviors such as injection drug use and unsafe sex. Harm reduction items such as condoms and bleach reduce the risk of transmission of disease and the harms consequent to infection.

Routine practices are a set of universal precautions to be employed at all times when a person is in contact with potentially infectious materials such as blood and body fluids.

Surveillance is the process of collecting, analyzing and sharing information about diseases occurring in a population so that the appropriate prevention, education and treatment requirements can be identified.

Directive(s)

The Adult Custody Branch shall be guided by public health principles in managing infectious diseases in the correctional environment.

The gender and cultural requirements of individuals and groups shall be respected and reflected in all activities aimed at addressing infectious diseases in the inmate population.

Approved harm reduction items shall be readily and discreetly accessible to inmates so that no inmate is required to make a request to a staff member for any item.

Staff and inmates have a personal responsibility to take universal precautions to avoid contracting and transmitting infectious diseases and to participate in training and education provided to them. Inmates living with infectious diseases shall be provided with humane treatment and support, in an environment free of discrimination.
The Institutional Head is responsible for ensuring that training and education is provided to staff and inmates on a regular basis which includes:

- the principles of routine practices to prevent and control diseases;
- their personal responsibility to protect themselves and others at all times;
- the principles of harm reduction;
- that inmates and staff involved in the handling and clean-up of blood and body fluids are trained in the use of and provided with protective clothing and equipment;
- that approved harm reduction items are available as provided in this policy; and
- that procedures are in place for the follow-up of any inmate or staff member exposed to the blood or body fluids of any other person.

Inmates living with infectious diseases shall normally be housed with the general inmate population unless they require a level of care which cannot be provided outside a health care setting.

**Confidentiality/Disclosure**

Medical information pertaining to inmates who are HIV positive may not be disclosed to non-health personnel without the inmate’s written consent. However, if there is cause to believe that the offender’s activities may constitute a danger to himself/herself or others, health care staff may provide this information to the Institutional Head.

**HIV Antibody Testing and Consent**

An inmate may not be forced to submit to an HIV Antibody Test. If a staff member does suspect that an inmate may be HIV infected because he/she exhibits certain symptoms or engages in high risk activities, the staff member should ensure that this information is conveyed to the medical officer.

Inmates who test positive for HIV antibodies may remain in the general population unless:

- the inmate’s behavior is threatening or high risk in nature such that segregation is necessary to prevent possible transmission of the disease to others;
- the inmate is threatened by the general population and requires special housing provisions to ensure his/her personal safety;
- the inmate’s condition of AIDS and the accompanying deterioration of the immune system is so severe that medical isolation is necessary to guard against the inmate’s vulnerability to other infections.

Protective clothing and universal precautions will be used by staff in situations where they are likely to come into contact with blood, semen or other bodily fluids which may be contaminated by the HIV antibodies.
Section: Health Care Services

Sub-Section: Special Health Care Services – Hunger Strike

Policy

To assess and manage inmates who, by their own choice, have elected to engage in a hunger strike.

Definition

A hunger strike consists of a situation where an individual refuses all solid food and all fluids except water and it has been verified that he or she has done so for a period of at least seven (7) days unless an underlying medical condition necessitates earlier intervention.

Directive(s)

The Institutional Head is responsible for the development of Standing Orders pertaining to a Refusal to Eat. A Refusal to Eat condition exists prior to the inmate’s actions being declared a Hunger Strike.

It shall be the policy of the Adult Custody Branch to regard the sanctity of life as the sovereign principle in the management of an inmate’s welfare when his/her vital well-being is jeopardized by a refusal to eat.

Each institution and lock-up shall develop a contingency plan to deal with inmates engaging in Refusal to Eat behaviours or a hunger strike. The plan shall ensure:

a) the timely identification of hunger strikes;

b) an initial assessment of the physical and mental state of the individual should be completed by a qualified medical practitioner. This assessment shall determine the competency of the individual to make such a decision and understand the consequences of that decision;

c) prompt identification of the reason(s) for the hunger strike;

d) referral to the mental health services team for counseling the inmate regarding underlying causative factors and the possible consequences of such activity;

e) regular monitoring of the inmate.

Inmates who refuse to eat are to be segregated from the general inmate population.

In circumstances where more than one inmate refuses to eat, they should be separated from each other to prevent mutual reinforcement of the behavior.

Inmates who refuse to eat will not be force-fed by correctional staff.
If the inmate's health condition is determined to be critical by the attending medical practitioner, he/she will be transferred, with proper security, to a community health facility.
Section 10: Health Care Services

Sub-Section: Special Health Care Services - Abortion

Policy

The decision to terminate a pregnancy is a choice to be made by the inmate within the context of the doctor-patient relationship.

Directives

The decision whether to terminate a pregnancy cannot be made by any official of the Division of Corrections and Community Services.

If a physician determines that the continuation of pregnancy would likely endanger the inmate's life or health, the patient may be transferred to an "accredited or approved hospital" as defined by the Criminal Code.

Since the provisions of the Criminal Code supercede the jurisdiction of the Division of Corrections and Community Services, consent for such a transfer by a corrections official is not a prerequisite.

If the decision to proceed with a therapeutic abortion has been made in accordance with the provisions of the Criminal Code, it is imperative that correctional staff avoid accentuating the difficult nature of the situation. In these situations, management of the case should be coordinated under the physician's direction.
Policy

The Division of Corrections and Community Services provides necessary support services to female inmates during, and following, their pregnancy in custody.

Directives

Female inmates who are pregnant upon incarceration shall be provided with all usual social and health support services that would be available in the community.

Counselling or social support services may be engaged to assist the inmate in coping with the pregnancy and/or planning for the child's future if there is an identified need for such services to intervene.
Section 10: Health Care Services

Sub-Section: Special Health Care Services – Gender Identity

Policy

Gender identity is linked to a person’s sense of self, and particularly the sense of being male or female. The Adult Custody Branch of the Division of Corrections and Community Services will make every attempt to reasonably accommodate an inmate with diagnosed gender identity special needs.

Directives

Where there are reasonable grounds to believe that an inmate has gender identity special needs, an employee of the institution may refer the inmate to the Institutional Psychiatrist. If such special needs are diagnosed, the Institutional Psychiatrist may refer the matter to a psychiatrist who is a recognized expert in the area of gender identity, if and when available, for an assessment and possible diagnosis.

For all placement and program decisions, individual assessments shall be conducted to ensure that offenders diagnosed with an issue pertaining to gender identity are accommodated with due regard for vulnerabilities with respect to their needs, including safety and privacy.

Employees are required to work with the inmate and/or psychiatrist to ensure that the inmate’s special needs are reasonably accommodated subject to any institutional requirements.
Section 10: Health Care Services

Sub-Section: Naloxone - Nasal Spray Administration

Policy

Directive(s)

1.0 General

1.1 Purpose:

The purpose of this policy is to provide standards for the training, provision and administration of Naloxone Spray for Adult Custody. Adherence to this protocol will ensure the safe administration and/or provision of Naloxone and mitigate the potential for opioid overdose deaths within Adult Custody facilities throughout the province.

1.2 Scope:

This policy applies to all Adult Custody staff including medical staff and contractual nurses.

1.3 Response to a medical emergency by Health Services Staff

Pursuant to policy 16.00, health care professionals, including those under contract will provide emergency first aid and cardiopulmonary resuscitation (CPR), according to their certification until external emergency services are available. In this context, nursing staff will respond to emergency situations involving known or suspected overdoses, accidental exposure to Fentanyl or related opioid substances, including the administration of Naloxone as required (see page 7 of this policy).

1.4 Response to a medical emergency by non-health services staff when no medical nurse is accessible

The purpose of this policy is to enable Non-Health Services Staff to use Naloxone Nasal Spray during a response to a suspected opioid overdose medical emergency of inmates or staff, when no nursing staff is accessible.

2.0 Principals

2.1 To ensure the safety and security of staff and inmates by employing the use of Naloxone Spray in the cases of suspected or confirmed opioid overdose.
3.0 Background

3.1 Naloxone Spray is an easy to use, lifesaving medication that can temporarily reverse the effects of overdose from opioid drugs.

Opioid overdose is a life threatening condition characterized by respiratory depression. If left untreated. Opioid overdose can result in respiratory arrest, coma, cardiac arrest and death. Persons are at risk for opioid overdose when too much of an opioid drug such as heroin, morphine, methadone, fentanyl, codeine, hydromorphone, etc. is introduced into the body by means of ingestion, injection or transdermal absorption, inhalation and/or injection. Naloxone is indicated for the reversal of either natural or synthetic opioid overdose. The administration of Naloxone can prevent severe brain, heart and lung damage, as well as death by binding to the opioid receptors in the brain; reversing the effects of opioids present in the body and restoring respiratory functioning. As Naloxone is only effective for 30-90 minutes, the individual must be assessed in the emergency room in all cases of confirmed or suspected and opioid overdose.

4.0 Definitions

Respiratory Depression

When the casualty’s respiratory rate falls below 12 breaths per minute or fails to provide full ventilation and perfusion of the lungs.

Naloxone Hydrochloride

An opioid antagonist that when administered, temporally reverses the opioids effects on the body following suspected or confirmed acute opioid overdose including respiratory depression.

Opioid

A substance administered for acute/chronic pain relief, management of difficult or labored breathing, cough relief, and Methadone Maintenance Treatment.

The following medications are classified as opioids:

<table>
<thead>
<tr>
<th>OPIOID CLASSIFICATION</th>
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<tbody>
<tr>
<td>Alfentanil HCL</td>
<td>Fentanyl</td>
<td>Oxycodone HCL</td>
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<tr>
<td>Buprenorphine</td>
<td>Fentanyl Citrate</td>
<td>Pentazocine Lactate</td>
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<tr>
<td>Butorphanol Tartrate</td>
<td>Hydrocodone HCL</td>
<td>Pethidine HCL</td>
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<tr>
<td>Codeine Monohydrate</td>
<td>Methadone HCL</td>
<td>Sufentanil Citrate</td>
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<td>Codeine Phosphate</td>
<td>Morphine HCL</td>
<td>Tapentadol HCL</td>
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<tr>
<td>Codine Sulfate Trihydrate</td>
<td>Morphine Sulfate</td>
<td>Tramadol HCL</td>
</tr>
<tr>
<td></td>
<td>Nalbuphine HCL</td>
<td>Pentazocine HCL</td>
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</tbody>
</table>
5.0 Standards

5.1 General

The Institutional Head for each facility is responsible for ensuring Naloxone Nasal Spray kits are available on specified duty posts within their facility.

In all situations involving suspected or confirmed opioid overdose, the individual must be transferred to the hospital by ambulance.

5.2 Naloxone (Narcan®) Nasal Spray

Narcan® nasal spray is a pre-filled, disposable, ready to use version of the medication naloxone. Narcan® is used to temporarily reverse the effects of an opioid overdose until emergency services arrive. Some examples of opiates include: Heroin, Methadone, Suboxone, Kadian (Morphine), OxyContin, Percocet, Codeine, and Fentanyl. Narcan® does not reverse overdose from drugs like Cocaine, Methamphetamine, Alcohol, or Benzodiazepines (Xanax; Valium). The Narcan® nasal spray is designed as a one-time-use only device. More information about the Narcan® nasal spray (including pictures of the device) can be found on their web-site at: http://www.narcan.com.

5.3 Response to suspected opioid overdose

Narcan® nasal spray will be available to all Non Health Services Staff during a response to a suspected opioid overdose medical emergency when no nursing staff is accessible. Narcan® nasal spray will be stored in specified locations at each facility at room temperature, and in a secured, labeled container. After giving Narcan® nasal spray, the staff member who gave it, must complete an Officer Statement and Observation Report (OSOR) and submit it to their supervisor for review and signature.

5.4 Administration of Narcan Nasal Spray

Narcan Nasal Spray shall only be administrated under the following conditions:

- An opioid overdose is suspected, and;
- The person has a decreased level of consciousness and/or distressed respiration.

5.5 Signs of opioid overdose:

- Gurgling or snoring sounds
- No movement (you can’t get the person to wake up)
- Severe sleepiness
- Trouble breathing or slow, shallow breathing
• Cold, clammy skin
• Lips and nails are blue
• Pupils are really small
• Trouble with walking or talking
• Choking or throwing up
• Seizures

5.6 Process for accessing and giving Narcan® nasal spray

If an opiate overdose is known or suspected staff will immediately retrieve the Narcan Nasal Spray from the nearest container and administer it as per the following:

1) Conduct an assessment and check for responsiveness
2) Check for signs of opioid overdose.
3) Call Emergency Medical Services (EMS) 911 in order to have the offender transported by ambulance to the hospital.
4) Provide First Aid/CPR
5) Remove Narcan® spray from the box. Peel back the tab with the circle to open the Narcan® nasal spray.
6) Hold the Narcan® nasal spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.
7) Gently insert the tip of the nozzle into either nostril. Tilt the person’s head back and provide support under the neck with your hand. Gently insert the tip of the nozzle into one nostril, until your fingers on either side of the nozzle are against the bottom.
8) Press the plunger firmly to give the dose of Narcan® nasal spray.
9) Remove the Narcan® nasal spray from the nostril after giving the dose.
10) Move the person on their side (recovery position).
11) Monitor the person closely.
12) If the person does not respond by waking up, to voice or touch, or breathing normally another dose of Narcan® nasal spray, every 2 to 3 minutes, may be given, if available.
13) Repeat steps 5 – 11 using a new Narcan® nasal spray to give another dose in the other nostril.
14) Whenever necessary, First Aid/CPR must be applied.

5.7 What are the possible side effects of NARCAN® Nasal Spray?

NARCAN® Nasal Spray may cause the following side effects: aggressive behavior, convulsions, body aches, diarrhea, increased heart rate, fever, runny nose, sneezing, goose bumps, sweating, yawning, nausea, vomiting, nervousness, restlessness, irritability, shivering, trembling, stomach cramping, weakness, increased blood pressure.
5.8 Use in Young Children and Pregnant Women

Health Canada would like to advise that the use of NARCAN® Nasal Spray in young children and pregnant women may not be appropriate. Other naloxone products, such as naloxone hydrochloride injection, may be more appropriate.

5.9 Ready Kits

A ready kit will be developed for assigned duty posts. This kit will contain the following items:

1) 4 doses of Narcan Nasal Spray;
2) 2 pairs of protective eyewear;
3) 6-N95 masks;
4) 8 pairs of protective Nitrile gloves;
5) First Aid breathing respirator.

Each kit must be secured with a plastic tie to ensure security and continuity of items. Kits shall not be maintained in a transport (x island) van. The driver, prior to the escort will retrieve the kit from the Duty Captains/Lieutenants office prior to an escort and return it upon completion of the escort.

5.10 Quality Control

It will be the responsibility of the Institutional Head to identify a manager or designated staff member to inspect, on a weekly basis each Ready Kit to ensure it has not been tampered with. The shelf life of each Naloxone Nasal Spray container is twenty four months. Outdated containers must be replaced immediately upon expiry.

5.11 Provision and Storage

Each Institutional Head will be responsible for identifying specific duty posts within their facility for placement of Ready Kits. The Ready Kits will be clearly identifiable secured containers which are easily accessible to staff.

5.12 Personal Protective Equipment (PPE)

The following Personal Protective will be available for all staff to ensure their safety:

1) Protective N95 masks (see Annex M for acceptable and non-acceptable facial hair);
2) Protective eyewear;
3) Nitrile gloves;
4) Tyvek suits, if required.
5.13 Replacement

If an item from a ready kit is used it must be immediately replaced. It will be the responsibility of the Duty Captain/Lieutenant to replace all missing items and secure the kit.

It shall be the responsibility of the OH &S Captain to ensure a suitable supply of all required Ready Kit items is available for all institutions.

5.14 Handling of Opioids

- Correctional staff shall treat all unknown tablets and powders as if they contain, or are, Fentanyl.
- Correctional staff shall not handle Fentanyl or any tablet or powder without wearing PPE.
- Correctional staff shall not taste, feel or smell Fentanyl or any unknown tablet or powder.
- Correctional staff shall not open any bags, packages or containers containing Fentanyl or an unknown substance allowing the substance to go airborne.
- Seizures of tablets and powders shall be double bagged using the appropriate size evidence bag and placed in an hard shelled container and secured. These containers must then marked “ALERT, May Contain Fentanyl”. These containers will then be handed over to the appropriate police agency for proper handling e.g. destruction or held as evidence.

5.15 Reports

A detailed OSOR must be submitted to the institutional head before end of shift whenever Narcan Nasal Spray has been administered, this report will include:

1) All relevant information explaining why Narcan Nasal Spray was used;
2) The number of doses used;
3) Other items that were used from the ready kit and require replacement.

5.16 Training

Training on the administration of Naloxone will be provided to all staff by way of information sessions, refresher sessions and updates shall be provide as required.
Adult Custody in partnership with the Center for Learning and Development (CLD) is responsible for maintaining an ongoing record of staff who receives training including refresher training and the personnel/agency that provided the training. Training shall include the following components:

- Overdose preventions
- General overdose knowledge
- Signs of opioid overdose
- Assessment skills to determine when Naloxone is to be administered
- Naloxone Nasal Spray administration
- Recovery Position and initiating and maintaining the persons airway (if required)
- Evaluation and after-care; and
- Care and storage of Naloxone Nasal Spray
- Fit testing for necessary personal protective equipment.

5.17 Accountability

All protocols are subject to review or revision at any time on an as-needed basis.

6.0 Nursing Policy: Administration of Naloxone

6.1 Overview:

Opioids are drugs derived from the opium poppy and include natural and synthetic products, such as Morphine, OxyContin and Methadone. Opiate use in the community is an issue within Canada and the province of Newfoundland and Labrador, and overdose deaths have risen sharply. These issues have led to the development of a strategy to decrease mortality associated with the use of these drugs. Strategies include the development of safe prescribing practices, introduction of new "safer" opioids, and improved access to Naloxone to treat suspected opioid overdose. As a result of these new policy directions, Naloxone is available for use in the pre hospital setting, including Adult Custody Facilities. Naloxone is listed as a Schedule 2 medication within the province of Newfoundland and Labrador, and does not require a prescription for use. It is reasonable to expect that staff within Adult Custody Facilities may be faced with the need to administer Naloxone, in light of their population. A number of inmates are currently receiving Methadone, and there is an intermittent, or weekend, population who may be at risk for overdose. In this regard, this policy is written to provide direction to nursing staff, including those who are contractual.

6.2 Policy:

Nursing staff within Adult Custody Facilities are authorized to administer Naloxone to treat an inmate who has a suspected or confirmed opioid overdose. All nursing staff must complete education to include the indications, contraindications, dosing, actions and side effects of Naloxone.

6.3 Procedure:

1) Upon notification of the suspected or confirmed overdose, obtain Naloxone and proceed to the inmate’s location.
2) Determine if the inmate is in opioid overdose, based on assessment of the following:

- decreased level of consciousness
- absence of respirations or decreased respiratory rate < ten per minute
- pupillary constriction
- slow, erratic or absent heart rate
- vomiting
- known or suspected opioid use

3) If inmate meets the criteria for suspected opioid overdose, call Emergency Medical Services (911)

4) Begin rescue breathing if respiratory rate is < ten. If pulse is absent, begin CPR.

5) Administer Naloxone 0.4 mg intramuscularly or via nasal spray. If no response after 2 or three minutes, repeat dose. The dose can be repeated as necessary.

5) Continue to assess and provide supportive care until the arrival of EMS personnel. Assess for side effects of drug withdrawal, which can include excitation, tachycardia, hypertension, dysrhythmias, nausea and vomiting, agitation, tremulousness.

6) Document treatment provided in the Medical Record

6.4 References:


a)
Potential copyright material

If you wish to obtain a copy please contact the ATIPP Office at (709) 729-7072 or atippoffice@gov.nl.ca.
Section 10: Health Care Services

Sub-Section: Communications - Notification of Illness

Policy

A standard communication procedure is to be implemented by each institution in relation to the serious illness of an inmate.

Directives

If an inmate has a serious illness or is required to be hospitalized for a serious illness, the Institutional Head or his/her designate shall ensure that the next of kin is notified at the time of hospitalization.

The next of kin shall be provided information about the illness in a compassionate and sympathetic manner.

The person providing such notification should not convey conclusions or opinions based on other than proven facts as provided by the attending physician.

The Officer-in-Charge or Institutional Head will advise the Superintendent should the illness requiring hospitalization be life threatening.
Section: Health Care Services

Sub-Section: Communications - Notification of Death – Next of Kin

Policy

In the event of the death of an offender, next of kin are to be notified immediately in a manner befitting the occasion by a person specifically trained in Crisis Counseling, which would typically be a member of the Pastoral Care Team.

Directive(s)

The Superintendent shall notify or cause to be notified the spouse, or if there is no spouse, the nearest relative of a prisoner who dies, is seriously ill or is certified insane, Prisons Regulations Section 4(g). Under normal circumstances, the notification of a next of kin will be done in person by a member of the Pastoral Care Team accompanied by the Institutional Head.

In the event that a Pastoral Care Team member cannot be contacted, notification shall be done by the Institutional Head. A police Chaplain may be contacted through the investigating agency to assist in delivering the notification with staff.

The person providing such information should do so in a manner befitting the situation and should not convey conclusions or opinions other than proven facts provided by the attending physician.

The location of the meeting with the next of kin should be selected to respect the dignity and privacy of the participants. Under normal circumstances, notification of the death of an offender would occur at the residence of the next of kin. The Institutional Head closest to the place of residence of the next of kin shall be responsible for notification and in cases where this is not possible, another law enforcement agency's assistance shall be requested.

The Superintendent or designate shall communicate with the next of kin in a timely manner following the notification of a critical incident to the next of kin:

- express appropriate concern for the situation
- if it is appropriate, to discuss disposition of personal assets and property.
Policy

Circumstances surrounding the death of an individual shall be documented in writing form by all staff members who possess knowledge related to the incident as per Emergency Response Plan.

Directive(s)

All personnel who possess information regarding the circumstances of a death in custody on institutional property or during a Temporary Absence from the institution shall complete an Officer Statement Observation Report (OSOR):

- any staff member on scene at the time of an incident leading to, or possibly related to, a death;
- any staff member discovering the body;
- any medical officer who attempted emergency life saving treatment or was present at the time.

The OSOR must be completed as soon as possible. It must include the following:

- specific details of the incident describing the reporter’s role;
- documented timing of events;
- observation of activities and names of persons on the scene.

OSOR’s should be forwarded to:

- Officer in Charge
- Institutional Head
- Superintendent of Prisons
Section 10: Health Care Services

Sub-Section: Communications – Death at a Correctional Facility

Policy

As soon as a death occurs in a correctional facility, the person in charge shall immediately notify a Medical Examiner and the police.

Directives

When an inmate dies in a correctional facility, the person in charge of the facility shall immediately notify a Medical Examiner and a member of the Royal Newfoundland Constabulary or Royal Canadian Mounted Police.

The Medical Examiner is to take possession of the body upon notification of death.

Unless required for the purpose of resuscitation, staff are instructed to refrain from any of the following without the consent of the Chief Medical Examiner or a Medical Examiner:

- clean or alter the body, clothing or any object attached to the body; or
- apply a chemical or other substance to the body (internal or external).
Section 10: Health Care Services

Sub-Section: Pharmaceuticals – Prescription Management

Policy

All pharmacy procedures will be managed in a cost-effective manner and adhere to applicable legislation and regulations relating to the utilization of controlled drugs and substances. Prescriptions will be issued in conformity with current standards applicable to the community.

Directives

No more than an estimated three months supply of any pharmaceutical requirements should be purchased.

Drugs should be purchased under their generic names wherever possible.

Disposable medical supplies shall be used wherever possible.

Prescription medication shall be issued only upon the order of a physician or nurse practitioner.

Over the counter drugs may be issued by correctional staff based on authorization from the Officer-in-Charge when the drug has been issued for the institution. All actions of this type must be recorded in the daily diary.

Verbal and telephone orders from a physician shall be entered in the inmate's medical file by a member of the medical staff.

The medical officer will enter in the inmate’s medical file all orders for medication. Each entry will indicate:

- the date the order was issued and schedule by which it is to be administered, dosage and duration;
- the name of the treatment.

All unused, old or outdated medication shall be returned to the supplier at a minimum of every ninety (90) days.
Section 10: Health Care Services

Sub-Section: Pharmaceuticals – Inventory

Policy

Inventory audits of all pharmaceuticals shall be conducted.

Directives

The Manager of Institutional Programs will ensure that procedures are in place to ensure:
- counts of dispensary stock of narcotics and controlled drugs are carried out daily and signed for;
- discrepancies are reported to the Institutional Head.

All narcotics and prescription drugs shall be inventoried on a regular basis, in accordance with medication standards.

Narcotics, prescription drugs, needles and syringes shall be inventoried by the staff member responsible for medication distribution.

Any losses or discrepancies shall be reported immediately to the Manager of Institutional Programs who will contact the Institutional Head.

If, after producing the appropriate identification and certification, federal inspectors wish to conduct an inspection of the medications supply, they are to be accorded all possible assistance, including access to appropriate records and storage areas.
Section 10: Health Care Services

Sub-Section: Pharmaceuticals – Administration of Medication

Policy

To ensure the safe and legal management, storage, recording, dispensing and administration of medication.

Directives

The Manager of Institutional Programs shall be responsible for the audit and monitoring of all elements of the institutional pharmaceutical process including:
- invoices from local pharmacies;
- medication incidents or errors;
- institutional medication trends; and
- prescribing practices of institutional clinicians.

The Manager of Institutional Programs will ensure all medical staff contracts are reviewed annually.

The Manager of Institutional Programs will ensure all medications are prescribed only by a clinician.

Entry to the dispensary and supplies area of the Medical Unit shall be restricted to members of the institution's medical staff and other approved personnel.

The procedure for the delivery of medication and supervision of issuance shall be set out in Institutional Standing Orders.
Section 10: Health Care Services

Sub-Section: Pharmaceuticals – Medication Distribution

Policy

Medications shall be distributed only by authorized staff on a scheduled basis with appropriate regard for proper record-keeping requirements.

Directives

Personnel who dispense medication shall check the medication order and the medication prior to its administration.

Any medication which is dispensed shall be recorded on the inmate's medical record, showing:

- the name and dosage of the medication;
- time of dispensing
- refusal to take any medication
- name of the person dispensing the medication.

A register of medication issue and supply will also be completed daily documenting:

- name of inmate
- name and dosage of medication
- name of person dispensing medication.

Where there is no nursing coverage, non-medical staff members shall deliver medications to inmates.

Medication shall be stored in appropriate individual containers or blisters, labeled with the inmate's name, names of medications, dosage, date of issue and name of physician who ordered the medication.

Medications prescribed for one inmate shall not be given to another inmate.

A small stock of non-prescription pharmaceuticals shall be maintained at each correctional centre and lock-up to be dispensed when required. Records of dispensation must be recorded.

Medication brought in by or for a newly admitted inmate shall be stored and the appropriate personnel consulted regarding prescription renewal.

Medication incidents and drug reactions shall be reported immediately to the medical officer, the Officer-in-Charge, the Institutional Head and the Manager of Institutional Programs.
Medications shall be prescribed only when indicated and shall never be used for disciplinary or control purposes.
Policy

The decision to prescribe medication is a medical judgment based upon clinical assessment.

Directives

The long term use of minor tranquilizers and analgesics subject to abuse will be discouraged and only prescribed when clinically indicated.

While the Adult Custody Branch cannot interfere in the doctor-patient relationship or with the treatment regime, there is a responsibility to seek justification from the institutional physician if there is an impression that there is too much reliance on behaviour-modifying drugs, either on an individual or institutional basis.

It is the valid responsibility of the Superintendent and the Institutional Heads to impress upon the medical officer any concerns they may have regarding a possible over-reliance on certain prescription drugs.

When appropriate, it may be necessary to refer the patient for psychiatric assessment and evaluation of the patient’s medication needs.
Section 10: Health Care Services

Sub-Section: Pharmaceuticals – Security and Storage

Policy

Proper control and security practices shall be implemented and maintained for the storage and issuance and documentation of all medications, drugs and narcotics.

Directives

The management, control, storage, documentation and dispensing of drugs and medical supplies shall be in accordance with generally accepted management practices.

The nurse or staff member responsible for dispensing medications will ensure that all receipts and issues of medications, drugs and narcotics are entered into a daily medication log.

All syringes and needles shall be secured at all times in areas supervised by medical staff or correctional officers.

Needles and syringes shall be disposed of in a Sharps Container and incinerated or collected at regular intervals.

Inmates who self-administer medication by injection must be kept under observation by a staff member during the procedure.
Section 10: Health Care Services

Sub-Section: Health Care Equipment - Prostheses

Policy

To provide essential prostheses at no cost to inmates when failure to provide these services would adversely affect the inmate’s health, personal safety or rehabilitation.

Directives

Inmates requiring specialized health care equipment, such as prostheses, have the right to seek appropriate medical referral to obtain same.

Cosmetic or otherwise elective treatment is not to be provided free of charge and is the inmate’s financial responsibility.

Any decision regarding the provision of prostheses should not be influenced by the length of incarceration.

When medical personnel determine that the inmate’s health and well being is in jeopardy, a referral shall be sought to the appropriate medical specialist to determine the necessity of specialized prostheses.

Prostheses must be requested by professionals specifically trained to assess the need for such equipment.
Section 10: Health Care Services

Sub-Section: Health Care Equipment – Dental and Vision Care and Audiology Entitlements

Policy

To provide proper dental care, vision care and audiology services at no cost to inmates when failure to provide these services would adversely affect the inmate’s health, personal safety or rehabilitation.

Directives

Every inmate has the right to seek dental care, vision care and audiology treatment.

Cosmetic or otherwise elective treatment is not to be provided free of charge but is the inmate’s financial responsibility.

Any decision regarding the provision of dental services or devices, eye care services or devices and hearing care or devices should not be influenced by the length of incarceration.

Dental Care

Referrals to a fully qualified dentist may be initiated by:

- the inmate;
- the institutional nurse or other designated medical personnel;
- the presiding licensed practitioner.

When medical personnel, a dentist or Superintendent determines that cosmetic dental enhancements to the inmate’s appearance would have a considerable bearing on the inmate’s rehabilitation, the Superintendent may authorize the provision of necessary treatment or devices at no cost to the inmate if available resources allow expenditures.

Vision Care

If an optometrist or ophthalmologist determines that an inmate’s health or safety is at risk, or the inmate’s health will deteriorate, or it is a prerequisite to the inmate’s full participation in institutional programs, the Adult Custody Branch will provide eyeglasses at no cost to the inmate.

When eyeglasses are provided by the Branch, the frames and lenses shall be standard in design; any enhancements in style will be the financial responsibility of the inmate. The schedule for the provision of eyeglasses will be consistent with the current policy of the Department of Human Resources, Labour and Employment (HRLE).
Audiology Services

If an audiologist or medical specialist determines that an inmate’s health or safety is at risk, or the inmate’s health will deteriorate, or it is a prerequisite to the inmate’s full participation in institutional programs, the Division of Corrections and Community Services will provide a hearing aid(s) at no cost to the inmate.

When hearing aid(s) are provided by the Division, it shall be standard in design; any enhancements in style will be the financial responsibility of the inmate.
Section: Health Care Services

Sub-Section: Medical Records – Information Management

Policy

To establish and maintain medical records for each inmate as a means of communication and documentation among health care personnel which will contribute to patient’s care.

Directive(s)

Records will be maintained by health professionals detailing the date each inmate confers with the medical practitioner and/or psychiatrist. Every significant interaction between the inmate and a member of the health services team will be recorded.

A separate medical file will be established and maintained on behalf of each inmate admission to a correctional facility.

The inmate medical file containing all relevant medical information pertaining to the inmate will be maintained and updated by medical staff on a continuous basis.

These records shall be maintained and accessed in the manner as outlined in the Institutional Standing Orders of each respective facility and in accordance with all relevant legislation regarding the protection of privacy.

In the context of a therapeutic association, the confidential relationship between physician and patient extends to inmates and the presiding licensed practitioner.

Unauthorized disclosure of an inmate’s medical record is legally actionable.

Medical personnel shall breach confidentiality only when they must report information regarding a threat or intention which they believe is likely to happen and which is dangerous or a threat to the safety of the inmate or others.

Medical information is not to be released to a third party without the inmate’s written consent.

Any person other than those authorized to seek access to a medical file shall be required to provide the following information:
- the specific information being sought;
- the purpose for which it will be used;
- the timeframe during which the information will be used, i.e. when the information is to be considered valid.
Any medical information disclosures and the reasons for the disclosures are to be recorded in the inmate's medical file.

It shall be the responsibility of health care personnel to ensure that a copy or summary of the medical file, in addition to a printed copy of the Health Status Form from PCOMS, accompanies any inmate who is transferred to another correctional or health care facility.

Security personnel should give health care staff as much advance notice as is possible of any impending inmate transfer.

The inmate medical file shall be enclosed in an envelope and marked as follows: “CONFIDENTIAL – TO BE OPENED BY HEALTH CARE STAFF ONLY”

A written summary of the inmate's special health needs should be made available to the correctional officer providing escort. This information will detail:

- medication needs during transit;
- special medical problems or needs, such as diabetes or epilepsy;
- psychiatric problems, especially suicidal tendencies;
- handicaps which may require special attention during transit.