Examples of Standard Formats
Jail Standards Commission
August 12, 2022

American Correctional Association (ACA)

What Does This Mean for Accreditation?

Guided by a review of significant incidents and a report that examines conditions of confinement, the Commission on Accreditation for Corrections currently examines issues that affect the life, health, and safety of staff and offenders. As data is collected for the new outcome measures, the Commission will have more information about *actual* and ongoing operations. More important, *you* will have an important new management tool.

II. The Fundamentals of Performance-Based Accreditation

ACA's performance-based accreditation are comprised of several elements:

- GOAL STATEMENT (one for each functional area)
- PERFORMANCE STANDARDS (as many as are needed to achieve the goal)
- OUTCOME MEASURES (for each performance standard)
- EXPECTED PRACTICES (for each performance standard)
- PROTOCOLS
- PROCESS INDICATORS

These elements are defined and described in Table 2.

TABLE 2: Definitions of Terms for Performance-Based Accreditation

Element	Definition
Goal Statement	General statement of what is sought within the functional area.
Performance Standard	A statement that clearly defines a required or essential *condition* to be achieved and maintained. A performance standard describes a "state of being," a condition, and does not describe the activities or practices that might be necessary to achieve compliance. Performance standards reflect the program's overall mission and purpose.
Outcome Measure	Measurable events, occurrences, conditions, behaviors or attitudes that demonstrate the extent to which the condition described in the performance standard has been achieved. Outcome measures describe the *consequences* of the program's activities, rather than describing the activities themselves. Outcome measures can be compared *over time* to indicate changes in the conditions that are sought. Outcome measure data are collected continuously but usually are analyzed periodically.

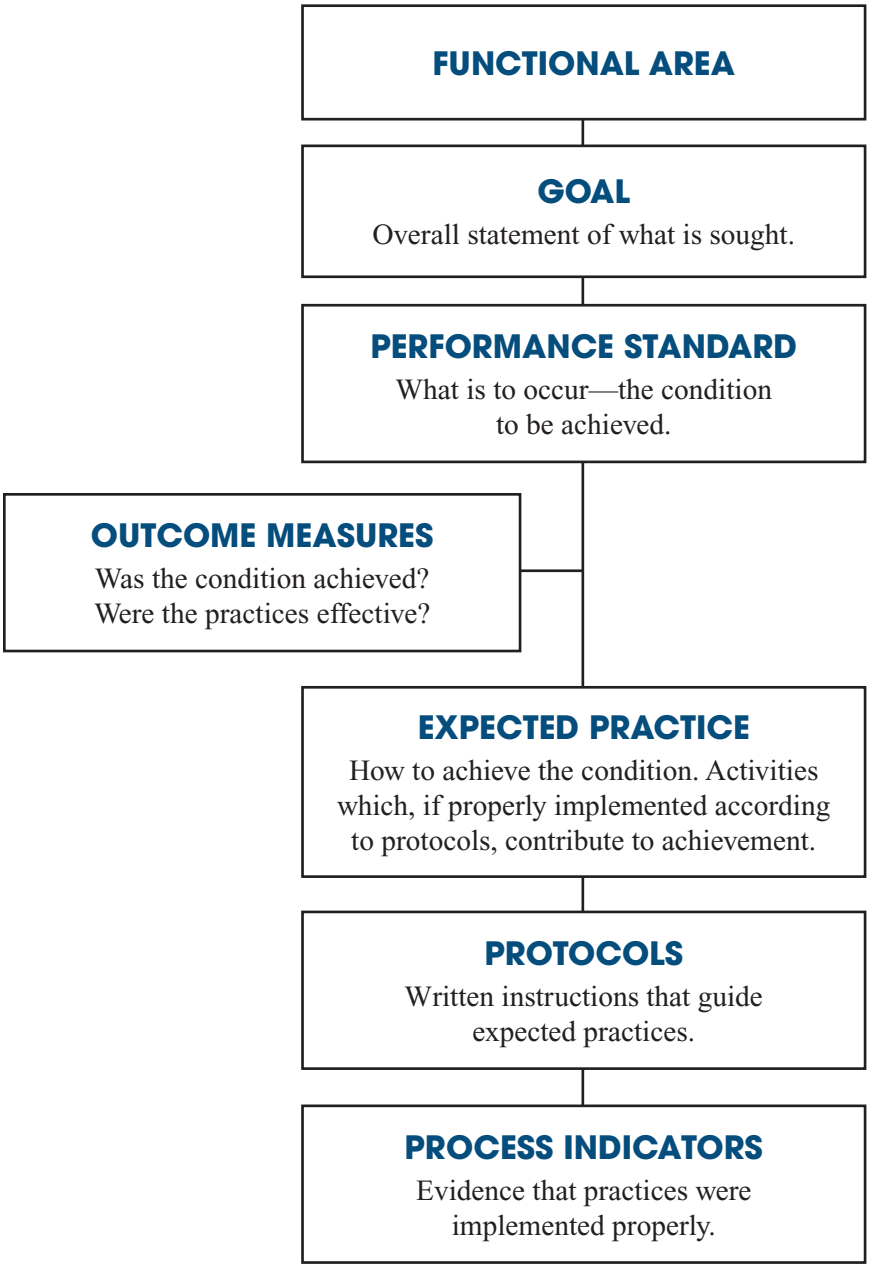
(continued)

TABLE 2: Definitions of Performance-Based Accreditation (continued)

Element	Definition
Expected Practice(s)	Actions and activities that, if implemented properly, will produce the desired outcome. What we *think* is necessary to achieve and maintain compliance with the performance standard—but not necessarily the *only* way to do so. Activities that represent the current experience of the field, but that are not necessarily supported by research. As the field learns and evolves, so will expected practices.
Protocol(s)	Written instructions that guide implementation of expected practices, such as: polices/procedures, post orders, training curriculum, formats to be used such as logs and forms, offender handbooks, diagrams such as fire exit plans, internal inspection forms.
Process Indicators	Documentation and other evidence that can be examined periodically and continuously to determine that practices are being implemented properly. These tracks, or footprints, allow supervisory and management staff to monitor ongoing operations.

The following diagram (Table 3) attempts to describe the functional relationships among the elements.

TABLE 3: Functional Relationship of Performance-Based Accreditation Elements



GOAL STATEMENT

Perhaps the least-appreciated element of the template, the goal statement attempts to establish an overall purpose for the performance standards in the functional area.

PERFORMANCE STANDARD

A performance standard is a statement that clearly defines a required or essential *condition* to be achieved and maintained. A performance standard describes a "state of being," a condition, and does not describe the activities or practices that might be necessary to achieve compliance. Performance standards reflect the program's overall mission and purpose and contribute to the realization of the goal that has been articulated.

Because performance standards are so fundamental and basic, it is less likely that they will require frequent revision. But as the field continues to learn from experience, it is predicted, and even hoped, that the expected practices that are prescribed to achieve compliance with the performance standards will continue to evolve.

OUTCOME MEASURES

Outcome measures are quantifiable (measurable) events, occurrences, conditions, behaviors, or attitudes that demonstrate the extent to which the condition described in the corresponding performance standard has been achieved. Outcome measures describe the *consequences* of the organization's activities, rather than describing the activities themselves.

Because outcome measures are quantifiable, they can be compared *over time* to indicate changes in the conditions that are sought. Measurable outcome data is collected continuously but is usually analyzed periodically. The first time you measure an outcome, you establish a point of reference. By comparing the next measurement (weeks or months later), you can identify progress, or lack of progress toward the desired outcome.

The first time you generate outcome measures, they may not mean much to you but their value grows every time you measure. The second time you measure outcomes, you will be able to compare current outcomes to those that you measured in the past. In this way, outcome measures become a valuable management tool. Over time, the series of outcome measures that you calculate can provide invaluable insight into many aspects of your operation. Sometimes, they will provide you with important "red flags" that identify troubling trends.

EXPECTED PRACTICES

Expected practices are actions and activities that, if implemented properly (according to protocols), will produce the desired outcome—achievement of the condition described in the performance standard.

Expected practices represent what the practitioners *believe* is necessary to achieve and maintain compliance with the performance standard—but may not be the *only* way to achieve compliance. These activities represent the best thinking of the field, supported by experience, but often are not founded on research. As conditions change and as we learn from our experience, we expect practices to evolve.

It is arguable that expected practices *should* be changed over time to reflect our growing body of knowledge and experience. On the other hand, it is likely that we will see much less change with the overarching performance standards, which are more basic and fundamental.

WHAT DOES THIS MEAN FOR ACCREDITATION?

Agencies applying for accreditation under the performance-based format will be required not only to submit the data from the outcome measures at the time of their audit, they also will be required to submit the data *yearly* as part of their annual report. The original outcome measures will be used to establish baseline data and each year's ensuing report will be added to the database. As each agency is considered for reaccreditation, the Commission on Accreditation for Corrections will review the historical data over the three-year period as well as the data generated by the most recent audit. When the Commission renders an accreditation decision, the outcome measures as well as levels of compliance with the expected practices will be considered as part of the *totality of conditions* of the system.

5-2C-4139-1 **(New Construction after June 2014). Inmates have access to operable showers with temperature-controlled hot and cold running water, at a minimum ratio of one shower for every 12 inmates, unless national or state building or health codes specify a different ratio. Water for showers is thermostatically controlled to temperatures ranging from 100 degrees Fahrenheit to 120 degrees Fahrenheit to ensure the safety of inmates and to promote hygienic practices.**

Comment: None.

Protocols: Written policy and procedure. Facility plans/specifications.

Process Indicators: Observation. Measurement. Inspection reports. Maintenance records. Documentation of periodic measurement of water temperature. Inmate grievances. Inmate interviews.

Housing for the Disabled

5-2C-4142 **Inmates with disabilities are housed in a manner that provides for their safety and security. Housing used by inmates with disabilities is designed for their use and provides for integration with other inmates. Programs and services are accessible to inmates with disabilities who reside in the facility.**

Comment: If the facility accepts individuals with disabilities, it must provide for their housing and use of facility resources. Housing includes, but is not limited to, rooms, sleeping areas, furnishings, dayrooms, toilets, washbasins, showers, and other common elements. An offender with a disability should not be placed in a special unit (for example, the infirmary, security room, or protective custody) that cannot accommodate the offender's disability. Program and service areas include, but are not limited to, exercise and recreation areas, visiting rooms, classrooms, dining rooms, commissary/canteen, telephone facilities, library, reception and classification areas, chapel, and administrative areas where appropriate.

Protocols: Written policy and procedure. Facility plans/specifications.

Process Indicators: Observation. Inmate records. Interviews. Inmate health records.

5-2C-4143 **Written policy, procedure, and practice provide for the assignment of appropriately trained individuals to assist disabled offenders who cannot otherwise perform basic life functions.**

Comment: None.

Protocols: Written policy and procedure. Job descriptions. Staffing plans. Training curriculum.

Process Indicators: Staff assignment rosters. Staff training records. Qualifications of persons assigned to assist disabled inmates.

5-2C-4144 **Written policy, procedure, and practice provide education, equipment and facilities, and the support necessary for inmates with disabilities to perform self-care and personal hygiene in a reasonably private environment.**

Comment: A "reasonably private" environment will vary, depending on individual and institutional circumstances, but is one which will maintain the dignity of the disabled individual in light of that person's disability.

Protocols: Written policy and procedure. Facility plans/specifications.

Process Indicators: Observation. Inmate interviews.

National Commission on Correctional Healthcare (NCCHC)

SECTION B
HEALTH PROMOTION, SAFETY, AND DISEASE PREVENTION

Standards in this section address the need to optimize education, safety, and preventive care. Policies and procedures related to these standards require involvement by all facility staff.

J-B-01
important

HEALTHY LIFESTYLE PROMOTION

Standard

Health care policies, procedures, and practices emphasize health promotion, wellness, and recovery.

Compliance Indicators

1. Health staff document that patients receive individual *health education* and instruction in *self-care* for their health conditions.
2. General health education (e.g., pamphlets, news articles, video, classes) is accessible to all inmates.
3. The facility provides a *nutritionally adequate* diet to the general population.
4. A *registered dietitian nutritionist* (RDN), or other licensed qualified nutrition professional, as authorized by state scope of practice laws, documents a review of the regular diet for nutritional adequacy at least annually.
5. The facility has a procedure in place to notify the RDN whenever the regular diet menu is changed.
6. Health staff promote and provide education on exercise and physical activity options in the facility.
7. Smoking is prohibited indoors. If the facility allows smoking outside, specific areas are designated.
8. Information on the health hazards of tobacco is available to inmates.
9. All aspects of the standard are addressed by written policy and defined procedures.

Definitions

Health education is information on preventing illness, self-care for an existing health condition, and maintaining a healthy lifestyle.

Self-care refers to care for a condition that can be treated by the patient and may include over-the-counter medications.

A *nutritionally adequate* diet incorporates current American Heart Association diet and lifestyle recommendations and U.S. Department of Agriculture dietary guidelines, consistent with the current Dietary Reference Intakes for age, gender, and activity levels of the population.

Registered dietitian nutritionist is a term adopted by the Commission on Dietetic Registration for optional use by registered dietitians and is equivalent to the "registered dietitian" designation still in use.

Discussion

Efforts should be made to educate patients in self-care strategies and to promote healthy lifestyle choices among all inmates. The health education may be provided by health staff, program staff, custody staff, the dietitian, or volunteers. Patients can benefit from individual instruction in self-care and in ways to maintain optimal health. This individual education may be the primary source of health education.

In addition to one-to-one health teaching and counseling during health encounters, all inmates should receive opportunities to enhance their knowledge of health and healthy lifestyles, including nutrition, exercise, and personal hygiene. Facilities with specialized populations or with longer lengths of stay should provide a variety of resources and opportunities for learning about health-related topics. General health education methods may include classes, reading material, or electronic media. Written material such as pamphlets or posters is often available in bulk quantities from community-based organizations. Facilities with in-house video channels may show programs on health matters. Educational programs for adolescents should be age and gender specific.

The following are suggested topics for health education:

a. Alcohol and other drug problems
b. Chronic diseases and disabilities
c. Comprehensive family planning, including services and referrals
d. Counseling in preparation for release
e. Effects of smoking, use of tobacco products, and smoking cessation
f. Hepatitis (A, B, and C)
g. HIV infection and AIDS
h. Immunizations
i. Keep-on-person medications
j. Nutrition
k. Parenting skills
l. Perinatal care
m. Personal hygiene
n. Physical fitness
o. Prevention of sexual or other physical violence
p. Preventive oral health care
q. Sexually transmitted infection
r. Stress management
s. Tuberculosis

The general menu should offer options for a heart-healthy diet. A heart-healthy diet plan emphasizes foods and beverages that are low in saturated fat, trans fat, and sodium; minimizes red meat and sugar-sweetened items; and is rich in fiber.

While serving a nutritionally adequate diet may substantially reduce the need for individual medical diets, patients with certain health conditions still require individual medical diets (see D-05 Medical Diets).

Recognizing the evidence that the use of all tobacco products and exposure to secondhand smoke are dangerous to health, it is recommended that facilities undertake prevention and cessation efforts such as health education, self-help classes, and informational digital media. The use of e-cigarettes is known to be detrimental to the user but the effects of secondhand vapor is unknown and is not addressed in this standard. Organizations such as the American Cancer Society, the American Lung Association, the American Dental Association, and the American Heart Association have resources to help facilities develop prevention and education programs.

J-B-07 COMMUNICATION ON PATIENTS' HEALTH NEEDS

essential

Standard

Communication occurs between the facility administration and treating health staff regarding inmates' significant health needs that must be considered in classification decisions in order to preserve the health and safety of that inmate, other inmates, or staff.

Compliance Indicators

1. Correctional staff are advised of inmates' special health needs that may affect:
   a. Housing
   b. Work assignments
   c. Program assignments or selection
   d. Disciplinary measures
   e. Transport to and from outside appointments
   f. Admissions to and transfers from facilities
   g. Clothing or appearance
   h. Activities of daily living
2. Communication of health needs is documented.
3. All aspects of the standard are addressed by written policy and defined procedures.

Discussion

Communication between custody and health staff helps make both groups aware of special considerations with inmate movement and decisions regarding special needs patients. Medical or mental health problems, medication, and treatments may complicate housing assignments, work assignments, program assignments, disciplinary management (see G-02 Segregated Inmates), or transfers to another facility.

Health and custody staff should communicate about accommodations for inmates with special needs conditions that may include, but are not limited to, the following:

a. Chronic diseases (see F-01 Patients With Chronic Disease and Other Special Needs)
b. Dialysis
c. Communicable diseases
d. Physical disability
e. Pregnancy
f. Frailty or old age
g. Terminal illness
h. Mental illness
i. Suicidal intent
j. Developmental disability

k. Intellectual disability
l. Physical or sexual abuse
m. Physical or mental contraindications to restraint or seclusion
n. Gender dysphoria, transgender

Communication on the special needs of adolescents in adult facilities is also essential.

Special clothing or appearance needs include shaving, hair length, transgender issues, and so forth when the health of the inmate would otherwise be adversely affected as determined by the responsible physician.

Other ideas?

<u>Standard</u>: Disabled individuals will be appropriately housed in the least restrictive and most integrated setting appropriate to meet their needs in a manner consistent with applicable law.[1]

Elements:

- People with disabilities will not be segregated on the basis of their disability (ex. Housed on a "mental health unit" or "ADA unit")
- People with disabilities will not be housed in medical unless they are actually receiving medical treatment.
- Reasonable accommodations and modifications will be made to ensure that people with disabilities have equal access to all programming, services, activities and benefits offered.
- No one shall be discriminated against or denied access on the basis of a disability.

Compliance Indicators:

- The facility does not contain any housing units identified as serving only those with disabilities.
- No one is held in a medical unit unless they are receiving medical care.
- Disabled people have access to all of the same programs, activities, services and benefits as the non-disabled.
- People with mobility limitations have access to ADA accessible: housing, showers, toilets, dining area, and all other areas required to access appropriate programs and services.
- No one is placed in a more restrictive setting on the basis of disability alone.
- Appropriate assistive devices are provided (ex. Shower chairs, mobility devices, hearing aids, etc.)

[1] *See* 28 C.F.R. § 35.152