UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF FLORIDA

UNITED STATES OF AMERICA, **Plaintiff,** **v.** **MIAMI-DADE COUNTY; MIAMI-DADE COUNTY BOARD OF COUNTY COMMISSIONERS; MIAMI-DADE COUNTY PUBLIC HEALTH TRUST** **Defendants,**	**1:13-CV- 21570 CIV** **The Honorable Beth Bloom**

Report No. 9 of the Independent Monitors

August 24, 2018

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This is the ninth report of the independent Monitors regarding Miami-Dade County's and the Public Health Trust's compliance with both the Settlement Agreement (effective April 30, 2013) and the Consent Agreement (effective May 22, 2013).

Since the last compliance tour in December 2017, the County proposed to the Court, and the Court accepted a Summary Action Plan (as amended) to expeditiously bring the Defendants into compliance with the Consent Agreement. The activities related to this Summary Action Plan included production of documents, review of these documents by the Monitors, meet and confer to discuss the submissions, corrective actions by the Defendants, and notification to the Court of compliance with the specific requirements of the Summary Action Plan. An outcome of a finding of non-compliance in April 2018 resulted in a sanction which was for the Defendants to hire experts to assist with compliance activities. These experts were engaged in May of 2018, and have been on-site to assist the County. No sanctions were imposed as the result of submissions after the April 2018 documents.

The Independent Monitors report that the volume of work required of the Defendants to produce the required documentation for the Summary Action Plan, based on the schedule the County provided to the Court, and the work by the Monitors to review and comment on the materials has been substantial. For example, the submissions for the April, June and July deadlines resulted in 568 documents related to 88 paragraphs. It is anticipated that the August – November deadlines for production of materials will also be less extensive. This information is provided to highlight the commitment of all parties to address the compliance issues. The concerns by the Monitors, and the Defendants, are that the pace of change associated with these initiatives and the requirements of sustainability.

The parties were given additional time to review this draft report following the compliance tours to clarify information and provide additional relevant details. The draft of this report was provided to all parties on July 31, 2018, with a requested date to return comments of August 21, 2018. The Monitors closely considered the comments from all parties in the finalization of this report, as well as reviewing materials, provided pre-and-post tour. We appreciate the candid and clear responses of all parties, and the report is improved because of this.

The Monitors thank the leadership of MDCR Director Dan Junior and CHS Corporate Director Edith Wright. We also extend our thanks to: Deputy Mayor Maurice L. Kemp, and, and Don Steigman, Chief Operating Officer, Jackson Health System for their time in meeting with the independent Monitors and their advice and actions. We also extend our thanks to the leadership teams from both organizations.

A summary of compliance status, by paragraph, for each agreement is provided as follows:

The narratives for both the Settlement Agreement and the Consent Agreement provide the analyses of findings, work accomplished to date, and recommendations. [1]

[1] The work of the monitoring team is assisted by subject matter experts: Nancy A. DeFerrari, B.S., CJM, Angela Goehring, R.N., M.S.A., C.C.H.P., and Catherine M. Knox M.N., R.N., CCHP-RN.

Report of Compliance
Settlement Agreement

Introduction

Compliance Report #9 describes Miami-Dade Corrections and Rehabilitation's (MDCR) efforts toward reaching compliance the requirements in the Settlement Agreement.

After Compliance Tour #8, the Monitor requested that MDCR begin the process of assessing and documenting their own compliance with the provisions of the SA through self-audits and critical reviews. This approach is the process by which MDCR will demonstrate sustainability of the changes made by the organization in the last five years. As noted below, this approach had mixed results.

Summary of Compliance - Settlement Agreement
As of Compliance Tour # 9

Report #					Total
1	1	26	23	6	56
2	7	27	22	0	56
3	13	31	10	2	56
4	23	32	0	1	56
5	30	26	0	0	56
6	30	26	0	0	56
7	53	3	0	0	56
8	37	19	0	0	56
9	42	14	0	0	56

Protection from Harm - Remaining Initiatives/Challenges

Reported Incidents

The continuing challenges for MDCR is inmate/inmate violence in the facilities. MDCR has developed a process to evaluate and "drill-down" into the causes of the altercations, and identify countermeasures and plans to address the findings of their analyses. As would be anticipated, there is a need for mid-course corrections and consideration of different approaches. As the initiatives and strategies developed require sequencing, and some ideas are more difficult to develop and implement (e.g. including staff training), the initiatives have not yet, by MDCR's own acknowledgement, reached the level at which the desired results have been achieved.

The Monitor's report regarding the specific provisions of the Settlement Agreement provides the data regarding uses of force and inmate/inmate violence.

Of remaining concern are uses of force involving inmates on the mental health caseload, and the application of tactics to deescalate the situation, absent an emergency. Sixty-nine percent (69%) of uses of force for the first quarter of 2018 (N=214) involved inmates on the mental health caseload. In another set of data, MDCR reported that 81% of incidents (as opposed to individual inmates) involved inmates on the mental health caseload. This data is confusing, and the Monitor recommends that the two data sources be reviewed and clarified.[2]

Since, and including the last compliance tour of December 2017, there have been five inmate deaths; three related to acute drug toxicity, and two in which the medical examiner's report is not complete. The introduction of highly toxic drugs, easily hidden, into jails around the country has been an on-going challenge for jail administrators. The two deaths in early December 2017 resulted in approval to purchase screening equipment for the inmate booking area. This equipment is being operationalized at this time.

Staffing

The Director reports that the County's administration supports the staffing identified as a result of the 2018 staffing analysis. It is now up to the Board of County Commissioners to approve the budget.

While there has been notable improvement in the County's administrative response to the needs of MDCR, the Monitors suggest that priority be given to filling vacancies as fast as is practical, especially those related to the anti-violence initiatives, fire life safety, and sanitation.

Classification

The Monitor recommended in Compliance Report # 8 " . . . that the County immediately contract with a subject matter expert to evaluate the current inmate classification processes, identify future needs, develop a validation plan (with and without the implementation of the new offender management system – see below), manage the collaboration in risk assessment for CHS and MDCR, assure that appropriate written directives and associated training materials are developed, and train/mentor staff."

The County is just now negotiating with a subject matter expert.

While MDCR embarked on data analyses of classification information using available software (e.g. Watson), this has not replaced the need for the input of a subject matter expert. The data presented to the Monitor is interesting and points to the

[2] The first set of data is from the violence report for the first quarter of 2018; the second set of data is from the response to resistance incidents self-audit for the first quarter of 2018.

need for further review and recommendations. As noted in other compliance reports, the Monitor is concerned that the level of violence in the facilities might be related to the effectiveness of the classification system. The recent addition of inmate disciplinary information into reclassifications, and the plan to add gang affiliation are improvements.

Most all of the strategies/countermeasures to address violence involve classification. The language of the Settlement Agreement regarding classification (SA III.A.1. (2)) provides that the Monitor annually reviews the classification system to determine if the system accomplishes the " . . . goal of housing inmates based on level of risk and supervisory needs." The Monitor remains unable to determine this based on currently available data.

Investigative Capacities and Protection from Harm

In Compliance Report # 8, the Monitor recommended a thorough review of the processes, staffing, and supervision of internal investigations in MDCR – those involving allegations of staff misconduct, excessive uses of force, and inmate violence/critical misconduct.[3] The Director and the Deputy Mayor reviewed the Monitor's recommendations and are re-implementing the gang unit, and exploring assignment of cross-certified staff in MDCR to conduct investigations, relieving the police department of the responsibilities. The initiatives are not yet implemented, and the Monitor will review the efforts again during the next compliance tour. As noted in this report, in the first quarter of 2018, 43% of the reasons for inmate/inmate assaults was undetermined. As 48% of uses of force are used to break up inmate/inmate altercations, accurately investigating the reasons for these assaults is of important to the level of violence.

Inmate Grievance Process

Following compliance tour # 8, MDCR and CHS established a grievance task force to review the grievance processes and develop an action plan. This work resulted in changes to the process, including the placing of grievance boxes in all inmate housing units, and better coordination with CHS.

The Medical and Mental Health Monitors have assessed the companion paragraphs in the Consent Agreement to be in partial compliance; hence as it is the same grievance process, the relevant section in the SA is in partial compliance. The Medical and Mental Health Monitors are encouraged by the progress, but find that the strategies are too new to evaluate in terms of impact, and need the County to demonstrate sustainability of the new initiatives.

[3] Settlement Agreement, III. A. 5. e.

Violence Countermeasures

As noted above, MDCR has engaged in aggressive data driven strategies to address violence. This work is proceeding expeditiously; but not yielding the desired results. The Monitor suggested to MDCR that the work be sequenced, as the accomplishment of the goals is really influenced by what work is completed when. For example, a significant finding in the analysis is that the inmate disciplinary process requires attention. Other elements of the action plan are proceeding, but it may be that until the disciplinary issues are solved that other actions will not find success. Adoption of direct supervision philosophies as a strategy to address violence also require alignment with these initiatives with current operations, for example, how inmate housing units are managed, and the role and responsibilities of officers and their authority better defined.

Offender Management System

As noted in all previous compliance reports, MDCR is the eight largest local jail system in the United States and is working with an information system that is woefully outdated and inadequate. The County's plan to agree that the inmate telephone vendor would provide a management system, free of charge, if the telephone contract was approved for inmate telephones has not proven successful. Almost four years later, the vendor is in default of their commitment and the County/MDCR must start over with identifying a new vendor. This *significant* delay impacts all areas of operation. Related to compliance with the Settlement Agreement, it is especially important for classification. MDCR has done a credible job of piecing together various software options to provide data.

Obtaining and Sustaining Compliance

A compliance coordinator was hired in early 2017 to oversee and coordinate the work related gaining compliance with both the Settlement Agreement and Consent Agreement. She resigned from the position in February 2018. This position remains vacant, with the Chief of the division designated as responsible for the compliance-related work, along with her other duties. The Monitor urges the County to expeditiously fill the position. The Monitor's view is that the results of this tour are reflective of the need for this additional laser-like focus on assistance with, production of, and review of compliance-related materials.

Collaboration with CHS

The Monitors remain convinced that the leadership of CHS and MDCR are equally committed to collaboration and mutual problem-solving. This message and actions have been slow to seep throughout both organizations. The newly named Corporate CHS director brings a wealth of experience and leadership to the position.

Fire and Life Safety

These provisions of the Settlement Agreement remain in compliance. The suggestions of the sub-Monitor are that MDCR do more *analysis* of the source logs and data. Only maintaining logs without review and corrective actions, as needed, is not productive.

Self-Audits and Critical Self-Analysis

In anticipation of Compliance Tour #9, MDCR provided deliverables to the Monitor based on a self-audit schedule agreed to in January 2018. As noted above, MDCR provided self-audits of critical paragraphs of the Settlement Agreement. The purpose of these audits are to demonstrate not only compliance with the Settlement Agreement, but adherence to MDCR's own policies and procedures and sustainability. These audits and reviews included:

- Improvements in data collection (III.D.1.2.)
- Countermeasure (III.A.5.c. (11) (14))
- Early warning system (III.A.6.a.b.)
- Classification (III.A.1.a.(2))
- Rounds conducted by staff; logs; and welfare checks (III.A.1.a. (3)(4) (6) (7))
- Shakedowns (III.A.1.a.(8))
- Training for staff transferred and those working in special management units (III. A. a. (9) (10))
- Staffing for medical escorts (III.A.2.b.)
- Chemical control, security equipment (III.A.5.c. (13))
- Early warning system (III.A.6.)
- Inmate grievances (III.C.)
- Outcomes of staff discipline related to allegations of inappropriate or excessive uses of form (III.A.6.a.)
- Fire drills and related staff training (III.B.4.)
- Supervision of chemicals and inmate and staff training (III.B.5.)

MDCR is commended for production of this work. As an initial effort, the work is credible, and identified areas that need improvement which most likely would not have been found without the audits. When MDCR found deficiencies, they were so reported. In most cases, where deficiencies were identified, action plans were developed. As the process evolves, the audits will be more accurate, and the scope of the action plans broadened.

The deficiencies identified in many of the County's self-audits impacted the findings of compliance in this report. The County argues in its response to changes in compliance noted in draft report #9 that the County's self-audits should not be considered by the Monitor: (1) because the methodology of the audits was flawed; and/or (2) the findings were incorrect: and/or (3) the audits are not included in the measures of compliance, and therefore not "required". The Monitor's findings and reasons are identified in the relevant paragraphs. Generally, the Monitor rejects the position that just, because the audits were

not part of the measures of compliance, they should not be considered in determining compliance. If the County wished to object to the production of the specific self-audits identified in Compliance Report # 8, it should have done so in January, 2018. The goal of producing these self-audits was for the County to begin to demonstrate that they had the capacity for self-monitoring, leading to compliance, and sustainability of compliance.

Sufficient time has not passed between the production of the action plans and the compliance tour to assess the success of the activities. This is the self-analyses and critical review of operations that will sustain compliance with the provisions of the Settlement Agreement and accepted correctional practices. The Monitor will follow-up prior to the next compliance tour.

The Monitor suggested that the Compliance and Inspection Bureau develop and publish a schedule for audits; and this has been done. The Monitor will notify MDCR of the audits she would like to see prior to the next compliance tour, to avoid duplication of work. Additionally, the Monitor suggests that as the process is implemented: (1) a format be developed for the audit reports; (2) assignment of sufficient leadership review of the final drafts to pose other questions and/or suggest other recommendations; and (3) that as many management staff be involved as reasonable to inculcate this approach (e.g. self-critical analysis) through the organization. Only through implementing such this process will the organization sustain the improvements.

There are four paragraphs in the Settlement Agreement which collectively speak to the issues of data collection, analysis, corrective actions, compliance and sustainability. These are:

> III. A. a. (11) - MDCR shall continue its efforts to reduce inmate-on-inmate violence in each Jail facility annually after the Effective Date. If reductions in violence do not occur in any given year, the County shall demonstrate that its systems for minimizing inmate-on-inmate violence are operating effectively.
>
> III. A. 5.c. (12) - Every 180 days, MDCR shall evaluate use of force reviews for quality, trends and appropriate corrective action, including the quality of the reports, in accordance with MDCR's use of force policy.
>
> III. D. 2. - 2. Bi-annual Reports
>
> a. Starting within 180 days of the Effective Date, MDCR will provide to the United States and the Monitor bi-annual reports regarding the following:
>
> (1) Total number of inmate disciplinary reports
>
> (2) Safety and supervision efforts. The report will include:
>
> i. a listing of maximum security inmates who continue to be housed in dormitory settings;
>
> ii. a listing of all dangerous contraband seized, including the type of contraband, date of seizure, location and shift of seizure; and
>
> iii. a listing of inmates transferred to another housing unit because of disciplinary action or misconduct.

(3) Staffing levels. The report will include:
   i. a listing of each post and position needed at the Jail;
   ii. the number of hours needed for each post and position at the Jail;
   iii. a listing of correctional staff hired to oversee the Jail;
   iv. a listing of correctional staff working overtime; and
   v. a listing of supervisors working overtime.

(4) Reportable incidents. The report will include:
   i. a brief summary of all reportable incidents, by type and date;
   ii. data on inmates-on-inmate violence and a brief summary of whether there is an increase or decrease in violence;
   iii. a brief summary of whether inmates involved in violent incidents were properly classified and placed in proper housing;
   iv. number of reported incidents of sexual abuse, the investigating entity, and the outcome of the investigation;
   v. a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit;
   vi. number of inmate grievances screened for allegations of misconduct and a summary of staff response; and
   vii. number of grievances referred to IA for investigation.

b. The County will analyze these reports and take appropriate corrective action within the following quarter, including changes to policy, training, and accountability measures.

IV. B. - The County shall develop and implement written Quality Improvement policies and procedures adequate to identify and address serious deficiencies in protection from harm and fire and life safety to assess and ensure compliance with the terms of this Agreement on an ongoing basis.

At this time, two of the paragraphs are assessed in compliance (III.A.5.c. (11)-(12), and the other paragraphs are assessed in partial compliance.

The Monitor closely reviewed the MDCR's self-audits, referenced above, the pre-tour and post-tour documentation, and referred to meetings held during the on-site compliance tour.[4] While it is absolutely acceptable to continually assess strategies and provide mid-course corrections, there is no sustainable successful findings to MDCR's work to this point. As noted in the documents reviewed, many audits/reports were provided just prior to, or on-site during the compliance tour or just after the tour (revised reports). While this new information is appreciated by the Monitor as an indication of MDCR's attention, it has few

[4] The documents reviewed, included, but were not limited to: PowerPoint presentation regarding Response to Resistance (RTR) and Battery on Inmate (BOI) Reduction Initiative, MDCR Court Corrections Provision SA III.A.1.a (11) Updated July 5, 2018, MDCR Inmate Violence Countermeasures Implementation Matrix – Updated 7/4/18, Quarterly Review of Response to Resistance Reports, Updated July 5, 2018, MDCR Course Corrections, 7/9/18, Quality Improvement Procedures and Protection from Harm, dated June 8, 2018, Inmate Classification System Analysis and Refinement (presentation and notebook) dated July 7, 2018.

sustainable outcomes, at this point. In fact, many of the elements of the action plans have dates through the end of 2018.

The work that MDCR needs to conclude, include, but is not limited to:

- Complete the review of the underlying causes of inmate/inmate violence, including a full and complete assessment of the effectiveness of the current inmate classification system.
- Improve investigations of inmate/inmate violence in order to determine, to the best of the investigator's abilities, the circumstances contributing to the violence.
- As noted above, sequence the countermeasures to provide a more realistic plan to address violence. (For example, addressing the deficiencies in the inmate disciplinary system as an underlying cause of inmate actions, recognizing until that matter is addressed, results of the application of other strategies may not yield reliable information.)
- Produce action plans with increased accountability and the production of underlying data to support conclusions/outcomes.
- Provision/scheduling of employee training related to the reduction strategies. For example, the Compliance Report has included recommendations for direct supervision training for staff for several years, which is not fully underway at this time.
- Implement improved investigations, training of investigators, and inclusion of gang-related data.
- Implement the Quality Improvement Procedures and Protection from Harm, dated June 8, 2018, including schedules for auditing. Committees, meetings, and other collaborations are important, but do not replace the data collection and analysis needed to support the Quality Improvement program.
- As noted in this, and previous Compliance Reports, address the quality and substance of quarterly, biannual and annual reporting, focusing on the data that is relevant to leadership decision making and corrective actions. Analyze the data, discuss the implications, develop findings and recommendations, and prepare and implement corrective action plans.

MDCR has, in the Monitor's view, the capacity to reach compliance on these important areas, but needs a clear assessment of current operations and organization, and implementation of any changes based on the leadership's review of this assessment.

Link Between Consent Agreement and Settlement Agreement

The County, in their response to the draft reports, now and in the past, objects to the Monitors' assessing compliance of paragraphs in the Settlement Agreement based on the findings of companion/related paragraphs in the Consent Agreement. For example, if the inmate grievance-related requirements of the CA are found in partial compliance, then the Monitor reviewing compliance with the provisions of the SA finds grievance-related paragraphs in partial compliance. The rationale for this approach is that: the County is the

defendant, not individually MDCR and CHS; these are single processes, not separate processes (for example, MDCR and CHS share the grievance process); and, finally, gaining and sustaining compliance requires successful collaboration between MDCR and CHS.

Next Steps

MDCR's priorities include developing and implementing strategies that reduce inmate/inmate violence and uses of force. Hiring a full-time compliance coordinator, with sufficient authority to coordinate work is essential. Sequencing the corrective actions is important to achievement of goals. Production of self-critical audits/reviews will assure that MDCR itself identifies non-compliance matters for their own policies, and takes corrective actions. This approach, involving managers, will help assure that this becomes part of the internal culture of the organization.

9th Compliance Tour - Settlement Agreement - Summary of Compliance
Tour the Week of July 9, 2018[1]

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
Safety and Supervision				
III.A.1.a. (1)	x			1. Complete internal audit, quality compliance/improvement directive. 2. Develop an audit schedule, format, and review process for drafts. 3. Assure that corrective action plans are developed, as needed, for findings in the audits. 4. Assure that audits are completed per MDCR policy, and not for the "DOJ monitors" – which, if referenced at all should be correctly labeled as Independent Monitors.
III.A.1.a. (2)		x		1. As the offender management system vendor is selected and implemented, revise the processes for validation. Assure that staff are trained, and that there is significant leadership review and oversight of the findings and action plans, if needed. 2. As noted in Compliance Report number 8, by the next tour, provide the required annual update, including findings, recommendations, and if needed, a corrective action plan.
III.A.1.a. (3)		x		1. Implement the corrective action plan and provide the findings prior to the next on-site compliance tour. 2. Engage in better editing of the findings of the audits, and conclusions to align with the data.
III.A.1.a. (4)	x			1. Re-audit findings in terms of compliance with MDCR policies on this matter.
III.A.1.a. (5)	x			1. Assure that recommendations from TAAP regarding cameras (repairs, relocation, new) are considered by MDCR leadership and acted on as deemed appropriate. Assure there is documentation regarding decisions. 2. MDCR should evaluate/audit the timeliness of repairs for cameras located in critical areas (e.g. IRB, mental health unit.)
III.A.1.a. (6)		x		See III.A.1.a.(3)
III.A.1.a. (7)		x		See III.A.1.a.(3)
III.A.1.a. (8)		x		1. For the audit dated June 7, 2018, complete the work (rather than just plan to conduct the work), develop measurable corrective actions, as needed, implement before the next tour.

[1] See also Attachment A for the history of compliance for each paragraph.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
				2. Develop better data reporting as to recoveries and the number of shakedowns as well as how the information is reported and analyzed. 3. Audit the specific provisions of this paragraph and/or otherwise demonstrate compliance (i-iv) 1. Provide an update of the outcome of the action plan dated July 5, 2018.
III.A.1.a. (9)	x			1. Re-do the audit for all of 2018 prior to the next tour. 2. Provide the results/outcomes of the action plan (may be included as part of the audit.) 3. Given the findings regarding current CPR certifications of employees (Consent Agreement III. C. 8. d.), MDCR should audit this training as well.
III.A.1.a. (10)	x			Provide an update of the action plan dated June 5, 2018 prior to the next on-site compliance tour.
III.A.1.a. (11)		x		1. As a suggestion, continue to refine the Quarterly/Annual violence reports to eliminate charts and rather use narratives; and especially eliminate the charts where there is no data reported (e.g. zero or a low number of events). The narrative analyses of the data provides the foundation for the findings and recommendations; the charts and graphs perhaps can be relocated to an appendix. This will streamline/shorten the report, and allow focus on the most critical findings. The analysis should consider avoiding comparisons of per incident rate (for example uses of force per 1,000 bookings, or uses of force per 1,000 inmates) as this bases for comparison has no foundation in terms of relevance except as a measure of prevalence. The use of the analyses should be reviewed for relevance – for example Figure 149 – in terms of what it displays and the usefulness to developing countermeasures and plans of action. There are pages and pages of charts, with no descriptions, findings, or notes regarding the relevance and potential use of the data. 2. The use of performance indicators to determine good performance, for example Figures 150a and 150b are questionable. How the performance measure was selected, and the relevance is unexplained. As noted elsewhere in this report, while targets/benchmarks may be desirable, the objective needs to be have a factual or data-driven anchor. The Monitor has made this observation before, and no further information has been provided as to the data or behavioral anchors called performance objectives. For example, in figure 150a – the performance measure appears to be 225 inmate/inmate incidents as somehow an acceptable number. This requires an explanation. If for example, MDCR reaches a reported 220 inmate/inmate incidents per quarter, is that then the acceptable, "good", level for the agency? MDCR continues to note it checks with

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
				other larger jails to determine their numbers of incidents in MDCR's efforts to determine benchmarks. While perhaps interesting, the use of data from other jails is extremely problematic as there are no uniform national (or even state) definitions of incidents and/or behaviors, no uniform policies governing self-reporting, no assessment of the validity of the reporting in other jails, nor how other jails train and/or audit their reporting. 3. Continue to refine measures; insure that implementation of critical factors, such as the inmate disciplinary system, be finalized. It is not possible to evaluate options until the "package" of reform has been put into place. 4. The continued level of violence suggests that the classification system is not working. This has not yet been analyzed. This work should be undertaken as soon as possible. While a full validation study is ultimately the goal, interim review of how classification contributes to safety needs to be done. While MDCR continues to document a very low "mis-classification" of inmates, the methodology is not provided. Further, the level of disorder in the facilities seems to suggest that classification most likely is a contributing factor. 5. Refine the countermeasure initiatives. The use of reports without explanation, analysis or findings is not helpful. 6. Assure that staffing of critical areas to support violence reduction is a priority for the County. 7. Continue to decrease the finding of "undetermined" for the reason for inmate/inmate violence; the same recommendations as included in the last compliance report.
Security Staffing				
III.A.2. a.	x			1. Assure that the County's human resources bureaucracy handles requests with a level of urgency, especially for positions related to violence reduction (e.g. counselors) and clinic and infirmary cleanliness (maintenance workers.) 2. MDCR may include calendar year 2018 data to document how long it takes from the time of a resignation until an individual is hired, as documentation of this collaboration.
III.A.2. b.		x		1. Conduct a complete audit as to how data is collected, analyzed, and the development of a meaningful action plan. 2. Prior to the next compliance tour, the County should identify the accurate data, and if necessary provide a corrective action plan.
III.A.2.c.	x			
III.A.2.d.	x			See III.A.2.a. See also CA III.C.7.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
Sexual Misconduct				
III. A.3.	x			1. The County is encouraged to conduct annual reviews of on-going PREA compliance in anticipation for the next formal audit; including implementation of recommendations as contained in the self-audit dated April 26, 2018. Monitor will follow-up at the next tour. 2. Review/document the MDPD's SVU's collaboration with CHS' mental health providers, pursuant to the Director's memo of May 23, 2018. Monitor will follow-up at the next tour. 3. Prior to the next tour, MDCR should review the management of transgender inmates; provide any findings and, in necessary, provide plans of action.
Incident and Referrals				
III. A.4 a.	x			1. See recommendations in III.A.1.a. (1)
III.A.4. b.	x			
III.A.4.c.	x			1. Assure the request for proposal and subsequent award processes insure that relevant paragraphs of both the Settlement Agreement and Consent Agreement, including interfaces with Cerner and other CHS data system, are required as part of any new system.
III.A.4.d.		x		1. Provide a more complete audit of findings, specifically how many staff may need training remediation and the length of time, and number of training sessions which have used outdated materials and lesson plans. 2. Prepare a corrective action plan that includes due dates, responsible parties, and how success is measured. See also CA provision III. B. 3. b. and c.
III.A.4.e.	x			1. Prior to the next on-site tour, MDCR is requested to conduct an audit of this provision. See recommendation for III.A.4.f.
III.A.4.f.	x			1. Consider conducting a more complete audit of findings, specifically how many staff may need training remediation and the length of time, and number of training sessions which have used outdated materials and lesson plans. 2. Prior to the next tour, report on the results of the corrective action plan (July 3, 2018).
Use of Force				
III.A. 5 a.(1) (2) (3)	x			1. Develop facility-specific plans to address the increases in uses of force (and inmate/inmate violence) 2. Provide training to all staff working with inmates (all levels) on the mental health caseload.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
				1. Continue re-envisioning Metro West to its original direct supervision design; develop that plan as well as what skills and strategies can be expanded. 2. New Recommendation – Assure that "de-escalation techniques" are not limited to verbal commands in non-emergency situations.
III.A.5. b. (1), i., ii, iii, iv, v, vi (2)	x			1. Prior to the next tour, provide an update on the elements of improved internal investigative capacity at MDCR based on the April 1, 2018 memorandum; including any corrective actions or revised plans.
III.A. 5. c. (1)	x			No recommendations at this time other than to consider the TAAP findings when MDCR conducts the annual evaluation of the policy.
III.A. 5. c. (2)		x		1. Prior to the next tour, provide an update on the elements of improved internal investigative capacity at MDCR based on the April 1, 2018; including any corrective actions or revised plans.
III.A. 5. c. (3)	x			1. Provide updated training for facility leadership to improve reviews prior to the next tour.
III.A. 5. c. (4)		x		See III.A.5.c. (3)
III.A. 5. c. (5)	x			1. Review the process to assure compliance with this paragraph. If the policy needs amendment, do so; if the training is an issue; provide training. Provide update prior to the next compliance tour..
III.A. 5. c. (6)	x			1. Develop relevant lesson plans, testing mechanisms, and provide documentation of training prior to the next tour. 2. Provide a training/re-training plan for CHS and, if necessary, MDCR staff. 3. Assess the outcomes of audit Tool # 30 for additional training needs See CA III.B.3.b.
III.A. 5. c. (7)	x			
III.A. 5. c. (8)	x			1. Repeat/update the audit for the last six months of 2018 and develop a corrective action plan, if indicated. 2. Include data in the audit, rather than language such as "a large percentage"; which cannot be measured in terms of progress.
III.A. 5. c. (9)	x			
III.A. 5. c. (10)	x			See CA III.B.3.b.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
III.A. 5. c. (11)	x			1. Update and revise the action plan to include how success is measured. There seems to be more attention to the physical plant than to the knowledge and skills of staff working in the mental health units particularly. The report should also assess the injuries that are a result of the underlying inmate/inmate altercation (as appropriate) versus the injury related to a use a force by MDCR. 2. Involve CHS' behavior health staff in the initiative. 3. De-escalation is more than just verbal commands. Review, revise and update training materials.
III.A. 5. c. (12)	x			
III.A. 5. c. (13)	x			1. Repeat/update the audit for the last six months of 2018. 2. Report on the corrective action prior to the next tour (can be part of the audit). 3. Be sure to date all audit reports.
III.A. 5. c. (14)	x			
III.A.5. d. (1) (2) (3) (4)	x			1. Provide the outcome of the 2018 testing prior the next compliance tour; provide the schedule for the annual testing for 2019 prior to the next tour.
III.A.5. e. (1) (2)	x			1. Assure that newly designated/assigned investigators receive training; provide documentation prior to the next compliance tour.
Early Warning System (EWS)				
III.A.6. a. (1) (2) (3) (4) (5)		x		1. Prior to the next compliance tour, provision of: a. Evidence (minutes, etc.) of how the information is used by leadership to make changes, (3) above; b. Regarding (5) ii and iii above – computation of the data, or an explanation of why it is not provided; or another alternative; c. Provision of the additional information noted by MDCR in the provision of documentation for this tour – that being a field audit has been scheduled to assess the effectiveness of the trainings that were conducted on the EWIS System back in May 2018. A make-up training is also occurring July 20, 2018, for those that were not available for the May trainings, this training will also include the Chiefs. d. MDCR will provide a revised policy/procedure (draft is acceptable); e. The recommendations for change to the program since moving it to the Regulatory and Compliance Division, and if those recommendations were implemented (action plans acceptable); f. Any benchmarks or measurable objectives established for the EIS; g. The training lesson plan(s) for facility based staff in EIS; h. The schedule for training; and

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
				i. Data indicating if changes to the process are achieving benchmarks or measurable objectives.
III.A.6.b.	x			See recommendations III.A.6. a.
III.A.6.c.		x		1. Prior to the next tour, identify the elements that indicate that the EWS is successful, and produce a report assessing its effectiveness.
Fire and Life Safety				
III.B.1.	x			
III.B.2.	x			
III.B.3.	x			
III.B.4.	x			
III.B. 5.	x			1. Ensure all inventory forms for chemicals are clear on what is being counted i.e. ounces, bottles, cases, cans etc.
III.B.6	x			
Inmate Grievances				
III.C. 1.,2.,3.,4.,5.,6.		x		1. Implement action plan of Grievance Committee; update findings prior to the next on-site compliance tour. See also III.A.3.a.(4) and III.D. 1.b.
Audits and Continuous Improvements				
III.D.1. a. b.	x			1. Update the reporting to match requirements of this paragraph. 2. Establish self-monitoring to address inmates' constitutional rights or the risk of constitutional violations. MDCR, as noted above, is encouraged to self-monitor and to take corrective action to ensure compliance with constitutional mandates in addition to the review and assessment of technical provisions of the Agreement.
III.D. 2. a. b.		x		1. See recommendations for III.D.1.a.b.
Compliance and Quality Improvement				
IV. A.	x			1. See previous recommendations about amending (editing/shortening) the quarterly and annual reports to include relevant data, analyses, and action plans, as necessary.
IV. B.		x		1. Assess the quarterly and annual reports for utility to the County. Determine how the data is used in decision-making, and amend accordingly. Assess the human resources used in this work compared to the return on investment. 2. Coordinate this assessment with CHS' data keeping and QA/QI processes. Determine what data can be jointly collected, analyzed, and how plans of action/countermeasures are developed, implemented and assessed for effectiveness. 3. See recommendations for III.D.1.a.b.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
IV. C.	x			
IV. D.	x			

Compliance Report - Settlement Agreement
Findings – Tour July 9 - 11, 2018

III. A. PROTECTION FROM HARM

Consistent with constitutional standards, the County's Jail facilities shall provide inmates with a reasonably safe and secure environment to ensure that they are protected from harm. The County shall ensure that inmates are not subjected to unnecessary or excessive force by the County's Jail facilities' staff and are protected from violence by other inmates. The County's Jail facilities' efforts to achieve this constitutionally required protection from harm will include the following remedial measures regarding: (1) Safety and Supervision; (2) Security Staffing; (3) Sexual Misconduct; (4) Incidents and Referrals (5) Use of Force by Staff; and (6) Early Warning System.

Paragraph	III. A. 1. Safety and Supervision: a. MDCR will take all reasonable measures to ensure that inmates are not subjected to harm or the risk of harm. While some danger is inherent in a jail setting, MDCR shall implement appropriate measures to minimize these risks, including: (1) Maintain implemented security and control-related policies, procedures, and practices that will ensure a reasonably safe and secure environment for all inmates and staff, in accordance with constitutional standards.			
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16	Partial Compliance: 3/28/14, 7/19/13, 10/24/14, 1/8/16	Non-Compliance:	Other: Per MDCR not reviewed in 5/15
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Manual of security and control-related policies, procedures, written directives and practices, consistent with Constitutional standards and contents of the Settlement Agreement. 2. Internal audits. 3. Documentation of annual review(s). 4. Schedule of review for policies, procedures, practices.			
Steps taken by the County to Implement this paragraph:	MDCR has implemented security and control-related policies and procedures, however, MDCR's own audits reveal significant deficiencies.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR's own audits demonstrate that there is a gap between policy/procedures and operational practices. MDCR is commended for conducting these audits, and identifying the deficiencies. Repeats of audits are requested in this compliance report.			
Monitor's Recommendations:	1. Complete internal audit, quality compliance/improvement directive. 2. Develop an audit schedule, format, and review process for drafts. 3. Assure that corrective action plans are developed, as needed, for findings in the audits. 4. Assure that audits are completed per MDCR policy, and not for the "DOJ monitors" – which, if referenced at all should be correctly labeled as Independent Monitors.			

Paragraph	III. A. 1. Safety and Supervision: (2) Within 90 days of the Effective Date, conduct an inmate bed and classification analysis to ensure the Jail has adequate beds for maximum security and disciplinary segregation inmates. Within 90 days thereafter, MDCR will implement a plan to address the results of the analysis. The Monitor will conduct an annual review to determine whether MDCR's objective classification system continues to accomplish the goal of housing inmates based on level of risk and supervision needs.			
Compliance Status:	Compliance:	Partial Compliance: 7/11/18, 12/7/17, 3/3/17, 10/24/14, 7/29/16, 7/11/18	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	See below.			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Completion of a bed and classification analysis. 2. Post-study housing plan. 3. Annual report by Monitor of the objective classification system and housing plan. 4. Data provided by MDCR regarding outcomes/impact of classification system.			
Steps taken by the County to Implement this paragraph:	The County's vendor for the offender management system has not fulfilled their commitments, and has advised the County that they, the vendor, GTL, will bear the costs of whatever vendor the County selects to develop a system. The GTL contract for a Jail Management System was signed on July 11, 2014. This would also be the official start date for work on this system. There were negotiations with Miami-Dade County for this system (scope of work included in the contract) that started in March 2014. The go live date in the contract was July 2016. This has put MDCR behind at least five years, and directly impacted the ability to collect and analyze data need to validate the classification system. To address this provision, the County has provided a memorandum dated April 2 with a snap shot of classification on March 31st. The report provided several recommendations, but there is no indication if these recommendations were considered or implemented. Also provided were a housing plan as of March 31st, and bed classification analysis and risk analysis of maximum security inmates, for the period July 1 – September 30, 2017. The County's position is that a validation study is outside the language of the Agreement, and that the materials provided are sufficient. The validation study recommendation and the County's understanding of the need for this work has been included in every compliance report – even if the Monitor concurred with the County's position, the element of the requirement is not met at this time -that being: inmate safety and the relationship to classification and housing. See below – the Monitor's determination.			
Monitor's analysis of conditions to assess compliance, verification of	The materials provided, with the exception of the April 2nd summary, do not include findings or recommendations. The Monitors have long expressed concern about the level of violence and how that might be related to the classification			

the County's representations, and the factual basis for finding(s)	system. Other than noting if inmates were properly classified at the time of incidents, there has been no evidence produced that the underlying system resulting in those classifications are valid. This is a continuous security risk. MDCR provided a presentation on July 10th demonstrating the use of "Watson" analytics and the classification data, including correlations. In the absence of the gang information, the data might not be as helpful as it will be in the future. While the presentation indicated relevant work on the issue of whether the system keeps inmates and staff safe, the Monitor's take-away was that more analyses are needed, as well as preliminary working hypothesis developed. The County has indicted after Compliance Report #8 that it would retain a subject matter expert to assist to review the system and engage in subsequent validation. The contract to engage the expert was not executed prior to this on-site tour. The Monitor notes it is, based on the language of this paragraph, the Monitor's responsibility to determine if the system accomplishes the goal of keeping inmates safe. At this time, the Monitor determines that there is insufficient information/data to make this determine, in spite of eight reports with recommendations. The level of inmate/inmate assaults, the absence of a meaningful gang assessment of arrestees/inmates, the County's commitment to hire a subject matter expert to assist with validation are all indicators of the recognition by all parties of this important work. The Monitor also notes, that while the work to date is seminal, the absence of meaningful analysis of the findings, and lack of specific action plans makes the information, at this point, interesting, but not informing operations. Therefore, the finding relative to this paragraph is partial compliance, not based on whether a validation study is completed or not, but the Monitor's inability to make a determination of whether the classification system houses inmates based on legitimate risk and supervision needs.
Monitor's Recommendations:	1. As the offender management system vendor is selected and implemented, revise the processes to assist with validation. 2. Assure that classification staff are trained, and that there is significant leadership review and oversight of the findings and action plans, if needed. 3. As noted in Compliance Report 8, by the next tour, provide the required annual update, including findings, recommendations, and if needed, a corrective action plan.

Paragraph	III. A. 1. Safety and Supervision: (3) Develop and implement a policy requiring correctional officers to conduct documented rounds, at irregular intervals, inside each housing unit, to ensure periodic supervision and safety. In the alternative, MDCR may provide direct supervision of inmates by posting a correctional officer inside the day room area of a housing unit to conduct surveillance.			
Compliance Status:	Compliance: 12/7/17, 3/3/17, 7/29/16, 10/24/14	Partial Compliance: 7/11/18, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16.
Unresolved/partially resolved issues from previous tour:	None			
Measures of Compliance:	Protection from Harm: 1. Policies and procedures requiring conduct of rounds. 2. Review of housing unit logs. 3. Review of staffing in housing units through observation and logs. 4. Interviews with inmates, employees.			
Steps taken by the County to Implement this paragraph:	MDCR conducted an audit of the provisions of this and III.A.1. (4), reviewing documents for the period October – December 2017. The audit is dated May 4, 2018. The findings of the audit indicated general compliance with policy provisions at Metro West, with concerns identified missing 11% of 30 minute checks in safety cells; for PTDC, 81% of 60 minute checks conducted, and 63% of checks for safety cells documented; and for TGK, significant areas of non-compliance – 20% of checks undocumented for the juvenile units; 44% of 15-minute checks in mental health units non-compliant, 25% of 60 minute checks noncompliance for the general population; 26% of checks for safety cells non-compliant, and 69% of supervisory checks (2 per shift) not documented. Analysis by MDCR of the information includes concerns about wi-fi reception related to the tablets and battery life used to document checks, not raised until the audit. The issue about the tablets is also raised for TGK. Based on discussion of the findings during the on-site tour, MDCR produced an updated audit and audit plan dated July 19, 2018. MDCR concluded that the audit results submitted to the Monitor were "misleading", and note that MDCR will be implementing corrective action and conduct another audit.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The audit is a good first step toward self-critical analysis of MDCR's policies and procedures related to inmate supervision/safety. The Monitor is concerned that the findings of the May 4th audit, documenting non-compliance with this paragraph, upon discussion, were then found to be inaccurate and misleading, with an action plan developed (July 19, 2018). The County's maintains that the audits conducted pursuant to demonstrating sustainability of compliance with this paragraph were not "required" as a measure of compliance, and as such should not be used to determine the current compliance rating. The County now states that the results of their audits were "overinflated", and so informed the Monitor. This is true; the Monitors was informed. The Monitor finds this argument is not compelling given that the County could have reviewed, amended or edited the findings prior to providing to the Monitor.			

	The Monitor is impressed by the fact that MDCR acknowledges that the audit was incorrect, but the confusion on this matter results in a finding of partial compliance with this paragraph. The Monitor asked for supplemental documentation about when issues with wi-fi and battery life of tablets used at TGK had been previously documented, as a measure of leadership knowledge and action. No additional information was provided by MDCR. The Monitor noted, however, that one of the morbidity and mortality reviews of a death at TGK included information about the tablets. Nonetheless these were reports provided by the County, and stand as documentation. After five years of compliance initiatives, the County is aware of the significance of materials provided to the Monitor and should appropriately review submissions for accuracy. The need for a full-time compliance manager is thus demonstrated. See also CA III. C. 6. a. (1)
Monitor's Recommendations:	1. Implement the corrective action plan and provide the findings prior to the next on-site compliance tour. 2. Engage in better editing of the findings of the audits, and conclusions to align with the data.

Paragraph	III. A. 1. Safety and Supervision: (4) Document all security rounds on forms or logs that do not contain pre-printed rounding times. Video surveillance may be used to supplement, but not replace, rounds by correctional officers.			
Compliance Status:	Compliance: : 7/11/18, 12/10/17, 3/3/17, 7/29/16, 5/15/15	Partial Compliance10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 1/16.
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures on reporting and logging. 2. Policy on use of video surveillance. 3. Review of staffing in housing units through observation and logs. 4. Interviews with inmates, employees, examination of logs.			
Steps taken by the County to Implement this paragraph:	See SA III.A.1.a. (3)			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See also III.A.1.a. (3) The May 4, 2018 audit identified that incorrect forms were used for supervisory accountability. No findings were made regarding whether pre-printed times were contained in the "red books". No findings were made regarding compliance or not with the provisions of DSOP 11-020. The County's maintains that the audits conducted pursuant to demonstrating sustainability of compliance with this paragraph were not "required" as a measure of compliance, and as such should not be used to determine the current compliance rating. The compliance with this paragraph will remain in compliance; pending a re-audit. The fact that the incorrect forms were used, is an important finding going to the heart of enforcement of current policy, supervisory oversight, and sustainability.			
Monitor's Recommendations:	1. Re-audit findings in terms of compliance with MDCR policies on this matter.			

<table>
<tr><td>Paragraph</td><td colspan="4">III. A. 1. Safety and Supervision:
(5) MDCR shall document an objective risk analysis of maximum security inmates before placing them in housing units that do not have direct supervision or video monitoring, which shows that these inmates have no greater risk of violence toward inmates than medium security inmates. MDCR shall continue to increase the use of overhead video surveillance and recording cameras to provide adequate coverage and video monitoring throughout all Jail facilities to include:
i. PTDC – 24 safety cells, by July 1, 2013
ii. PTDC – 10B disciplinary wing, by December 31, 2013; kitchen, by Jan. 31, 2014;
iii. Women's Detention Center – kitchen, by Sept. 30, 2014;
iv. Training and Treatment Center - all inmate housing units and kitchen, by Apr. 30, 2014;
v. Turner Guilford Knight Correctional Center – kitchen; future intake center; by May 31, 2014; and
vi. Metro West Detention Center – throughout all areas; by Aug. 31, 2014.</td></tr>
<tr><td>Compliance Status:</td><td>Compliance: 7/11/18, 12/10/17, 3/3/17, 7/29/16, 10/24/14</td><td>Partial Compliance: 3/28/14, 7/19/13</td><td>Non-Compliance:</td><td>Other: Per MDCR not reviewed in 5/15, 1/16.</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><u>Protection from Harm:</u>
1. Re-classification screening documentation for inmates moved to maximum security housing that does not have direct supervision or video monitoring.
2. Plan to increase video surveillance and recording capacity; implementation dates; contracts; evidence of completion on required dates; plan of action if dates specified in the Settlement Agreement for completion not met.</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="4">Various TAAP reports note that the location and number of cameras should be reconsidered based on the findings of the review. There is no information as to the outcome of those recommendations.</td></tr>
<tr><td>Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)</td><td colspan="4">The Monitor requested evidence of camera repairs and was provided with a Facilities Management Bureau Electronic Tech Work Order for the first quarter of 2018. As these repairs are done in-house, a listing was provided.</td></tr>
<tr><td>Monitor's Recommendations:</td><td colspan="4">1. Assure that recommendations from TAAP regarding cameras (repairs, relocation, new) are considered by MDCR leadership and acted on as deemed appropriate. Assure there is documentation regarding decisions.
2. MDCR should evaluate/audit the timeliness of repairs for cameras located in critical areas (e.g. IRB, mental health unit.)</td></tr>
</table>

Paragraph	III. A. 1. Safety and Supervision: (6) In addition to continuing to implement documented half-hour welfare checks pursuant to the "Inmate Administrative and Disciplinary Confinement" policy (DSOP 12.002), for the PTDC safety cells, MDCR shall implement an automated welfare check system by July 1, 2013. MDCR shall ensure that correctional supervisors periodically review system downloads and take appropriate action with officers who fail to complete required checks.			
Compliance Status:	Compliance: 12/10/17, 3/3/17, 7/29/16, 10/24/14, 3/28/14	Partial Compliance: 7/11/18, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures governing welfare checks. 2. Implementation of an automated welfare check system in PTDC by 7/1/13. 3. Policies and procedures regarding management of data generated from automated welfare check system, including re-training and corrective action. 4. Review of incidents from housing units in which automated welfare check system is deployed.			
Steps taken by the County to Implement this paragraph:	See SA III.A.1.a. (3)			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See also III.A.1.a. (3) The County's maintains that the audits conducted pursuant to demonstrating sustainability of compliance with this paragraph were not "required" as a measure of compliance, and as such should not be used to determine the current compliance rating. MDCR determined, subsequent to providing the audit to the Monitor that the results were "incorrect" and "overinflated" apparently based on the method of compiling data from the automated system. MDCR produced an action plan, and the Monitor was advised of these issues; which is true. The County notes that the audit is not included in the measures of compliance, and therefore should not be considered when compliance is determined. Nonetheless these were reports provided by the County, and stand as documentation. After five years of compliance initiatives, the County is aware of the significance of materials provided to the Monitor and should appropriately review submissions for accuracy. The need for a full-time compliance manager is thus demonstrated.			
Monitor's Recommendations:	See III.A.1.a. (3)			

Paragraph	III. A. 1. Safety and Supervision: (7) Security supervisors shall conduct daily rounds on each shift in the inmate housing units, and document the results of their rounds.			
Compliance Status:	Compliance: 12/10/17, 3/3/17, 7/29/16, 10/24/14	Partial Compliance: 7/11/18, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	NA			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding daily supervisory rounds in inmate housing units on all shifts. 2. Examination of logs/documentation. 3. Inmate interviews. 4. Corrective actions for any supervisory findings from rounds (examples of), if any.			
Steps taken by the County to Implement this paragraph:	See SA III.A.1.a. (3)			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See also III.A.1.a. (3) The County's maintains that the audits conducted pursuant to demonstrating sustainability of compliance with this paragraph were not "required" as a measure of compliance, and as such should not be used to determine the current compliance rating. The County now states that the results of their audits were "overinflated", and so informed the Monitor. This is true; the Monitors was informed. Nonetheless these were reports provided by the County, and stand as documentation. After five years of compliance initiatives, the County is aware of the significance of materials provided to the Monitor and should appropriately review submissions for accuracy. The need for a full-time compliance manager is thus demonstrated.			
Monitor's Recommendations:	See III.A.1.a. (3)			

Paragraph	III. A. 1. Safety and Supervision: (8) MDCR shall maintain a policy ensuring that security staff conduct sufficient searches of cells to ensure that inmates do not have access to dangerous contraband, including at least the following: i. Random daily visual inspections of four to six cells per housing area or cellblock; ii. Random daily inspections of common areas of the housing units; iii. Regular daily searches of intake cells; and iv. Periodic large scale searches of entire housing units.			
Compliance Status:	Compliance: 12/10/17, 3/3/17, 7/29/16, 1/8/16	Partial Compliance: 7/11/18, 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 5/15.
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding staff searches of inmate cells and living areas, meeting language in this Settlement Agreement. 2. Shakedown logs/records. 3. Operational plans for large scale searches; and post search evaluations/management reviews. 4. Reports provided by MDCR regarding contraband and shakedowns.			
Steps taken by the County to Implement this paragraph:	MDCR conducted an audit of the provisions of this paragraph and DSOPs 11-045 and 14-001. This audit reviewed and evaluated shakedowns from the three facilities for the period January 1 – March 31, 2018. The audit report is dated June 7, 2018. This audit was conducted against the backdrop of inmate deaths potentially related to contraband, and the issues presented in the last compliance tour for both the SA and CA regarding excess medication and medical administration. The findings of the audit address the issue of excessive medication, reporting of seizure of contraband, and the frequency of shakedowns. The "preliminary observations and conclusions" include: needed improvements in data reviews regarding excessive medication, more staff training, staff meetings and spot inspections are needed; the use of liquid and floating medication to minimize medication hoarding; improvements in incident reporting and related inmate disciplinary reports; and acknowledgement of an increase in the number of shakedowns in TGK and PTDC, attributed to additional staffing made available to conduct the shakedowns. MDCR provided an updated action plan, dated July 5, 2018, which includes a self-assessment of the root cause of the contraband (7/27/18), the establishment of performance objectives, and the development of a process to track performance. The County maintains that since an audit was not part of the measures of compliance, the results should be disregarded when determining compliance. Nonetheless these were reports provided by the County, and stand as documentation. The County's line of reasoning is illogical and inconsistent with the agreement that the County be in compliance for 18 months after an initial findings of compliance. Whether documentation of sustained compliance is produced by the			

	County, or assessed through primary or secondary data by the Monitor is irrelevant. If the County had an objection to producing audits following pursuant to Compliance Report #8, the time to object would have been at that time.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	• There is no finding about the frequency of shakedowns in MW. • It is unclear in Figure 1, if no contraband was found, what is the data that is reported? Additionally, the Monitor finds it exceedingly unlikely that shakedowns find no contraband, unless the inmates or staff are anticipating the shakedown. The data in Figure 1 appears to miss recoveries and shakedowns and is confusing. The statement that the disparity of what is found in shakedowns " . . . indicate[s] inconsistent business practices, documentation guidelines, or management expectations." Is unclear as to the meaning, and the ability to draw any conclusions supported by data. • 22% of the recovering should have been found by or controlled by the staff – bed sheets , pillow cases, towels, blankets, pilots and mattresses. The same might be found for the 7% of recoveries regarding perishable food – something also that should be the routine work of officers to discover. • The conclusion that MW has more recoveries due to the open design that allows inmates to "hide" contraband is illogical, in the Monitor's opinion based on subject matter expertise, review of reporting, and observation. There is no data to support this statement. In fact, in open dorms, the contraband should be easier to see if staff are routinely walking the unit, as contrasted to the cell configurations of PTDC. The conclusion regarding PTDC supports the Monitor's review. • Removing the unexplained data of "no contraband found" reveals that excessive medication accounted for 11% of the recoveries; and this is after MDCR and CHS initiated improvements in medication administration in 2017. • The actions taken lack documentation, data, or the ability to evaluate initiatives. There are no dates regarding the actions, and no indication of how success will be measured. • The corrective action plan (Appendix 4) notes that performance objectives will be developed in the future. Given the urgency of this matter, the Monitor anticipated that this work would have been accomplished in a tighter time frame, and looks forward to reviewing the next set of reports from MDCR. • Figure 1 does not identify serious contraband recovered, such as tobacco or illegal drugs. • The category of "other" in Figure 1 accounts for 15% of recoveries. The category needs further definition if the data is to be useful in assessing the problem and developing a corrective action plan. • There is no analysis regarding the recoveries of excessive medication. The Monitor's conclusion is that the work to analyze contraband and develop effective strategies was intended to be done by this tour; not pushed to the next tour. This analysis only peripherally addresses the collaboration with CHS regarding excessive medication, and provides to cogent plan, with measures. The analysis did not include the specifics of the requirements of this paragraph. To accomplish this analysis, the Monitor reviewed shakedown logs provided for the facilities to October 2017 – April 2018 to assess: random daily visual inspections of four to six cells per housing area or cellblock; random daily inspections of common areas of the housing units; regular daily searches of intake cells; and periodic large scale searches of entire housing units.

	The logs provide an overview of searches of housing units, but do not include, for example, intake cells. There is no information about daily visual inspections of four to six cells per housing areas or cellblock, etc. The Monitor requested after the last compliance tour that an analysis of searches of cells/shakedowns; action plans related to seizures/findings be provided before the next tour. MDCR provided the same audit, as noted above, for the documentation. This audit does not address the issues, particularly the specifics of this paragraph.
Monitor's Recommendations:	1. For the audit dated June 7, 2018 , complete the work (rather than just plan to conduct the work), develop measurable corrective actions, as needed, implement before the next tour. 2. Develop better data reporting as to recoveries and the number of shakedowns as well as how the information is reported and analyzed. 3. Audit the specific provisions of this paragraph and/or otherwise demonstrate compliance (i-iv) 4. Provide an update of the outcome of the action plan dated July 5, 2018.

Paragraph	III. A. 1. Safety and Supervision: (9) MDCR shall require correctional officers who are transferred from one facility to a facility in another division to attend training on facility-specific safety and security standard operating procedures within 30 days of assignment.			
Compliance Status:	Compliance: 7/11/18, 12/10/17, 3/3/17, 7/29/16, 1/8/16	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15.
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training for officers who transfer from one division to another. 2. Facility specific operational procedures/written directives. 3. Lesson plans on facility-specific safety and security. 4. Proof of attendance within 30 days of assignment. 5. Demonstration of knowledge gained (e.g. pre-and post-tests) 6. Examples of remedial training, if any.			
Steps taken by the County to Implement this paragraph:	MDCR conducted an audit regarding the provisions of this paragraph for the period October 2017 thru December 2017, dated May 29, 2018. The audit found that 85% of staff received required training within 30 days of assignment. In 11% of those instances the Training Bureau did not receive the transfer orders, thus triggering training. An action plan was provided.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This paragraph will remain in compliance; and the results of the action plan will be assessed during the next compliance tour.			
Monitor's Recommendations:	1. Re-do/update the audit for all of 2018 prior to the next tour. 2. Provide the results/outcomes of the action plan (may be included as part of the audit.) 3. Given the findings regarding current CPR certifications of employees (Consent Agreement III. C. 8. d.), MDCR should audit this training as well.			

Paragraph	III. A. 1. Safety and Supervision: (10) Correctional officers assigned to special management units, including disciplinary segregation and protective custody, shall receive eight hours of specialized training for working on that unit on at least an annual basis.			
Protection from harm: Compliance Status:	Compliance: 7/11/18, 12/10/17, 3/3/17	Partial Compliance: 10/24/14, 3/28/14, 7/19/13, 7/29/16	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	Training for staff who are assigned to work with inmates on the (non-acute) mental health caseload.			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training of staff assigned to special management units. 2. Lesson plans for the 8 hours of training. 3. Evidence training was held annually; evidence those working in the units attended. 4. Documentation of knowledge gained (e.g., pre-and post-tests) 5. Remedial training, if any.			
Steps taken by the County to Implement this paragraph:	MDCR conducted a review, dated May 28, 2018, of the provisions of this paragraph for calendar year 2017. The distinction is made between officers assigned to housing units designated as special management, disciplinary segregation and protective custody; and officers assigned to PTDC where there are areas in the building with specialize cells; but not specialized units. In the case of PTDC, MDCR works to assure that 30% of the staff assigned to that facility have specialized training, as the officers may work in a variety of posts, and are available in the building on each shift. MDCR provided an action plan dated June 4, 2018 in which the Training Bureau will create a tracker to note officers' assignments and assure training is provided as required for all facilities. Among the action items is to obtain a training management system.			
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Segregation cells at PTDC are on several floors (3,4,5,6); training is provided to assure that there are a sufficient number of trained staff on each shift, even though MDCR maintains this is not a special management unit. MDCR will improve tracking to assure that the training requirements are met in Metro West and TGK.			
Monitors' Recommendations:	1. Provide an update of the action plan dated June 5, 2018 prior to the next on-site compliance tour.			

Paragraph	III. A. 1. Safety and Supervision: (11) MDCR shall continue its efforts to reduce inmate-on-inmate violence in each Jail facility annually after the Effective Date. If reductions in violence do not occur in any given year, the County shall demonstrate that its systems for minimizing inmate-on-inmate violence are operating effectively.			
Compliance Status:	Compliance: 3/3/17	Partial Compliance: 7/11/18, 12/7/17; 10/24/14; 3/28/14, 7/19/13, 7/29/16	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	1. Operational plan to reduce/address inmate-on-inmate violence, including definitions of what constitutes inmate-on-inmate violence; 2. Data regarding inmate-on-inmate violence, by year. 3. If violence increases from one reporting year to the next, documentation of the MDCR's evaluation of the current operational plan and proposed changes, improvements.			
Steps taken by the County to Implement this paragraph:	MDCR's violence report for the first quarter of 2018 indicates that the number of inmate/inmate batteries was 1,237 in 2017 (1,159 in 2014, 1066 in 2015 and 1,111 in 2016). This is plotted against a decrease in the average inmate population. To the extent the information was determined for the first quarter of 2018, the reasons for the assaults were undetermined (43.11%). This is critical as MDCR notes that 48% of their uses of force are attributed to stopping inmate fights. MDCR's Inmate Violence Report for the last quarter of 2017 noted the following: uses of force rose from 445 reported incidents in 2014 to 712 incidents in 2017; the use of force involving inmates on the acute mental health caseload represented approximately 11% of total uses of force; and the number of inmate/inmate batteries rose from a reported 1,159 in 2014 to 1,237 in 2017. In the analysis of the causes of the inmate/inmate assaults for 2017, the largest category is "undetermined" – 42%, providing virtually no basis for assessment and plans of action. The report also highlights inmates who are transferred to prevent fights (no description of how this is determined is provided) or inmates transferred due to aggressive/disruptive behaviors. MDCR provided a report on countermeasures/corrective action plans to reduce inmate violence, dated June 11, 2018. MDCR also provided an update on implementation of countermeasures dated July 4, 2018; and the course corrections for the inmate violence reduction initiative dated July 5, 2018. The County notes in response to this draft compliance report that "MDCR has recently identified relevant data metrics and has developed a new Quarterly Report . . ." The Monitor has been consistently supportive of the County efforts to drill down into the information and produce useful data. The work continues, but the results of the work do not reach compliance with this paragraph. The Monitor looks forward to discussing the intricacies of data reporting and management in a jail setting. The questions posed to the Monitor in the County's response to the draft can be addressed in a forum other than this one. For example, in the absence of any evidence-based standard for acceptable violence in a jail, the County posts the question of what the			

	Monitor would use to "deem the number of inmate-on-inmate fight [sic] within MDCR facilities as excessive or even at a higher rate than that of jails of similar size"? The Monitor looks forward to that conversation and debate; including progress on the issues noted below. The Monitor has never set a number or standard for what constitutes a safe environment, but the data produced by MDCR indicates that inmates are not uniformly safe, and the trends are upward.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	If the cause of inmate fights cannot be determined, effective countermeasures are unlikely to be developed. The Monitor provides these recommendations. • All the data provided will be more relevant if it were plotted against the average daily population as well as the classification of inmates involved. This is the one rate of occurrence that would be significant (see recommendations, below). • The quarterly reports do not have summaries of relevant, important data. • While the data regarding transferring of inmates to attempt to avoid fights, the very core issue there – appropriateness/accuracy of classification is not reviewed. Additionally, while avoiding fights is a worthy goal, the moving of inmates also does not assess the quality of staff supervision of inmates, nor the type of housing (e.g. direct supervision/linear indirect). There are no recommendations regarding how the data can inform decisions and ensure inmate/staff safety. • The data regarding uses of force involving inmates on the mental health caseload needs to be aligned with that reported by the facilities in their self-audit reports. • The June 11th report regarding countermeasures and corrective actions appears to repeat earlier findings. • Continuing to measure progress in targeted and non-targeted housing units without addressing and fixing core issues leads to frustration among all involved, and is not sufficiently holistic in the approach. The conclusions about the effectiveness in reducing violence do not appear to be statistically significant and/or sufficiently analyzed and explained. Although promising, the implementation of the entire range of fixes needs to be implemented before conclusions can be drawn with any certainty of sustainability. • MDCR acknowledges that the countermeasures have not yielded the results of sustainable lower rates of uses of force and inmate/inmate assaults. This may be due to not addressing core/root causes such as classification, housing options, providing incentives and disincentives to promote inmate behaviors, assurance of adequate staffing in critical areas, training and supervision of staff, and appropriate provision of mental health services. • MDCR's important work continues at this time.
Monitor's Recommendations:	1. As a suggestion, continue to refine the Quarterly/Annual violence reports to eliminate charts and rather use narratives; and especially eliminate the charts where there is no data reported (e.g. zero or a low number of events). The narrative analyses of the data provides the foundation for the findings and recommendations; the charts and graphs perhaps can be relocated to an appendix. This will streamline/shorten the report, and allow focus on the most critical findings. The analysis should consider avoiding comparisons of per incident rate (for example uses of force per 1,000 bookings, or uses of force per 1,000 inmates) as this bases for comparison has no foundation in terms of relevance except as a measure of prevalence. The use of the analyses should be reviewed for relevance – for example Figure 149 – in terms of what it displays and the usefulness to developing countermeasures and plans of action. There are pages and pages of charts, with no descriptions, findings, or notes regarding the relevance and potential use of the data.

	2. The use of performance indicators to determine good performance, for example Figures 150a and 150b are questionable. How the performance measure was selected and the relevance is unexplained. As noted elsewhere in this report, while targets/benchmarks may be desirable, the objective needs to be have a factual or data-driven anchor. The Monitor has made this observation before, and no further information has been provided as to the data or behavioral anchors called performance objectives. For example, in figure 150a – the performance measure appears to be 225 inmate/inmate incidents as somehow an acceptable number. This requires an explanation. If for example, MDCR reaches a reported 220 inmate/inmate incidents per quarter, is that then the acceptable, "good", level for the agency? MDCR continues to note it checks with other larger jails to determine their numbers of incidents in MDCR's efforts to determine benchmarks. While perhaps interesting, the use of data from other jails is extremely problematic as there are no uniform national (or even state) definitions of incidents and/or behaviors, no uniform policies governing self-reporting, no assessment of the validity of the reporting in other jails, nor how other jails train and/or audit their reporting. 3. Continue to refine measures; insure that implementation of critical factors, such as the inmate disciplinary system, be finalized. It is not possible to evaluate options until the "package" of reform has been put into place. 4. The continued level of violence suggests that the classification system is not working. This has not yet been analyzed. This work should be undertaken as soon as possible. While a full validation study is ultimately the goal, interim review of how classification contributes to safety needs to be done. While MDCR continues to document a very low "mis-classification" of inmates, the methodology is not provided. Further, the level of disorder in the facilities seems to suggest that classification most likely is a contributing factor. 5. Refine the countermeasure initiatives. The use of reports without explanation, analysis or findings is not helpful. 6. Assure that staffing of critical areas to support violence reduction is a priority for the County. 7. Continue to decrease the finding of "undetermined" for the reason for inmate/inmate violence; the same recommendations as included in the last compliance report.

III. A. 2. Security Staffing

Correctional staffing and supervision must be sufficient to adequately supervise incidents of inmate violence, including sexual violence, fulfill the terms of this Agreement, and allow for the safe operation of the Jail, consistent with constitutional standards. MDCR shall achieve adequate correctional officer staffing in the following manner:

Compliance Status:	Compliance: 7/11/18, 12/10/17, 3/3/17, 7/29/16, 5/15/15	Partial Compliance: 10/24/14, 3/28/14	Non-Compliance: Not yet due (11/27/13)	Other: Per MDCR not reviewed in 1/16.
Unresolved/partially resolved issues from previous tour:				
Steps taken by the County to Implement this paragraph:	MDCR has updated the staffing plan; the Mayor has indicated his support for funding the staffing as required.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR conducts very good staffing analyses, and adjusts the findings as needed. The County's human resources bureaucracy **needs to be responsive to the needs to fill positions, including civilian positions.** At the time of the last tour, the Monitor noted that counselors were needed to help implement the violence reduction program at MW, yet those positions were not filled for four months. The last report also needed the critical need for cleanliness in the clinics and infirmaries (custodial workers); and those civilian positions have just been filled.			
Monitor's Recommendations:	1. Assure that the County's human resources bureaucracy handles requests with a level of urgency, especially for positions related to violence reduction (e.g. counselors) and clinic and infirmary cleanliness (maintenance workers.) 2. MDCR may include calendar year 2018 data to document how long it takes from the time of a resignation until an individual is hired, as documentation of this collaboration.			

<table>
<tr><td>Paragraph
<u>Coordinate with Drs. Johnson and Greifinger</u></td><td colspan="4">III. A. 2. Security Staffing:
b. MDCR shall ensure that the staffing plan includes staffing an adequate number of correctional officers at all times to escort inmates to and from medical and mental health care units.</td></tr>
<tr><td>Protection from Harm: Compliance Status:</td><td>Compliance: 12/7/17, 3/3/17, 5/15/15</td><td>Partial Compliance: 7/11/18, 10/24/14, 3/28/14, 7/29/16</td><td>Non-Compliance: 7/19/13</td><td>Other: Per MDCR not reviewed in 1/16</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><u>Protection from Harm:</u>
1. Staffing plan; staffing for escorts in each facility.
2. Policies and procedure for officer escorts to and from medical and mental health care units.
3. Overtime records, if any.
4. Consultation with Drs. Johnson and Greifinger; interview with medical and mental health personnel
5. Review of patient scheduling deficiencies (e.g. cancelled, rescheduled appointments).

<u>Medical Care:</u>
• Audit Step a: (Inspection) This compliance measure will be assessed by exception, i.e. any credible reports of lack of staff from CHS, MDCR and/or inmates to escort inmates to and from the medical health care appointments.
<u>Mental Health:</u>
1. Staffing plan; staffing for escorts in each facility.
2. Policies and procedure for officer escorts to and from medical and mental health care units.
3. Overtime records, if any.
4. Consultation with Drs. Johnson and Greifinger; interview with medical and mental health personnel
5. Review of patient scheduling deficiencies (e.g. cancelled, rescheduled appointments).</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph</td><td colspan="4">MDCR conducted an audit of the provisions of this paragraph, dated May 22, 2018, using data provided by Corrections Health Services for January – March 2018. The audit cited a substantial discrepancy in the numbers reported by CHS (38) and MDCR (1,056). During the on-site compliance tour, the parties noted that this data was not correct, and would be corrected. The issue appeared to be a data-input issue.

In CHS' documentation production for the materials due under Summary Action Plan 4 (7/16/18), CHS noted that more staff had been hired since the last on-site compliance tour for the purpose of following-up on any clinic no-shows. If no-shows are identified, CHS immediately notifies the facility administrator. For April , CHS reported a total of 239 clinic no-shows (51 for PTDC, 135 for Metro West, and 53 for TGK). The reasons for the no-shows provided in this snap shot were:
○ 27% patient refusal
○ 42% clinic overbooking/overscheduling
○ 4% patient transfer
○ .04% no movement officer
○ 25% undetermined
○ .8% clinic lockdown or movement delay</td></tr>
</table>

	The data provided by CHS is incomplete – and with 25% of the reasons as underdetermined, the data remains questionable. An additional 7 working days was provided to CHS/MDCR to update this information; and on July 24th additional clarification was provided, citing the need to train CHS staff on how to enter information into the data system regarding "no shows" related to no officer being available. The additional information also noted that a directive was put in place requiring CHS to notify the shift commander is there are any concerns by CHS that relate to staffing.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As there are conflicts in the data, and late-submitted data and information, acknowledged by the County, the Monitor finds that this provision is in partial compliance. Prior to the next compliance tour, the County should identify the accurate data, and if necessary provide a corrective action plan. The County's maintains that the audits conducted pursuant to demonstrating sustainability of compliance with this paragraph were not "required" as a measure of compliance, and as such should not be used to determine the current compliance rating. Nonetheless these were reports provided by the County, and stand as documentation. After five years of compliance initiatives, the County is aware of the significance of materials provided to the Monitor and should appropriately review submissions for accuracy. The need for a full-time compliance manager is thus demonstrated. There is no other way to report on this paragraph at this time except for partial compliance.
Monitors' Recommendations:	1. Conduct a complete audit as to how data is collected, analyzed, and the development of a meaningful action plan. 2. Prior to the next compliance tour, the County should identify the accurate data, and if necessary provide a corrective action plan.

Paragraph	III. A. 2. Security Staffing: c. MDCR shall staff the facility based on full consideration of the staffing plan and analysis, together with any recommended revisions by the Monitor. The parties shall agree upon the timetable for the hiring of any additional staff.			
Compliance Status:	Compliance: 7/11/18, 12/10/17, 3/3/17, 7/29/16, 5/15/15,	Partial Compliance: 10/24/14; 3/28/14	Non-Compliance: Not yet due 11/27/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Completed staffing plan; discussion of recommendations by the monitor, if any. 2. Determination of the need for more hiring, if any. 3. Hiring plan, if needed, with timetable. 4. Results of hiring, if needed.			
Steps taken by the County to Implement this paragraph:	Staffing plan completed and updated; Director states that Mayor supports additional staffing request.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)				
Monitor's Recommendations:	No further recommendations. The hiring will be assessed at the next tour.			

Paragraph	III. A. 2. Security Staffing: d. Every 180 days after completion of the first staffing analysis, MDCR shall conduct and provide to DOJ and the Monitor staffing analyses examining whether the level of staffing recommended by the initial staffing analysis and plan continues to be adequate to implement the requirements of this Agreement. If the level of staffing is inadequate, the parties shall re-evaluate and agree upon the timetable for the hiring of any additional staff.		
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16,1/8/16	Partial Compliance:	Not Yet Due: 5/15/15 10/24/14; 3/28/14
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	1. Report from MDCR comparing if recommended staffing is adequate to implement the requirements of this agreement. 2. Review of overtime costs; vacancies and vacancy trends. 3. Re-evaluation of hiring and hiring timetable, if needed. 4. Review/comment by the monitor of report in III.A.2.a., above.		
Steps taken by the County to Implement this paragraph:	Completed and provided		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)			
Monitor's Recommendations:	Nothing further at this time.		

III.A.3. Sexual Misconduct

Paragraph Coordinate with Drs. Johnson and Greifinger	III. A. 3. Sexual Misconduct MDCR will develop and implement policies, protocols, trainings, and audits consistent with the requirements of the Prison Rape Elimination Act of 2003, 42 U.S.C. § 15601, et seq., and its implementing regulations, including those related to the prevention, detection, reporting, investigation, data collection of sexual abuse, including inmate-on-inmate and staff-on-inmate sexual abuse, sexual harassment, and sexual touching.		
Protection from Harm: Compliance Status:	Compliance: 7/11/18, 10/24/14,	Partial Compliance: 12/7/17, 3/3/17, 7/29/16, 1/8/16, 3/28/14, 7/19/13	Non-Compliance: MDCR did not request review during tour of 5/15; compliance was reviewed due to identifying issues of conflict with the PREA audit.
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Protection from Harm: 1. PREA policies and procedures 2. Self-audit (separate action plan to be based on MDCR's self-audit) [see http://static.nicic.gov/Library/026880.pdf] 3. Implementation of plans of action, etc., including audit results based on self-audit.		
Steps taken by the County to Implement this paragraph:	MDCR resolved all issues with the formal PREA audits of all facilities. MDCR conducted a self-assessment of PREA compliance, April 26, 2018.		
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This paragraph is found in compliance as all MDCR facilities have been audited per the requirements of the PREA standards, and passed these audits. These audits will now take place every three years. The Monitor will not review PREA compliance going forward; unless an incident(s) is identified by the SA and/or CA monitors indicates that the County is not in compliance with PREA standards. This must be a systemic issue rather than a single incident. MDCR posted their audits on their website as required by the PREA standards: http://www.miamidade.gov/corrections/library/2017-08-29-prea-audit-report.pdf Monitors were advised that there needs to be attention to the management of/communications with transgender inmates; and MDCR was also informed. They are reviewing the concerns. This is not sufficient information to find this paragraph in anything but compliance. The Monitors will follow-up on this matter in the next audit.		
Monitors' Recommendations:	1. The County is encouraged to conduct annual reviews of on-going PREA compliance in anticipation for the next formal audit; including implementation of recommendations as contained in the self-audit dated April 26, 2018. Monitor will follow-up at the next tour. 2. Review/document the MDPD's SVU's collaboration with CHS' mental health providers, pursuant to the Director's memo of May 23, 2018. Monitor will follow-up at the next tour. 3. Prior to the next tour, MDCR should review the management of transgender inmates; provide any findings and, in necessary, provide plans of action.		

III. A. 4. Incidents and Referrals

Paragraph	4. Incidents and Referrals a. MDCR shall ensure that appropriate managers have knowledge of critical incidents in the Jail to act in a timely manner to prevent additional harm to inmates or take other corrective action. At a minimum, MDCR shall document all reportable incidents by the end of each shift, but no later than 24 hours after the incident. These incidents should include inmate fights, rule violations, inmate injuries, suicide attempts, cell extractions, medical emergencies, contraband, destruction of property, escapes and escape attempts, and fires.			
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 10/24/14	Partial Compliance: 3/28/14,7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	None at this time			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding notifications to managers regarding critical incidents; actions required. 2. Policies and procedures regarding reportable incidents. 3. Documentation of notification managers; checklists/incident reports. 4. Review of incident reports. 5. Review of critical incidents. 6. Interview with supervisory and management staff.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR is in compliance with this paragraph by documenting the incidents. MDCR needs to develop a format and processes for critical incident reviews. The reviews of critical incident provided did not contain findings and/or recommendations. Two of the reviews had a section entitled "additional considerations" which were somewhere between findings and recommendations. It is essential that the organization develop self-critical review of serious incidents, including findings and recommendations (and action plans as needed).			
Monitor's Recommendations:	1. See recommendations in III.A.1.a. (1)			

Paragraph	4. Incidents and Referrals b. Staff shall report all suicides and other deaths immediately, but no later than one hour after the incident, to a supervisor, Internal Affairs ("IA"), and medical and mental health staff.			
Compliance Status: .	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 10/24/14	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/14	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding notifications for critical incidents, including suicides and deaths. 2. Documentation of notification checklists/documentation. 3. Review of incident reports/investigations.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation evidenced compliance.			
Monitor's Recommendations:	No recommendations at this time.			

Paragraph	4. Incidents and Referrals c. MDCR shall employ a system to track, analyze for trends, and take corrective action regarding all reportable incidents. The system should include at least the following information: 1. unique tracking number; 2. inmate(s) name; 3. housing classification; 4. date and time; 5. type of incident; 6. any injuries to staff or inmate; 7. any medical care; 8. primary and secondary staff involved; 9. reviewing supervisor; 10. any external reviews and results; 11. corrective action taken; and 12. administrative sign-off.		
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 1/8/16	Partial Compliance: 5/15/15; 10/24/14; 3/28/14	Non-Compliance: 7/19/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures to track, analyze data, develop corrective action plans, as needed for all reportable incidents. 2. Definition of reportable incidents. 3. Review of reports, analysis, corrective action plans. 4. Review of elements in database. 5. Review of incident reports 6. Review of any external reviews/results. 7. Review of corrective action plan, if any. 8. Review of data/reports generated from the information in the system.		
Steps taken by the County to Implement this paragraph:	The current information system captures this information.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The County's plan to have the current inmate telephone vendor include in their contract the new offender management system has not come to fruition. The vendor has indicated to the Director that it, GTL, will pay for the costs associated with a vendor of the County's choice to develop the system. This has essentially put MDCR a few more years away from implementation of a system needed for an agency of this size and complexity. Nonetheless, the current jail management system supports the requirements of this paragraph.		

Monitor's Recommendations:	1. Assure the request for proposal and subsequent award processes insure that relevant paragraphs of both the Settlement Agreement and Consent Agreement, including interfaces with Cerner and other CHS data system, are required as part of any new system.

Paragraph Coordinate with Dr. Johnson See Also Consent III.A.3.(4)	4. Incidents and Referrals d. MDCR shall develop and implement a policy to screen incident reports, use of force reports, and inmate grievances for allegations of staff misconduct and refer an incident or allegation for investigation if it meets established policy criteria.			
Protection from Harm: Compliance Status:	Compliance: 3/3/17, 7/29/16, 5/15/15	Partial Compliance: 7/11/18, 12/7/17, 10/24/14	Non-Compliance: 3/28/14, 7/19/13 (not yet due)	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding incident reports, including criteria for screening for critical incidents (see also III.A.3); 2. Documentation of referrals of grievances for investigations; outcomes. 3. Corrective actions for incidents not referred as required. 4. Review of medical and mental health policies and procedures regarding referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc. 5. Medical and mental health policies and procedure regarding review of medical grievances to screen for critical incidents. 6. Documentation of referrals to investigators by medical and/or mental health staff, if any. 7. Assure that companion CHS policies are in place, and medical providers are trained at recognizing signs and symptoms of use of force, use of excessive force, and inmate/inmate assault and sexual assault. Mental Health: 1. Policies and procedures regarding incident reports, including criteria for screening for critical incidents (see also III.A.3); 2. Documentation of referrals of grievances for investigations; outcomes. 3. Corrective actions for incidents not referred as required. 4. Review of medical and mental health policies and procedures regarding referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc. 5. Medical and mental health policies and procedure regarding review of medical grievances to screen for critical incidents. 6. Documentation of referrals to investigators by medical and/or mental health staff, if any.			
Steps taken by the County to Implement this paragraph:	MDCR and CHS have established a grievance committee working to improve all processes. The Medical/MH Monitors report partial compliance with this provision of the CA; hence it is in partial compliance for the Settlement Agreement. In its review of this draft compliance report, the County renews its objection that there should be no link between compliance in the Settlement Agreement and Compliance in the Consent Agreement.			
Monitors' analysis of conditions to assess compliance, verification of	Protection from harm: **NOTE that Consent III. A.3.(4) is in partial compliance.** See also recommendations contained in III. C. Inmate Grievances			

the County's representations, and the factual basis for finding(s)	Mental Health: There is evidence that responses are being provided to inmates on the mental health caseload who file grievances. There is a disproportionally low number of grievances submitted from this population indicating attention/advocacy is needed for this population. Additionally, the responses are not sufficiently in-depth in terms of problem solving rather than justifying the actions taken or not taken.
Monitors' Recommendations:	Protection from Harm/Mental Health: 1. MDCR coordinate with CHS to assure all inmates' medical care includes visual screening for these incidents. 2. Assure that MDCR's inspectional processes assesses this requirement. 3. Provide any self-audit of this provision prior to the Monitors next tour, including any evidence of specific inmate grievances referred based on the requirements of this paragraph.

Paragraph	4. Incidents and Referrals e. Correctional staff shall receive formal pre-service and biennial in-service training on proper incident reporting policies and procedures.			
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16	Partial Compliance: 10/24/14; 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training on preparing incident reports; and notification criteria for critical incidents. 2. Lesson plans; pre-service and in-service. 3. Training schedule and attendance rosters. 4. Documentation of knowledge gained (e.g. pre-and post-tests) 5. Evidence of remedial training, if needed. 6. Review of incident reports.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Audit findings regarding other training required by the SA and CA revealed deficiencies. A recommendations is included with paragraph III.A.4.f. for MDCR to consider an audit of the entire training function.			
Monitor's Recommendations:	1. Prior to the next on-site tour, MDCR is requested to conduct an audit of this provision. See recommendations for III.A.4.f.			

Paragraph	4. Incidents and Referrals f. MDCR shall continue to train all corrections officers to immediately inform a member of the Qualified Medical Staff when a serious medical need of an inmate arises.		
Protection from Harm: Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 1/8/16	Partial Compliance: 7/29/16, 5/15/15, 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	1. Policies and procedures regarding training for notifications for Medical Care and mental health emergencies. 2. Lesson plans; training schedule. 3. Documentation of knowledge gained (e.g. pre-and post-tests) 4. Evidence of remedial training, if needed. 5. Review of incidents in which medical/mental health issues reported and not reported. 6. Minutes of meetings between security and medical/mental health.		
Steps taken by the County to Implement this paragraph:	MDCR conducted an audit of the provisions of this paragraph, dated May 9, 2018. The audit concluded that the training materials were not being updated when new policies and related written directives were implemented, and that test questions had not been revised since the unspecified date of the lesson plan. The audit does not address how many staff may not have received the updated/correct training, whether these individuals will be identified, and some remediation undertaken. An action plan was prepared, and updated July 3, 2018.		
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The MDCR audit found that the training lesson plans, the core of the required training, tests, and related materials were not timely updated. An action plan was prepared, but it lack dates when the work will be done, who is responsible for the work, and changes to internal procedures in the training bureau that will assure on-going compliance. The audit does not address how long this situation has continued – e.g. since 2017 or 2016, etc. therefore the scope of the needed remedies cannot be determined. With this finding for this training topic, it raises questions regarding the other training lesson plans, related materials, and the quality of the training program. Perhaps, MDCR should undertake an audit of all training. This paragraph will remain in compliance, but the results of the corrective action plan will be reviewed prior to the next on-site compliance tour.		
Monitor's Recommendations:	1. Consider conducting a more complete audit of findings, specifically how many staff may need training remediation and the length of time, and number of training sessions which have used outdated materials and lesson plans. 2. Prior to the next tour, report on the results of the corrective action plan (July 3, 2018).		

III. A. 5. Use of Force by Staff

Paragraph	III. A. 5. Use of Force by Staff a. Policies and Procedures (1) MDCR shall sustain implementation of the "Response to Resistance" policy, adopted October 2009. In accordance with constitutional requirements, the policy shall delineate the use of force continuum and permissible and impermissible uses of force, as well as emphasize the importance of de-escalation and non-force responses to resistance. The Monitor shall provide ongoing assistance and annual evaluation regarding whether the amount and content of use of force training achieves the goal of reducing excessive use of force. The Monitor will review not only training curricula but also relevant data from MDCR's bi-annual reports. (2) MDCR shall revise the "Decontamination of Persons" policy section to include mandatory documentation of the actual decontamination time in the response to resistance reports. (3) The Jail shall ensure that each Facility Supervisor/Bureau Commander reviews all MDCR incidents reports relating to response to resistance incidents. The Facility Supervisor/Bureau Commander will not rely on the Facility's Executive Officer's review.		
Compliance Status:	Compliance: 7/11/18, 3/3/17	Partial Compliance: 12/7/17, 7/29/16, 1/8/16, 5/15/15, 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force, response to resistance, including reporting and review protocols. 2. Monitor's annual evaluation of relevant data, including whether the amount and content of use of force training achieves the goal of reducing use of excessive force; review of bi-annual reports from MCDR. 3. Policies and procedures regarding decontamination; corresponding medical policies/procedures. 4. Policies and procedures on review of incident reports (see also III.A.4.a, III.A. 4.b.) by Facility Supervisor/Bureau Commander. 5. Review of reports; data.		
Steps taken by the County to Implement this paragraph:	MDCR continues to examine the causes and countermeasures for the uses of force and inmate/inmate violence. The MDCR inmate violence report for the first quarter of 2018 reports that the uses of force have increased from 445 in 2014 to 712 in 2017, with fewer inmates in custody. MDCR reports that 48% of the uses of force in this quarter were to stop inmate fighting, although the cause of the fight in 43% of the instances was undetermined. Thus the need to address the causes (via investigations and other proactive measures) of inmate/inmate altercations is a necessary first step to addressing uses of force. MDCR has suggested an amendment to the definition of a use of force excluding instances where staff simply pull inmates apart without using any force and where no injuries result to staff or the inmate. Such an event would be reported as an inmate/inmate altercation. MDCR's survey of other jails indicates that are varying definitions; and there is no national definition.		

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Monitor assesses this paragraph in compliance at this time as there is no evidence of excessive uses of force, or any pattern of excessive uses of force.. However, there are too many uses of force, for which the underlying causes have not been identified. The Monitor suggests that de-escalation training be a priority. MDCR noted that there is a report done by staff when a fight is avoided due to de-escalation; but it was not provided to the Monitor.
Monitor's Recommendations:	1. New Recommendation – Assure that "de-escalation techniques" are not limited to verbal commands in non-emergency situations.

<table>
<tr><td>Paragraph
<u>See Consent Agreement III.B.3.c.</u></td><td colspan="4">III. A. 5. Use of Force by Staff
b. Use of Restraints
(1) MDCR shall revise the “Recognizing and Supervising Mentally Ill Inmates” policy regarding restraints (DSOP 12-005) to include the following minimum requirements:
i. other than restraints for transport only, mechanical or injectable restraints of inmates with mental illness may only be used after written approval order by a Qualified Health Professional, absent exigent circumstances.
ii. four-point restraints or restraint chairs may be used only as a last resort and in response to an emergency to protect the inmate or others from imminent serious harm, and only after the Jail attempts or rules out less-intrusive and non-physical interventions.
iii. the form of restraint selected shall be the least restrictive level necessary to contain the emerging crisis/dangerous behavior.
iv. MDCR shall protect inmates from injury during the restraint application and use. Staff shall use the least physical force necessary to control and protect the inmate.
v. restraints shall never be used as punishment or for the convenience of staff. Threatening inmates with restraint or seclusion is prohibited.
vi. any standing order for an inmate’s restraint is prohibited.
(2) MDCR shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15 minute in-person visual observation by trained custodial staff. For any custody-ordered restraints, Qualified Medical Staff are notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.</td></tr>
<tr><td>Protection from Harm: Compliance Status:</td><td>Compliance: 7/11/18, 3/3/17, 7/29/16</td><td>Partial Compliance: 12/7/17, 5/15/15, 10/24/14, 3/28/14, 7/19/14</td><td>Non-Compliance:</td><td>Other: Per MDCR not reviewed in 1/16</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4">1. Policies and procedures regarding recognizing and supervising inmates with mental illness; use of restraints; monitoring those in restraints and elements of this paragraph of the Settlement Agreement.
2. Corresponding medical and mental health policies/procedures. Consistency between the directives of security and medical/mental health.
3. Minutes of meetings between security and medical/mental health in which these topics are reviewed/discussed; or other documentation of collaboration, and problem-solving.
4. Review of uses of restraints; required logs.
5. Identification of employees requiring training.
6. Review of use of seclusion.
7. Lesson plans and schedule for training.
8. Maintenance of data regarding uses of force involving inmates on the mental health caseload, by facility.</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="4">In its review of this draft compliance report, the County renews its objection that there should be no link between compliance in the Settlement Agreement and Compliance in the Consent Agreement.</td></tr>
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Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Mental Health Monitor has found CHS and MDCR to be in compliance with the companion standard in the CA. Therefore this paragraph in the SA is now in compliance. See CA III. B. c. (1-3) which is now in compliance.
Monitors' Recommendations:	1. Provide training to all staff working with all levels of inmates on the mental health caseload. Consider conducting an audit of the training to assure that staff have the tools, other than verbal commands, to deescalate in non-emergency situations. 2. Continue to document discussions in MAC and mini-MAC meetings.

Paragraph	III. A. 5. Use of Force by Staff c. Use of Force Reports (1) MDCR shall develop and implement a policy to ensure that staff adequately and promptly report all uses of force within 24 hours of the force.		
Compliance Status this tour:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 10/24/14, 3/28/14	Partial Compliance:	Non-Compliance: July 2013, not reviewed 5/11/15
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	<u>Protection from Harm:</u> a. Policies and procedures regarding reporting of uses of force; definitions; reporting formats; time requirements. b. Review of incident reports. c. Review of investigations into uses of force. d. Review of remedial/corrective actions, if any.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Remains in compliance with policy.		
Monitor's Recommendations:	No recommendations at this time other than to consider the TAAP findings when MDCR conducts the annual evaluation of the policy. This should include developing corrective action plans, as necessary. For the next tour, the Monitor will be asking to see any such action plans, based on TAAP recommendations and/or leadership decisions as to which TAAP recommendations to pursue.		

<table>
<tr><td>Paragraph</td><td colspan="4">III.A. 5.c.
(2) MDCR shall ensure that use of force reports:
i. are written in specific terms and in narrative form to capture the details of the incident in accordance with its policies;
ii. describe, in factual terms, the type and amount of force used and precise actions taken in a particular incident, avoiding use of vague or conclusory descriptions for describing force;
iii. contain an accurate account of the events leading to the use of force incident;
iv. include a description of any weapon or instrument(s) of restraint used, and the manner in which it was used;
v. are accompanied with any inmate disciplinary report that prompted the use of force incident;
vi. state the nature and extent of injuries sustained both by the inmate and staff member
vii. contain the date and time any medical attention was actually provided;
viii. include inmate account of the incident; and
ix. note whether a use of force was videotaped, and if not, explain why it was not videotaped.</td></tr>
<tr><td>Protection from Harm: Compliance Status:</td><td>Compliance: 3/3/17</td><td>Partial Compliance: 7/11/18, 12/17/17, 7/29/16, 1/8/16, 10/24/14, 3/28/14</td><td>Non-Compliance: 7/19/13</td><td>Other: Other: Not reviewed per MDCR 5/15</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><u>Protection from Harm:</u>
1. Policies and procedures regarding use of force reports; specifications for reporting.
2. Review of incident reports.
3. Review of investigations.
4. Review of inmate disciplinary reports.
5. Review of lesson plans.
6. Review of Medical Care/mental health records regarding injuries, including any required off-site hospitalizations.
7. Review of sample of staff workers' compensation claim relating to uses of force, inmate/inmate altercations.
8. Remedial, corrective action if necessary.
9. Review of digitally recorded incidents.
10. Review of MDCR Inmate Violence Report</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="4">MDCR has worked to update investigative practices in response to gathering victim/inmate statements. A memorandum dated April 1, 2018 notes these proposed improvements: policy revision to include investigators attempts to gather statements, resolve any inconsistencies, including adding training for these investigators; add more aggressive oversight of investigations into uses of force from SIAB; reinstitute internal surveillance of security threat groups in collaboration with MDPD, evaluation of the feasibility of dual-certified corrections officers and assign to facilities to provide for more timely reviews, enhance quality of investigations, and develop corrections specific expertise; and standardize critical incident reviews. The goal is to assign three investigators, one assigned to each facility, by July 2018.

MDCR's report on violence for the first quarter reports that the reasons for the assaults were undetermined (43.11%). This is relevant as MDCR reports that 48% of "uses of force" are related to stopping up inmate fights. Having such large</td></tr>
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	number of undetermined causes is problematic to establishing an effective countermeasure, and related to the lack of focus on interviews with combatants. The County notes in their review of this draft report that they are making efforts to gain witness statements; and cite their strategies to improve the outcomes of "undetermined" altercations; therefore asking for substantial compliance. As noted below, these witness statements are critical to improving outcomes, and have been referenced in previous compliance reports.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The proposal of April 1st are excellent first steps; and the Monitor awaits an update, and timelines for implementation. The Monitor's review of use of force reports indicates efforts are improving to obtain witness and victim statements; and improvements are still needed. TAAP did a good job of flagging inmate statements that were not accurately summarized by the facility-investigators and returned for clarification. As the implementation of changes to address the issue of victim/witness statements remain outstanding, this provision will remain in partial compliance. The recommendations to address this matter have been included in previous reports, but not until after Compliance Tour # 8 were they addressed in any substantive way. The work to date, is commendable, but as the credible witness interviews and statements are crucial to developing strategies to address violence, substantial compliance is not noted at this time. The County reports that in the near future one investigator in each facility will be assigned to follow-up.
Monitors' Recommendations:	1. Prior to the next tour, provide an update on the elements of improved internal investigative capacity/human resources at MDCR based on the April 1, 2018 memorandum; including any corrective actions or revised plans.

Paragraph	III. A. 5.c. (3) MDCR shall require initial administrative review by the facility supervisor of use of force reports within three business days of submission. The Shift Commander/Shift Supervisor or designee shall ensure that prior to completion of his/her shift, the incident report package is completed and submitted to the Facility Supervisor/Bureau Commander or designee.			
Compliance Status:	Compliance: 7/11/18, 12/10/17, 3/3/17, 7/29/16, 5/15/15	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force reports; supervisory review of reports; time deadlines. 2. Review of incident reports; review of a sample of use of force incident report packages for each facility. 3. Review of investigations. 4. Remedial, corrective action if necessary 5. Lesson plans regarding supervisory review of use of force reports.			
Steps taken by the County to Implement this paragraph:	There was a change in the process since the last tour, in which the facility supervisor's [commander] review of the use of force are contained in the reporting format, rather than requiring a separate memorandum.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Monitor's review of use of force packages reveals that the commanders' reviews are not always identifiable, or they reviews fail to confirm or agree with findings and recommendations of those who have thus far reviewed the reports. As this is a new process, continuing compliance is noted above; but upon review of two quarters of reports for the next tour, the facility supervisors' reviews need to be more substantial, reflecting both the comments made by others, and any additional recommendations.			
Monitor's Recommendations:	1. Provide updated training for facility leadership to improve reviews prior to the next tour.			

Paragraph	III. A. 5.c. (4) The Facility Supervisor/Bureau Commander or his/her designee shall submit the MDCR Incident Report (with required attachments) and a copy of the Response to Resistance Summary (memorandum) to his/her Division Chief within 14 calendar days. If the MDCR Incident Report and the Response to Resistance Summary (memorandum) are not submitted within 14 calendar days, the respective Facility Supervisor/Bureau Commander or designee shall provide a memorandum to his/her Division Chief explaining the reason(s) for the delay.			
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 10/24/14	Partial Compliance: 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force reports; supervisory review of reports; time deadlines. 2. Review of MDCR Incident Report and Response to Resistance Summary, as specified above. 3. Review of memoranda with exceptions. 4. Review of investigations. 5. Remedial, corrective action if necessary 6. Review of post orders; job descriptions for Facility supervisor/Bureau Commander.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See the comments/findings in SA III.A.5.c. (3)			
Monitor's Recommendations:	See SA III.A.5.c. (3)			

Paragraph See Consent Agreement III. B. 3	III. A. 5.c. (5) The Division Chief shall review use of force reports, to include a review of medical documentation of inmate injuries, indicating possible excessive or inappropriate uses of force, within seven business days of submission, excluding weekends. The Division Chief shall forward all original correspondences within seven business days of submission, excluding weekends to Security and Internal Affairs Bureau.			
Protection from Harm: Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 10/24/14, 3/28/14	Partial Compliance: 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force reports; review of reports; time deadlines. 2. Review of incident reports. 3. Review of Division Chiefs' reports 4. Referrals to IAB. 5. Review of inmate medical records. 6. Review of investigations. 7. Remedial, corrective action if necessary. 8. Review of post orders/job descriptions of Division Chief.			
Steps taken by the County to Implement this paragraph:	See III.A.5.c.3.			
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The revised use of force reporting process moves the facility and division commander's report to the form, rather than in a cover memorandum. The Monitor's review of use of force packages for the last quarter of 2017 did not identify the facility commander's response in some of the reports; especially concerning when the sergeant or lieutenant found issues in the use of force and/or the reporting. MDCR's observation was that if the leadership/management staff agreed with the observations of their subordinate staff, they didn't write anything further. MDCR should assure that the findings/recommendations of the facility commander are reported/identified.			
Monitors' Recommendations:	1. Review the process to assure compliance with this paragraph. If the policy needs amendment, do so; if the training is an issue; provide training. Provide update prior to the next compliance tour.			

Paragraph See Consent Agreement III. B. 3. b.	III. A. 5.c. (6) MDCR shall maintain its criteria to identify use of force incidents that warrant a referral to IA for investigation. These criteria should include documented or known injuries that are extensive or serious; injuries of suspicious nature (including black eyes, injuries to the mouth, injuries to the genitals, etc.); injuries that require treatment at outside hospitals; staff misconduct; complaints by the inmate or someone reporting on his/her behalf, and occasions when use of force reports are inconsistent, conflicting, or suspicious.			
Protection from Harm: Compliance Status:	Compliance: 7/11/18, 3/3/17, 7/29/16, 5/15/15	Partial Compliance: 12/7/17, 10/24/14	Non-Compliance: 7/19/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:	Assure that CHS staff are trained per CA III.B.3. c.			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding criteria for referrals to IAB for use of force investigations. 2. Review of reports. 3. Review of medical and mental health policies and procedures for referrals regarding injuries consistent with excessive use of force, and other related critical incidents. 4. Documentation of referrals from medical/mental health to IAB. 5. Minutes of meeting between security and medical/mental health in which these topics are discussed/reviewed. 6. Treatment of inmates at outside hospitals. 7. PREA policies, data. 8. Review of investigations. 9. Review of remedial or corrective action plans, if any.			
Steps taken by the County to Implement this paragraph:	MDCR and CHS conducted a review, dated June 1, 2018. The review found that MDCR provided CHS staff with orientation training, including 37 new CHS staff from 1/1/18 – 5/3/18. The review identified that a formal lesson plan was never developed for this training, which will be developed by October 31, 2018. CHS provided, in their most recent submission (7/16/18) in response to Summary Action Plan 4, information about their training. In this submission, CHS produced "curriculum" – which is really Power Points to train staff. This material does not address the injuries noted in this paragraph. Further, audit tool # 30 provides data about conformance with CHS/MDCR policies. In its review of this draft compliance report, the County renews its objection that there should be no link between compliance in the Settlement Agreement and Compliance in the Consent Agreement.			
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	To their credit, MDCR and CHS have identified that training for CHS staff, the front line of identifying possible sexual abuse and excessive uses of force, although provided, was never finalized in terms of a lesson plan. The County provided the outline of a web-based training for CHS which includes important information, dated May 8, 2018, however, it needs to be adapted for a jail setting. CA III.B.3.b. is in compliance.			

	The information provided does not indicate the total number of newly hired CHS staff needing orientation training in the first five months of 2018; nor what number may need re-training on this critical topic. The CHS "curriculum" need revision to address the provisions of this paragraph; audit Tool #30 documents issues with compliance.
Monitor's Recommendations:	1. Develop relevant lesson plans, testing mechanisms, and provide documentation of training prior to the next tour. 2. Provide a training/re-training plan for CHS and, if necessary, MDCR staff. 3. Assess the outcomes of audit Tool # 30 for additional training needs.

Paragraph	III. A. 5.c. (7) Security supervisors shall continue to ensure that photographs are taken of all involved inmates promptly following a use of force incident, to show the presence of, or lack of, injuries. The photographs will become evidence and be made part of the use of force package and used for investigatory purposes.			
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 10/24/14, 3/28/14	Partial Compliance: 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding reporting, recording, photographing use of force incidents. 2. Review of job descriptions/post orders. 3. Review of training for those who may/will be photographers. 4. Review of incident reports; use of force packets. 5. Review of investigations; critique of utility of photographs. 6. Review of remedial or corrective action plans, if any. 7. Interview with IAB staff.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Monitors reviewed use of force packages prepared by TAAP. All contained photos. If there are any issues with photographs, TAAP identifies, and works to improve compliance.			
Monitor's Recommendations:	Nothing further at this time.			

Paragraph	III.A.5.c. (8) MDCR shall ensure that a supervisor is present during all planned uses of force and that the force is videotaped.			
Compliance Status:	Compliance: 7/11/18, 12/10/17, 3/3/17, 7/29/16, 10/24/14, 7/11/18	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force; supervisory presence; location of recording equipment; supervision of recording equipment (batteries charged, repairs needed, etc.) 2. Policies and procedures regarding digitally recording incidents; training for users; instructions. 3. Review of incident reports; including exceptions in which digital recordings not made. 4. Review of investigations; review of digitally recorded incidents. 5. Review of remedial or corrective actions, if any. 6. Interview with IAB staff.			
Steps taken by the County to Implement this paragraph:	As requested by the Monitor, MDCR conducted an audit of this provision, produced in June 1, 2018.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR's self-audit found that 8/9 planned uses of force had video recording; and one did not due to error or malfunction of equipment. In one planned use of force, a supervisor was not present. MDCR also found that "a large percentage" of RTR incidents were received by TAAP without the hand held camera video submitted. There was no action plan provided to address the issue. It would have been more precise to include how many are "a large percentage". This paragraph is found in compliance for this tour; and will remain in compliance pending a repeated audit of this matter prior to the next tour, including a production of a corrective action plan, if indicated by the audit.			
Monitor's Recommendations:	1. Repeat/update the audit for the last six months of 2018 and develop a corrective action plan, if indicated. 2. Include data in the audit, rather than "a large percentage". This cannot be measured in terms of progress.			

Paragraph	III.A.5.c. (9) Where there is evidence of staff misconduct related to inappropriate or unnecessary force against inmates, the Jail shall initiate personnel actions and systemic remedies, including an IA investigation and report. MDCR shall discipline any correctional officer with any sustained findings of the following: i. engaged in use of unnecessary or excessive force; ii. failed to report or report accurately the use of force; or iii. retaliated against an inmate or other staff member for reporting the use of excessive force; or iv. interfered with an internal investigation regarding use of force.		
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 1/8/16	Partial Compliance: 5/15/15, 10/24/14	Non-Compliance: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Personnel policies and procedures regarding employee discipline; relevant portions of CBAs. 2. Employee disciplinary reports; investigations. 3. Employee disciplinary sanctions. 4. Records of hearings, including arbitration hearings, if any. 5. Documentation of terminations for cause.		
Steps taken by the County to Implement this paragraph:	MDCR provided a summary of actions taken.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Monitor is concerned about the length of time between an incident where staff misconduct is potentially founded, and the disciplinary process – which is taking more than six months (based on the six reviews conducted by the Monitor for the first quarter of 2017). The reasons for the delays should be evaluated and changes made where necessary. The Monitor did not meet with the SAO this tour, but invited any comments or concerns; none were reported.		
Monitor's Recommendations:	No further recommendations at this time.		

Paragraph See also Consent Agreement III. B. 3. b.	III.A.5.c. (10) The Jail will ensure that inmates receive any required medical care following a use of force.			
Compliance Status:	Compliance: 7/11/18, 3/3/17, 7/29/16, 5/15/15, 10/24/14, 3/28/14	Partial Compliance: 7/19/13, 12/7/17	Non-Compliance:	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	1. Policies and procedures regarding medical care following a use of force, including use of digital recordings. 2. Incident reports. 3. Review of inmate medical records 4. Interview with medical personnel. 5. Lesson plans.			
Steps taken by the County to Implement this paragraph:	A change since the last tour is that CHS uses the electronic medical record to document an inmate's examination/injuries related to a use of force. The challenge has been for the provider to note that the examination was pursuant to a use of force and that there is, as appropriate and safe, a confidential screening. In its review of this draft compliance report, the County renews its objection that there should be no link between compliance in the Settlement Agreement and Compliance in the Consent Agreement.			
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	A review of TAAP reports shows that inmates are referred to medical care even if there are no apparent injuries, or no complaints by the inmates involved or if the inmate refuses treatment. See III. CA A. 5. c.			
Monitors' Recommendations:	1. Coordinate with CHS regarding the similar paragraph in the Consent Agreement.			

Paragraph	III. A. 5.c. (11) Every quarter, MDCR shall review for trends and implement appropriate corrective action all uses of force that required outside emergency medical treatment; a random sampling of at least 10% of uses of force where an injury to the inmate was medically treated at the Jail; and a random sampling of at least 5% of uses of force that did not require medical treatment.			
Protection from Harm: Compliance Status:	Compliance: 7/11/18	Partial Compliance 12/7/17, 3/3/17, 7/29/16, 5/15/15	Non-Compliance: 10/24/14, 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding production of reports, and corrective action plans meeting above criteria. 2. Quarterly reports, and corrective action plans. 3. Review of quarterly medical/mh QA/QI reporting.			
Steps taken by the County to Implement this paragraph:	MDCR conducted an undated review of the provisions of this paragraph for the first quarter of 2018. There were 166 uses of force in the first quarter of 2018 and reviews were conducted regarding the six inmates who received outside emergency medical treatment, a review of 10% of the 106 uses of force for which inmates were treated inside the facility, and a review of 5% of the 19 uses of force for which the inmate did not require medical treatment. There are recommendations and an action plan presented. In its review of this draft compliance report, the County renews its objection that there should be no link between compliance in the Settlement Agreement and Compliance in the Consent Agreement.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Monitor finds this paragraph in partial compliance as the documentation provided that an appropriate corrective plan has been developed/implemented and the findings are dated July 5 (above referenced report appears to be from May 2018). The Monitor requested and received the spreadsheets providing the source data for the MDCR's self -review referenced above: 2018 Q1 – events not requiring medical treatment – were a total of 19 uses of force involving inmates who did not require medical treatment (N=9 in the review); 2018 Q1 – uses of force required outside emergency treatment – a total of six inmates required outside emergency treatment (N=6 in the report); 2018 Q1 uses of force required basic medical attention in the facility – 106 inmates reported involved in uses of force requiring treatment in the facility (10%) (N=15 in the MDCR report). One issue not included in MDCR's report is the extent to which the injuries were the result of the underlying inmate/inmate altercation.			
Monitor's Recommendations:	1. Update and revise the action plan to include how success is measured. There seems to be more attention to the physical plant than to the knowledge and skills of staff working in the mental health units particularly. The report should also assess the injuries that are a result of the underlying inmate/inmate altercation (as appropriate) versus the injury related to a use a force by MDCR. 2. Involve CHS' behavior health staff in the initiative. 3. De-escalation is more than just verbal commands. Review, revise and update training materials.			

Paragraph See also Consent Agreement III. B. 3. b.	III.A.5.c. (12) Every 180 days, MDCR shall evaluate use of force reviews for quality, trends and appropriate corrective action, including the quality of the reports, in accordance with MDCR's use of force policy.			
Protection from Harm: Compliance Status:	Compliance: 7/11/18, 3/3/17, 5/15/15	Partial Compliance: 12/10/17, 7/29/16	Non-Compliance: 10/24/14, 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding uses of force. 2. Semi-annual report/evaluation of uses of force/quality control. 3. Corrective action plans, if any. 4. Documentation of meetings with MDCR leadership regarding the report's findings; documentation of collaboration with medical/mh staff, if necessary.			
Steps taken by the County to Implement this paragraph:	MDCR also notes that a new incident code has been implemented to better capture this data; but do not indicate when the relevant directive, and related lesson plans, will be revised. In its review of this draft compliance report, the County renews its objection that there should be no link between compliance in the Settlement Agreement and Compliance in the Consent Agreement.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR is commended for undertaking the above review, although, methodologically, it is unclear if any of the reported data is an unduplicated count. The work to assess the emergency treatment orders for 2017 to learn about categorizing uses of force is also good work. MDCR continues to work on countermeasures and plans of action.			
Monitor's Recommendations:	1. Analyze the data in the quarterly reports. 2. Develop plans of action/countermeasures as needed.			

Paragraph	III.A.5.c. (13) MDCR shall maintain policies and procedures for the effective and accurate maintenance, inventory and assignment of chemical and other security equipment.			
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 10/24/14, 3/28/14	Partial Compliance:	Non-Compliance: 7/19/13	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures for maintenance, inventory and assignment of and other security equipment. 2. Logs and/or other documentation of inventory inspections. 3. Invoices for repair of equipment. 4. Review of incident reports. 5. Visual inspections.			
Steps taken by the County to Implement this paragraph:	MDCR conducted an updated audit of security equipment, for the period October 2017 – March 2018. The finding of the audit is that the inventories and logs were maintained in accordance with departmental policies and procedures. However, deficiencies were noted for MW's Electronic Control Devices (33% compliance); OC at MW and PTDC (83%), and at TGK – 50% compliance. Radio equipment inspections were found in 100% compliance. An action plan was presented.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This paragraph is found in compliance as MDCR has identified and corrected deficiencies. This paragraph, including the results of the corrective action plan will be reviewed at the next tour.			
Monitor's Recommendations:	1. Repeat/update the audit for the last six months of 2018. 2. Report on the corrective action prior to the next tour (can be part of the audit). 3. Be sure to date all audit reports.			

Paragraph	III.A.5.c. (14) MDCR shall continue its efforts to reduce excessive or otherwise unauthorized uses of force by each type in each of the Jail's facilities annually. If such reduction does not occur in any given year, MDCR shall demonstrate that its systems for preventing, detecting, and addressing unauthorized uses of force are operating effectively.			
Compliance Status:	Compliance: 7/11/18, 3/3/17	Partial Compliance: 12/7/17, 7/29/16, 5/15/15	Non-Compliance: 10/24/14, 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding unauthorized uses of force and/or allegations of excessive force. Evaluation of uses of force involving inmates on the mental health caseload. 2. MDCR annual reporting, by facility. 3. Review of incidents. 4. Review of baseline for determining increases/decreases, and subsequent data reporting. 5. Observation and interview. 6. Review of a corrective action plans, if needed			
Steps taken by the County to Implement this paragraph:	Analysis of incidents and labor management reports does not reveal a pattern of excessive or otherwise unauthorized uses of force. MDCR also provided a mid-course correction for this provision regarding minimizing uses of force and inmate/inmate assaults. (July 5, 2018)			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR needs to reduce uses of force, especially for inmates on the mental health caseload. Data and review of incidents does not reveal a pattern of excessive or otherwise unauthorized uses of force. The County continues its efforts to generally reduce the uses of force, which will require more work. In regard to the paragraph's requirement to review "excessive or otherwise unauthorized uses of force", the Monitor does not find this to be occurring in individual instances or in a pattern.			
Monitor's Recommendations:	No further recommendations at this time.			

<table>
<tr><td>Paragraph</td><td colspan="4">III. A. 5. Use of Force by Staff
d. Use of Force Training
(1) Through use of force pre-service and in-service training programs for correctional officers and supervisors, MDCR shall ensure that all correctional officers have the knowledge, skills, and abilities to comply with use of force policies and procedures.
(2) At a minimum, MDCR shall provide correctional officers with pre-service and biennial in-service training in use of force, defensive tactics, and use of force policies and procedures.
(3) In addition, MDCR shall provide documented training to correctional officers and supervisors on any changes in use of force policies and procedures, as updates occur.
(4) MDCR will randomly test at least 5% of the correctional officer staff annually to determine their knowledge of the use of force policies and procedures. The testing instrument and policies shall be approved by the Monitor. The results of these assessments shall be evaluated to determine the need for changes in training practices or frequency. MDCR will document the review and conclusions and provide it to the Monitor.</td></tr>
<tr><td>Compliance Status:</td><td>Compliance: 7/11/18, 3/3/17</td><td>Partial Compliance: 12/7/17, 7/29/16, 10/24/14, 3/28/14, 7/19/13</td><td>Non-Compliance:</td><td>Other: Per MDCR not reviewed in 5/15, 1/16</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><u>Protection from Harm:</u>
A. Policies and procedures regarding training.
B. Lessons plans. Evidence that data and information gathered (as noted in the Settlement Agreement) is used to inform and update training lesson plans, including information from IAB investigations. Evidence that the results of random interviews used to inform update of lesson plans.
C. Training schedules.
D. Documentation of provision of updates to supervisors; sign-offs, etc.
E. Reports of random interviews.
F. Observation and interviews.
G. Report noted in III.A.5.c.(12)</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="4">In March 2018, MDCR provided the Monitor with information that the 5% testing had not taken place in 2017. Additionally, the Monitor reviewed the testing process and test questions, raising significant concerns and providing recommendations. On July 6, 2018, MDCR produced evidence of an in-depth process to reform this testing process, including use of subject matter expert panels, analysis of test questions, and trial testing. Based on that exercise, MDCR produced a plan, questions for the Monitor's approval, and scheduling.</td></tr>
<tr><td>Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)</td><td colspan="4">MDCR acknowledged the issues with testing in 2017, the process to develop the questions, and the reform process for the testing. The testing for 2018 will be completed prior to the next compliance tour.

In other provisions, the Monitors have approved the training plan and schedule, in lieu of waiting for all employees to be trained. As such, the Monitor finds this provision in compliance; and notes that if there are any deviations from MDCR's plan, these will be noted in the next compliance tour, and any adjustments to compliance noted at that time.</td></tr>
</table>

Monitor's Recommendations:	1. Provide the outcome of the 2018 testing prior the next compliance tour; provide the schedule for the annual testing for 2019 prior to the next tour.

<table>
<tr><td>Paragraph</td><td colspan="4">III. A. 5. Use of Force by Staff
e. Investigations
(1) MDCR shall sustain implementation of comprehensive policies, procedures, and practices for the timely and thorough investigation of alleged staff misconduct.
(2) MDCR shall revise its “Complaints, Investigations & Dispositions” policy (DSOP 4-015) to ensure that all internal investigations include timely, thorough, and documented interviews of all relevant staff and inmates who were involved in, or witnessed, the incident in question.
i. MDCR shall ensure that internal investigation reports include all supporting evidence, including witness and participant statements, policies and procedures relevant to the incident, physical evidence, video or audio recordings, and relevant logs.
ii. MDCR shall ensure that its investigations policy requires that investigators attempt to resolve inconsistencies between witness statements, i.e. inconsistencies between staff and inmate witnesses.
iii. MDCR shall ensure that all investigatory staff receives pre-service and in-service training on appropriate investigations policies and procedures, the investigations tracking process, investigatory interviewing techniques, and confidentiality requirements.
iv. MDCR shall provide all investigators assigned to conduct investigations of use of force incidents with specialized training in investigating use of force incidents and allegations, including training on the use of force policy.</td></tr>
<tr><td>Protection from harm: Compliance Status:</td><td>Compliance: 7/11/18, 3/3/17</td><td>Partial Compliance: 12/7/17, 7/29/16, 10/24/14, 3/28/14</td><td>Non-Compliance: 7/19/13</td><td>Other: Per MDCR not reviewed in 5/15, 1/16</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><u>Protection from Harm:</u>
1. Policies and procedures for IAB. Recordkeeping/data reporting.
2. Review of a sample of internal investigations.
3. Evidence that IAB attempts to resolve inconsistencies between statements by staff, witnesses, subject inmate, medical and mental health staff.
4. Review of investigative logs.
5. Review of timeliness of completion of investigations.
6. Memorandum of agreement with State’s Attorney regarding referrals for prosecutions. Documentation of referrals for prosecution, if any. Acceptance and/or declination of prosecution by State’s Attorney; reasons for declinations.
7. Interviews with IAB staff.
8. Training records of investigators.
9. Interviews with prosecutors.
10. Medical/mental health policies and procedures regarding cooperation with IAB investigations, release of medical reports, input into IAB review.
11. Evidence of medical and mental health cooperation/collaboration in IAB investigations into uses of force; e.g. requests for and release of inmate medical records.
12. Interviews with medical and mental health staff.</td></tr>
</table>

	Mental Health: See Protection from Harm Review of investigations as they relate to inmates with severe mental illness and in the process of detoxification. This shall include but not be limited to inmate-on-inmate assaults, deaths, and suicides.
Steps taken by the County to Implement this paragraph:	The County is implementing more investigative capacity at the facility level, and at SIAB. These investigators, who may be cross-certified, require training on use of force investigations. MDCR is working to improve response to the requirements of ii. above – "MDCR shall ensure that its investigations policy requires that investigators attempt to resolve inconsistencies between witness statements, i.e. inconsistencies between staff and inmate witnesses." MDCR's first quarter report for 2018 indicates that 43%of inmate/inmate assaults have an "undetermined" cause.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See CA III.A. 5.c This paragraph is in compliance; which means SA III.A.5.e. is in compliance as well.
Monitor's Recommendations:	1. Assure that newly designated/assigned investigators receive training; provide documentation prior to the next compliance tour.

III. A.6. Early Warning System

Paragraph	III. A. 6. Early Warning System a. Implementation (1) MDCR will develop and implement an Early Warning System ("EWS") that will document and track correctional officers who are involved in use of force incidents and any grievances, complaints, dispositions, and corrective actions related to the inappropriate or excessive use of force. All appropriate supervisors and investigative staff shall have access to this information and monitor the occurrences. (2) At a minimum, the protocol for using the EWS shall include the following components: data storage, data retrieval, reporting, data analysis, pattern identification, supervisory assessment, supervisory intervention, documentation, and audit. (3) MDCR Jail facilities' senior management shall use information from the EWS to improve quality management practices, identify patterns and trends, and take necessary corrective action both on an individual and systemic level. (4) IA will manage and administer the EWS. IA will conduct quarterly audits of the EWS to ensure that analysis and intervention is taken according to the process described below. (5) The EWS will *analyze the data according to the following criteria:* i. number of incidents for each data category by individual officer and by all officers in a housing unit; ii. average level of activity for each data category by individual officer and by all officers in a housing unit; iii. identification of patterns of activity for each data category by individual officer and by all officers in a housing unit; and iv. identification of any patterns by inmate (either involvement in incidents or filing of grievances).			
Compliance Status:	Compliance: 12/7/17, 3/3/17, 1/8/16	Partial Compliance: 7/11/18, 7/29/16, 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed 5/15
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures establishing and maintaining the early warning system; including criteria for thresholds and referrals. 2. Existence of a fully functioning early warning system. 3. Reports generated by the early warning system as described above. 4. Evidence of employee actions (e.g. remedial training, EAP, disciplinary actions, terminations) based on early warning system. 5. MDCR report of trends, etc. regarding use of force and employee corrective actions. 6. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.			
Steps taken by the County to Implement this paragraph:	MDCR conducted a review/audit of the Early Warning (EWS) and Intervention System, dated June 1, 2018, with the goal of improving the overall quality of reviews by MDCR shift supervisors and the effectiveness of the EWS, and the objective to mitigate any potential liabilities through training of shift supervisors on the intervention review process			

	and provision of the resources needed to achieve the overall objective of an effective EWS. Recommendations were provided. Also provided was the Annual Review of the system for calendar year 2017 in which the system alerted 292 times. The report notes that "It is too soon at this point to collect data or to determine if changes to the process are achieving the measurable objectives because training [supervisory] is still on-going. . . "(page 21) More information is noted as being available beginning August 1, 2018. Samples of counseling reports were provided. Upon request, MDCR noted these categories of alerts: alerts per facility, alerts per cells, alerts per employee, alerts per month, alerts per quarter, alerts per year, alerts per shift, average response times for alerts per quarter, # of dispositions/actions, % of dispositions/action, open/past due alerts, reviews that are incorrect/incomplete information, percentage of alerts per facility, RTRs per facility, RTRs per cells, RTRs per employee, RTRs per month, RTRs per quarter, percentage of RTRs per facility, RTRs per shifts and total RTRs generating alerts. Although this list was provided, MDCR indicates that the average level of activity by facility is shown in the report graphically (page 6); however by officer and housing unit is not shown graphically and would have to be calculated manually. This information will be detailed and also shown graphically in the updated version of the report
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This paragraph will remain in partial compliance, . What needs to be addressed prior to the next compliance tour are: • Evidence (minutes, etc.) of how the information is used by leadership to make changes, (3) above; • Regarding (5) ii and iii above – computation of the data, or an explanation of why it is not provided; or suggestions of another alternative; • Provision of the additional information noted by MDCR in the provision of documentation for this tour – that being a field audit has been scheduled to assess the effectiveness of the trainings that were conducted on the EWIS System back in May 2018. A make-up training is also occurring July 20, 2018, for those that were not available for the May trainings, this training will also include the Chiefs. From Compliance Report # 8 – require initial and updated information: • MDCR will provide a revised policy/procedure (draft is acceptable); • The recommendations for change to the program since moving it to the Regulatory and Compliance Division, and if those recommendations were implemented (action plans acceptable); • Any benchmarks or measurable objectives established for the EIS; • The training lesson plan(s) for facility based staff in EIS; • The schedule for training; and • Data indicating if changes to the process are achieving benchmarks or measurable objectives. The primary purpose of an EWS is to quickly identify and remove/remediate officers who are involved with potentially excessive uses of force. The goal of this MDCR's review, referenced above, was to look at improving responses, and mitigating department liability. While not mutually exclusive goals, the EWS needs to focus on the identifying and

	removing officers who are under investigation from inmate contact and protecting inmates, and that's what the evaluation should have assessed. The Monitor notes that MDCR has no allegations of excessive force. MDCR's report notes that TAAP holds annual meetings to discuss statistical and practical data associated with the EWS and that data is used to determine individual and/or systemic problems and develop an effective methodologies for corrective actions if necessary. The report suggests that TAAP has made recommendations for several years that may or may not have been implemented. Regarding the annual report, the Monitor suggests that MDCR may wish to evaluate the utility and usefulness of the data, citing how the information is issued in decision making (3 above). A 144 page report without findings or recommendations does not see as particularly useful. It is the prerogative of MDCR to change it or not. MDCR provided a current list of 18 names of officers who received or are pending disciplinary action related to use of force incidents. The incidents are from 2015 – 2018. If the case file is sent to the State's Attorney for review prior (N=12) to imposition of discipline, the time lag can be significant. For example, one incident from November of 2015 was with the SAO until May 2017, and the final disciplinary action imposed by MDCR on June 5, 2018. The SAO chose not to take any action on any of the 18 cases. While the time lines are not specifically included in the relevant paragraph of the Settlement Agreement, the longer the disciplinary process drags on, the less impact it has on employee behavior. For the six cases not forwarded to the SAO, the time from incident until disciplinary action appears to average around 7.5 months; but only 1 of those incidents is shown as completed.
Monitor's Recommendations:	1. Prior to the next compliance tour, provision of: a. Evidence (minutes, etc.) of how the information is used by leadership to make changes, (3) above; b. Regarding (5) ii and iii above – computation of the data, or an explanation of why it is not provided; or another alternative; c. Provision of the additional information noted by MDCR in the provision of documentation for this tour – that being a field audit has been scheduled to assess the effectiveness of the trainings that were conducted on the EWIS System back in May 2018. A make-up training is also occurring July 20, 2018, for those that were not available for the May trainings, this training will also include the Chiefs. d. MDCR will provide a revised policy/procedure (draft is acceptable); e. The recommendations for change to the program since moving it to the Regulatory and Compliance Division, and if those recommendations were implemented (action plans acceptable); f. Any benchmarks or measurable objectives established for the EIS; g. The training lesson plan(s) for facility based staff in EIS; h. The schedule for training; and i. Data indicating if changes to the process are achieving benchmarks or measurable objectives.

Paragraph	III. A. 6. Early Warning System b. MDCR will provide to DOJ and the Monitor, within 180 days of the implementation date of its EWS, and on a bi-annual basis, a list of all staff members identified through the EWS, and any corrective action taken.		
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 1/8/16	Partial Compliance: 7/29/16, 5/15/15	Non-Compliance: 10/24/14, Not yet due, 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding EWS and reporting. 2. Reports on EWS (180 days and bi-annually), as specified above. 3. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The list was provided.		
Monitor's Recommendations:	See recommendations III.A.6. a.		

Paragraph	III. A. 6. Early Warning System c. On an annual basis, MDCR shall conduct a documented review of the EWS to ensure that it has been effective in identifying concerns regarding policy, training, or the need for discipline.		
Compliance Status:	Compliance: 3/3/17, 1/8/16	Partial Compliance: 7/11/18, 12/7/17, 7/29/16, 5/15/15	Non-Compliance: 10/24/14 not yet due; 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding annual report. 2. Production of a review of the EWS; recommendations for changes, if needed. 3. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.		
Steps taken by the County to Implement this paragraph:	The reports provided by MDCR do not address the question of whether EWS is effective. In fact, the report notes that it is too soon to tell (page 22) regarding pending training to support the EWS' effectiveness.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	There is data generated by the EWS, but the analysis does not answer the question required by this paragraph – does it work.		
Monitor's Recommendations:	1. Prior to the next tour, identify the benchmarks that indicate that the EWS is successful, conduct analysis and produce a report regarding effectiveness.		

III. B. Fire and Life Safety

MCDR shall ensure that the Jail's emergency preparedness and fire and life safety equipment are consistent with constitutional standards and Florida Fire Code standards. To protect inmates from fires and related hazards, MDCR, at a minimum, shall address the following areas:

Paragraph(s):	III. B. 1. Fire and Life Safety 1. Necessary fire and life safety equipment shall be properly maintained and inspected at least monthly. MDCR shall document these inspections.			
Compliance Status:	Compliance: 7/11/18, 12/7/17; 3/17	Partial Compliance: 7/16, 10/14; 3/14; 7/13	Non-Compliance:	Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):	None			
Measures of Compliance:	Fire and Life Safety: 1. Develop a detailed controlled document inventory of all fire and life safety equipment for each facility. The list should include but is not limited to sprinkler heads, fire alarm pull boxes, and smoke detector units, and its location for each facility 2. Establish either a MDCR or facility specific formal policy outlining the procedure and staff responsibility including accountability for the monthly inspection, repair, and or replacement of all fire and life safety equipment included in the controlled document inventory. 3. Annual master calendar for all internal and external inspection of all fire and life safety system components. 4. Completed, signed, and supervisory review of all inspection and testing reports, along with documented corrective actions taken to resolve identified non-conformances.			
Steps taken by the County to Implement this paragraph:	MDCR provided inventories of and internal inspections of, extinguishers, sprinklers, smoke detectors pull stations , etc. as well as annual external inspections from vendor inspections as well as the fire inspector. They also provided extinguisher inventories, Policy revision of DSOP-10-022, FMB device checklist and Monthly Fire Inspections			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR is in compliance with this paragraph and has expressed the desire to continue to improve and streamline or automate some of these processes where possible. While an annual master calendar for all internal and external inspections was not provided, it is clear they are being conducted.			
Monitor's Recommendations:	No additional recommendations.			

Paragraph(s):	III. B. 2. Fire and Life Safety 2. MDCR shall ensure that fire alarms and sprinkler systems are properly installed, maintained and inspected. MDCR shall document these inspections.			
Compliance Status:	Compliance: 7/11/18, 12/7/17; 3/17; 10/14; 3/14; 7/13	Partial Compliance: 7/16	Non-Compliance:	Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):	None			
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. Development of either a MDCR or facility specific policy mandating at least an annual inspection of all fire alarms and sprinkler systems. The policy needs to include assurance of installation in accordance with all applicable fire codes and require effective repairs for any deficiency found. All policies and procedure are to be reviewed and updated as necessary at least annually on a schedule. 2. Establishment and implementation of a written contract with a company licensed to conduct the inspection, and make repairs. 3. Copies of the annual inspection reports and corrective actions taken for all non-conformances.			
Steps taken by the County to Implement this paragraph:	MDCR provided annual and monthly inspections of the above mentioned systems to include documentation from outside vendors contracted for inspection and repair.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Upon inspection the Monitor observed this equipment to be in good repair and operational. All facilities passed their inspections.			
Monitor's Recommendations:	No additional recommendations.			

Paragraph(s):	III. B. 3. Fire and Life Safety 3. Within 120 days of the Effective Date, emergency keys shall be appropriately marked and identifiable by sight and touch and consistently stored in a quickly accessible location; MDCR shall ensure that staff are adequately trained in the location and use of these emergency keys.			
Compliance Status:	Compliance: 7/11/18, 12/7/17; 3/17	Partial Compliance: 7/29/16; 10/14; 3/14; 7/13	Non-Compliance:	Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):	None			
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. Establishment of a MDCR or facility specific policy outlining the policy and procedure and staff responsibility and accountability for the systematic marking of emergency keys. It must include sight and touch identification and designated locations for quick access for all keys. All policies and procedure are to be reviewed and updated as necessary at least annually on a schedule. 2. Implementation of the policy and procedure. 3. Documented evidence of officer and staff training on the policy and procedure.			
Steps taken by the County to Implement this paragraph:	MDCR continues to follow DSOP Policy 11-023 "Key Control" reauthorized 11/4/16. MDCR sent samples of training documentation from all four facilities including pre and post tests.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This monitor was able to observe the keys from PTDC to be notched and in compliance with this provision. Discussions with the key control officer additionally confirmed the training method and scheduling of such training. This provision remains in compliance.			
Monitor's Recommendations:	No additional recommendations.			

Paragraph(s):	III. B. 4. Fire and Life Safety 4. Comprehensive fire drills shall be conducted every three months on each shift. MDCR shall document these drills, including start and stop times and the number and location of inmates who were moved as part of the drills.		
Compliance Status:	Compliance: 7/11/18, 12/7/17; 3/17	Partial Compliance: 7/16; 1/16; 5/15; 10/14; 3/14; 7/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour(s):			
Measures of Compliance:	Fire and Life Safety: 1. Establishment of a MDCR or facility specific policy outlining the policy and procedures including staff responsibility and accountability for conducting fire drills within each facility at least once every three months on each shift. The policy shall include applicable drill reports that outline at a minimum start and stop times of the drills and the number of inmates who were moved as part of the drills, a formal review process for each drill that identifies the root cause of any identified non-conformities, along with documented verified corrective actions taken as a result of the analysis. 2. Appointment of facility specific fire safety officers that assures at least one trained designated officer on duty on all shifts to oversee fire drills and verify corrective actions as necessary for non-conformities. 3. Development of a confidential annual drill schedule that meets the minimum requirements of the "Settlement Agreement." 4. Documented evidence that the fire drills are conducted that meet the minimum requirements specified. 5.		
Steps taken by the County to Implement this paragraph:	MDCR provided comprehensive documentation to include the DSOP 10-022 revision, 6-month fire drill audit, the Training unit's response to the 6 month audit and monthly drill audits for each facility to include corrective action.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	All provided drill reports were reviewed. For any drills missed by a facility, written explanations were provided.		
Monitor's Recommendations:	No recommendations at this time		

Paragraph(s):	III. B. 5. Fire and Life Safety 5. MDCR shall sustain its policies and procedures for the control of chemicals in the Jail, and supervision of inmates who have access to these chemicals.			
Compliance Status:	Compliance: 7,11,18, 12/7/17; 3/17	Partial Compliance: 7/16; 10/14; 3/14	Non-Compliance: 7/13	Other: Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):	None			
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. Establishment of either a MDCR or facility specific documented policy outlining the procedures including staff responsibility and accountability for the control of all chemicals in the jail including cleaning, maintenance, pest control, food service and flammables. This includes procedures for chemical spill response and cleanup and personal protective equipment including but not limited to gloves, eye, and skin protection. 2. Establishment of either a MDCR or facility documented specific policy outlining the safe and effective use of chemicals including training requirements and supervision of inmates who have access to them. 3. Evidence of effective implementation of the policies and procedures. 4. Each facility shall maintain spill kits in their designated chemical supply areas that are replaced as necessary. 5. Observations by the monitor.			
Steps taken by the County to Implement this paragraph:	MDCR provided documentation of Staff Chemical Training, Inmate Chemical Training, Chemical Inventory logs, Decontamination Cart Inventories and Universal Chemical Spill kit Inventories for all facilities.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Monitor observed numerous chemical/supply closets containing the correct inventories. These inventories were in pictorial as well as narrative form. This paragraph continues to be substantially compliant.			
Monitor's Recommendations:	1. Ensure all inventory forms for chemicals are clear on what is being counted i.e. ounces, bottles, cases, cans etc.			

Paragraph(s):	III. B. 6. Fire and Life Safety 6. MDCR shall provide competency-based training to correctional staff on proper use of fire and emergency equipment, at least biennially.			
Compliance Status:	Compliance: 7/11/18, 12/7/17; 3/17	Partial Compliance: 7/16; 10/14	Non-Compliance: 3/14; 7/13	Other: Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):				
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. Establishment of either an MDCR or facility specific policy and procedures for competence-based biennial training for correctional staff on safe and effective use of all fire and emergency equipment. 2. Written training outline/syllabus for the training that identifies all elements for safe and effective use of all fire and emergency equipment including training time. 3. Written procedure on how MDCR will identify each officer and staff who is required to receive training, the training date, name of the officer trained competency measurement score, and trainer. 4. Verification by sign-in logs of participants, and validation of successful completion of training. 5. Observation of implementation.			
Steps taken by the County to Implement this paragraph:	MDCR provided as documentation: Biennial Training sheets, CHS Rapid Response Policy 034, Maintenance Training memo, Samples of FLS training for staff from all facilities to include pre and Post tests as well as Practicums. Currently MDCR has 2041 sworn staff. They have developed a schedule demonstrating that all staff will complete initial training by mid-2018. At this point MDCR reports approx. 1700 staff have been trained.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The status of the training will be reviewed at the next compliance tour			
Recommendations:	No recommendations at this time			

III. C. Inmate Grievances

Paragraph Coordinate with Drs. Johnson and Greifinger See also Consent Agreement III.A.3.a.(4) and III.D. 1.b.	III. C. Inmate Grievances MDCR shall provide inmates with an updated and recent inmate handbook and ensure that inmates have a mechanism to express their grievances and resolve disputes. MDCR shall, at a minimum: 1. Ensure that each grievance receives follow-up within 20 days, including responding to the grievant in writing, and tracking implementation of resolutions. 2. Ensure the grievance process allows grievances to be filed and accessed confidentially, without the intervention of a correctional officer. 3. Ensure that grievance forms are available on all units and are available in English, Spanish, and Creole. MDCR shall ensure that illiterate inmates, inmates who speak other languages, and inmates who have physical or cognitive disabilities have an adequate opportunity to access the grievance system. 4. Ensure priority review for inmate grievances identified as emergency medical or mental health care or alleging excessive use of force. 5. Ensure management review of inmate grievances alleging excessive or inappropriate uses of force includes a review of any medical documentation of inmate injuries. 6. A member of MDCR Jail facilities' management staff shall review the grievance tracking system quarterly to identify trends and systemic areas of concerns. These reviews and any recommendations will be documented and provided to the Monitor and the United States.			
Protection from Harm: Compliance Status:	Compliance: 3/3/17, 7/29/16, 5/15/15	Partial Compliance: 7/11/18, 12/7/17, 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding inmate grievances per the specifications above. 2. Updated inmate handbook. 3. Review of grievance forms (Creole, English, Spanish) 4. Review of procedures for LEP inmates, and illiterate inmates. 5. Review of a sample of grievances. 6. Observation of grievances boxes and processing of grievances. 7. Interview with inmates. 8. Evidence of referral of grievances alleging use of force; sexual assault. 9. Quarterly tracking/data reporting; recommendations, if needed. 10. Documentation of collaboration between security and medical/mental health regarding inmate grievances. 11. Quarterly report of trends, by facility; corrective action plans, if any. Medical Care: • Review of Quality Improvement Plan and bi-annual evaluations • QI committee minutes			

	• Clinical performance measurement tracked and trended over time, with remedial action timelines and periodic re-measurement • Review of grievances, responses, and data analysis <u>Mental Health:</u> See Protection from Harm and Medical Care
Steps taken by the County to Implement this paragraph:	Since the last compliance tour, MDCR/CHS established a grievance task force to examine the process and develop corrective actions. This includes creation of an audit tool regarding grievances. MDCR provided an Inmate Grievance Process Improvement Report, dated June 6, 2018 with the objective to report on MDCR and CHS' efforts to improve the inmate grievance process. The report addresses the delay in processing medical grievances, the substance of the grievance response, processing allegations of staff misconduct and uses of force, complaint categorization, developing of electronic submission of medical grievances, and a description of the CHS/MDCR grievance task force, formed in January 2018. The improvement work includes: giving inmates an updated and recent inmate handbook (by 7/1/18), ensure grievance has a follow-up within 20 days, including responding to the grievant in writing and tracking resolutions, assuring confidentiality of medical grievances (locked grievance boxes on 3/5/18), assuring forms are on each unit in English, Spanish and Creole, as well as providing assistance to LEP inmates and/or inmates with cognitive disabilities, assure timely review to identify emergencies, assure review of grievances alleging excessive or inappropriate uses of force, and a quarterly review by jail management to identify trends and systemic areas of concerns. Also the information management system has been amended to require additional information be inputted to allow assessment of grievances, including improved categorization of the grievance. An audit of the grievance process, dated June 12, 2018, using the audit tool, was conducted. The results in most instances were within acceptable limits, with work needed in timely responses and referrals of grievances for further investigations (to SIAB). In its review of this draft compliance report, the County renews its objection that there should be no link between compliance in the Settlement Agreement and Compliance in the Consent Agreement.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	**NOTE that <u>CA III. A. 3. (4)</u> is in partial-compliance as it was in Compliance Report # 8.** This finding by the Medical and MH monitors acknowledges progress, but note that the initiatives are new, and there is not yet demonstration of sustainability. MDCR and CHS have done substantial credible work to examine the inmate grievance process and develop specific plans of actions and remedies (as noted above). This work should serve as a model for other problem-solving in the organization. The audit documented elements of the process outside acceptable limits, for which an action plan was developed. The Monitor heard from inmates in one housing unit, that the counselor would either not accept their grievance (there is a box for submission), or returned it to them because, in one instance, there were two medical issues on the form. Those grievances were provided to the facility commander by the Monitor for her action. Another concern heard by the Mental Health Monitors was that staff was not available to assist inmates with SMI to write a grievance, and that forms

	or pencils to use to write the grievance not available. Neither of these examples would result in a finding of non-compliance or partial compliance in and of themselves.
Monitors' Recommendations:	1. Implement action plan of Grievance Committee; update findings prior to the next on-site compliance tour.

III. D. Audits and Continuous Improvement

Paragraph Coordinate with DeFerrari	III. D. Self Audits 1. Self Audits			
Protection from Harm: Compliance Status:	Compliance: 7/11/18, 3/3/17	Partial Compliance: 12/7/17, 7/29/16, 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed 5/15, 1/16
Fire and Life Safety: Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/17	Partial Compliance: 7/29/16, 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not Reviewed 1/16; 5/15
Unresolved/partially resolved issues from previous tour:				
	_____ _____			

	2. Inspections should result in identifying specific non-conformities to the policies and include the assigning of persons responsible for taking and documenting corrective actions including oversight to measure the effectiveness of same.
Steps taken by the County to Implement this paragraph:	MDCR provided a review of this provision, dated May 1, 2018, outlining the goal of providing quarterly summary reports to inform staff and note the agency's performance, and establish a continuous performance improvement strategy (analyze performance, describe corrective action plans). The corrective action plans are addressed using the countermeasure process or the Rapid Response Process, or through "direct assignment". This process including identifying Key Performance Indicators (KPIs) to be tracked, analyzed, and used for decision-making and corrective action planning. MDCR also provided a summary of Quality Improvement Procedures and Protection from Harm, dated June 8, 2018. This report summarized the relevant policies, procedures, and committees involved in continuous improvement processes. No examples of the outcomes were provided (other than the self-audits requested by the Monitor prior to this on-site compliance tour). MDCR also provided the Quarterly Summary Report – Response to KPI Analysis for the fourth quarter of 2017.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	<u>Protection from Harm:</u> MDCR has reviewed the quarterly reports to determine if the information is relevant to operational decision-making, and usable throughout the organization. The reporting is not self-monitoring. The Monitor's request to have self-audits conducted prior to this tour is the direction for MDCR. Following the compliance tour, the County produced a list of when self-auditing will begin. While the Monitor understands that the agency wishes to establish numerical benchmarks for various key performance indicators, there is no bases for these benchmarks in the "industry". In that sense, these data are arbitrary, not supported by "industry" data, and subject future findings to questions about the efficacy of the approach. It is the agency's choice to do this; and the Monitor raises these matters for their consideration. As MDCR has proceeded; the Monitor presumes they are informed about the questions associated with the strategy. MDCR indicates that the summary report provides recommendations and corrective actions. Perhaps this is what is anticipated in the future, as this report did not contain recommendations or corrective actions. Additionally, the analyses could be more robust, using narrative rather than charts to inform the readers, as well as decisions-makers. As with the key performance indicator report referenced above, this is a suggestion not a requirement by the Monitor. The measure of whether these processes work can be seen in the outcomes related to the relevant paragraph of this Settlement Agreement in addition to this specific paragraph (above): III.A. "The MDCR Jail facilities' efforts to achieve this constitutionally required protection from harm will include the following remedial measures regarding: (1) Safety and Supervision; (2) Security Staffing; (3) Sexual Misconduct; (4) Incidents and Referrals (5) Use of Force by Staff; and (6) Early Warning System."

	Fire and Life Safety: Nothing further at this time.
Monitors' Recommendations:	Protection from Harm: 1. Update the reporting to match requirements of this paragraph. 2. Establish self-monitoring to address inmates' constitutional rights or the risk of constitutional violations. MDCR, as noted above, is encouraged to self-monitor and to take corrective action to ensure compliance with constitutional mandates in addition to the review and assessment of technical provisions of the Agreement. Fire and Life Safety: No recommendations at this time.

<table>
<tr><td>Paragraph
See Consent Agreement III. D. 2.</td><td colspan="4">D. Self Audits
2. Bi-annual Reports
a. Starting within 180 days of the Effective Date, MDCR will provide to the United States and the Monitor bi-annual reports regarding the following:
(1) Total number of inmate disciplinary reports
(2) Safety and supervision efforts. The report will include:
i. a listing of maximum security inmates who continue to be housed in dormitory settings;
ii. a listing of all dangerous contraband seized, including the type of contraband, date of seizure, location and shift of seizure; and
iii. a listing of inmates transferred to another housing unit because of disciplinary action or misconduct.
(3) Staffing levels. The report will include:
i. a listing of each post and position needed at the Jail;
ii. the number of hours needed for each post and position at the Jail;
iii. a listing of correctional staff hired to oversee the Jail;
iv. a listing of correctional staff working overtime; and
v. a listing of supervisors working overtime.
(4) Reportable incidents. The report will include:
i. a brief summary of all reportable incidents, by type and date;
ii. data on inmates-on-inmate violence and a brief summary of whether there is an increase or decrease in violence;
iii. a brief summary of whether inmates involved in violent incidents were properly classified and placed in proper housing;
iv. number of reported incidents of sexual abuse, the investigating entity, and the outcome of the investigation;
v. a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit;
vi. number of inmate grievances screened for allegations of misconduct and a summary of staff response; and
vii. number of grievances referred to IA for investigation.
b. The County will analyze these reports and take appropriate corrective action within the following quarter, including changes to policy, training, and accountability measures.</td></tr>
<tr><td>Protection from Harm: Compliance Status:</td><td>Compliance: 3/3/17</td><td>Partial Compliance: 7/11/18, 12/7/17, 7/29/16, 1/8/16, 5/15/15, 10/24/14</td><td>Non-Compliance: 3/28/14, Not Yet Due (10/27/13)</td><td>Other:</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><u>Protection from Harm:</u></td></tr>
</table>

	1. Policies and procedures regarding self-audits. 2. Bi-Annual Reports. 3. Corrective action plans, if needed. 4. Evidence of implementation of corrective action plans, if any.
Steps taken by the County to Implement this paragraph:	MDCR produces a biannual report
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Work needs to be completed to fully implement the draft policy.
Monitor's Recommendations:	Protection from Harm: See all recommendations and dates for III. D. 1. a. b.

IV. Compliance and Quality Improvement

Paragraph Coordinate with DeFerrari	IV. COMPLIANCE AND QUALITY IMPROVEMENT (duplicate CA IV.A) A. Within 180 days of the Effective Date, the County shall revise and develop policies, procedures, protocols, training curricula, and practices to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement. The County shall revise and develop, as necessary, other written documents such as screening tools, logs, handbooks, manuals, and forms, to effectuate the provisions of this Agreement. The County shall send any newly-adopted and revised policies and procedures to the Monitor and DOJ for review and approval as they are promulgated. MDCR shall provide initial and in-service training to all Jail staff in direct contact with inmates, with respect to newly implemented or revised policies and procedures. The County shall document employee review and training in policies and procedures.			
Protection from Harm: Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17	Partial Compliance: 7/29/16, 10/24/14	Non-Compliance: 3/28/14, Not yet due (10/27/13)	Other: Per MDCR not reviewed 5/15, 1/16
Fire and Life Safety: Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17	Partial Compliance: 7/29/16; 1/8/16; 10/24/14	Non-Compliance: Not yet due (10/27/13)	Other: Per MDCR, not Reviewed 5/15
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from harm: 1. Policies and procedures regarding compliance and quality improvement. 2. Schedule for production, revision, etc. of written directives, logs, screening tools, handbooks, manuals, forms, etc. 3. Schedule for pre-service and in-service training. 4. Evidence of notification to employees regarding newly-adopted and/or revised policies and procedures. 5. Provision of newly-adopted and/or revised policies and procedures to the Monitor for review and approval. 6. Lesson plans. 7. Evidence training completed and knowledge gained (e.g. pre-and post-tests). 8. Observation. 9. Staff interviews. Fire and Life Safety: 1. Development and implementation of a formal training plan and training matrix for affected staff 2. Course syllabus for the training that addresses all applicable provision mandated in specific policies related to fire and life safety. 3. Evidence of validation of training as well as verification of attendance 4. Results of staff interviews documenting understanding of all applicable policies and ability to carry out the provisions of the policies.			
Steps taken by the County to Implement this paragraph:	MDCR conducted a review of self-audit reporting, dated May 1, 2018. The self-audits are "... designed to encourage MDCR Jail facilities to self-monitor and to take corrective action ..."			

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: This self-review noted the elements to be reviewed and the commitment to ". . . robust analysis of information, trends, and patterns . . ." but did not assess if current efforts are consistent with current procedures/policies. The recommendations provides no specific direction to those charged with doing this audits. The Monitors identified several areas in fire/life safety/environmental conditions where MDCR is producing checklists, but there is no analysis of the checklists at any level – to determine if the forms are completed correctly, completed timely, and/or if there are substantial findings of non-conformance with policy. As such these piles of forms provide no means to assess the County's goals of a sustainable constitutional jail. Self-monitoring and critical self-analyses are key elements to MDCR's compliance with its own policies and procedures, which are developed and implemented to insure a constitutional jail. Absent involvement of outside Monitors, MDCR's initiatives need to assure that the policies are followed, and provide remediation as needed. This paragraph is noted in compliance; at this time, although the Monitor is concerned about the areas of operations that require further review, such as training, to continue to meet the requirements of this provision. Fire and Life Safety: Nothing further at this time.
Monitor's Recommendations:	1. See previous recommendations about amending (editing/shortening) the quarterly and annual reports to include relevant data, analyses, and action plans, as necessary.

Paragraph Coordinate with DeFerrari	IV. COMPLIANCE AND QUALITY IMPROVEMENT (See also Consent IV.B., III.D.1.c., III.D.1.d.) B. The County shall develop and implement written Quality Improvement policies and procedures adequate to identify and address serious deficiencies in protection from harm and fire and life safety to assess and ensure compliance with the terms of this Agreement on an ongoing basis.			
Protection from Harm: Compliance Status:	Compliance: 3/3/17	Partial Compliance: 7/11/18, 12/7/17, 7/29/16, 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed 5/15, 1/16
Fire and Life Safety: Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17	Partial Compliance: 7/29/16, 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not Reviewed 1/16, 5/15
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding compliance and quality improvement. 2. QI reports. 3. Corrective action plans, if needed. 4. Evidence of implementation of corrective action plans, if any. Fire and Life Safety: 1. Development and implementation of compliance with the provision 2. A process for corrective action plans and responsibility assigned			
Steps taken by the County to Implement this paragraph:	MDCR's efforts to achieve compliance with this paragraph have included several audit and self-reviews of operations, as requested by the Monitor in Compliance Report # 8. The County notes in its review of this draft compliance report that it will "launch new performance improvements initiatives each quarter."			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: MDCR collects data. There is improving, but still inadequate analyses of the data, nor development of corrective action plans/countermeasures where indicated. These initiatives are evolving, and will gain compliance with the provision when fully implemented. The amount of time and human resources spent on collecting data, and formatting it into quarterly reports is substantial; but in the view of the Monitors, does not yield a sufficient return on investment. The Monitors have been providing comments on the usefulness of the data included in the quarterly reports for several years, and amendments are beginning to be made. Importantly, this data is for the use of the County; not the Monitors. The Monitors recommend a complete review and overhaul of the system, clarity of why data is collected and how it is used.			

	Fire and Life Safety: Nothing further at this time.
Monitor's Recommendations:	Protection from Harm: 1. Assess the quarterly and annual reports for utility to the County. Determine how the data is used in decision-making, and amend accordingly. Assess the human resources used in this work compared to the return on investment. 2. Coordinate this assessment with CHS' data keeping and QA/QI processes. Determine what data can be jointly collected, analyzed, and how plans of action/countermeasures are developed, implemented and assessed for effectiveness. 3. See recommendations for III.D.1.a.b. Fire and Life Safety: No further recommendations.

Paragraph Coordinate with DeFerrari	IV. COMPLIANCE AND QUALITY IMPROVEMENT (See also Consent IV. A., D.) C. On an annual basis, the County shall review all policies and procedures for any changes needed to fully implement the terms of this Agreement and submit to the Monitor and DOJ for review any changed policies and procedures.		
Protection from Harm: Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 1/8/16	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, Not yet due 7/19/13
Fire and Life Safety: Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16	Partial Compliance: 10/24/14	Non-Compliance: Not yet due 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding compliance and quality improvement. 2. Evidence of annual review. 3. Provision of amendments to Monitor, if any. 4. Implementation, training, guidelines, schedules for any changes Fire and Life Safety: See protection from Harm above. Development and implementation of policies that demonstrate the effectiveness of quality improvement initiatives.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	A memorandum from the Director was provided attesting to the annual review of policies and procedures.		
Monitor's Recommendations:	No further recommendations.		

Paragraph Coordinate with DeFerrari	V. COMPLIANCE AND QUALITY IMPROVEMENT D. The Monitor may review and suggest revisions on MDCR policies and procedures on protection from harm and fire and life safety, including currently implemented policies and procedures, to ensure such documents are in compliance with this Agreement.			
Protection from Harm: Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 10/24/14	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed 5/15, 1/16
Fire and Life Safety: Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	NA			
Measures of Compliance:	Protection from Harm: 1. Production of policies and procedure for review. 2. Production of lesson plans, training schedules, tests Fire and Life Safety: 1. Providing drafts of revised/new policies for all provisions of Fire and Life Safety 2. Providing drafts of training plans for fire, life safety, sanitation, key control, chemical control that include documentation that the plan address all of the provisions of the applicable policies for each of the provisions. 3. Training Schedule and a training matrix that identifies specifically what training is required for each position within MDCR 4. Evidence of how training effectiveness will be measured and process for addressing staff that can or do not demonstrate MDCR specified effectiveness.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)				
Monitor's Recommendations:	No recommendations at this time.			

Compliance Report # 9
Consent Agreement - Medical and Mental Health Care
Report of Compliance Tour, June 25 – 28, 2018

In summary, within the Consent Agreement (CA), the Monitors assigned the following compliance status:

Consent Agreement – Compliance Report # 9 - Status of Compliance[1]

Report #	Compliance	Partial Compliance	Non-Compliance	Not Applicable/Not Due/Other	Total Paragraphs
1	1	56	40	22	119
2	0	38	73	8	119
3	2	19	98	0	119
4	6	35	75	0	116[2]
5	4	50	61	0	115
6	10	65	40	0	115
7	16	51	48	0	115
8	29	70	16	0	115[3]
9	48	60	7	0	115

Preparation for the Tour

The monitors continue to have concerns of CHS' responsiveness to the Monitors' data requests ahead of the tour. The information provided in response to the document request included poorly analyzed data, and some documents that did not tangibly meet the request or the associated provision. However, fewer data were internally inconsistent though the data that was raised realistic concerns for the potential impact on any resultant decision making.

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1 For provisions containing both a Medical and Mental Health component and a status that is not the same, status was determined as follows. If either component was compliant or partially compliant, a status of partial compliance was assigned; if either component was partially compliant or non-complaint, non- compliant is noted.

2 Joint reporting paragraphs removed.

3 For historical data regarding compliance by paragraph, see Appendix B.

Compliance with Summary Action Plan

The medical and mental health Monitors assessed CHS' compliance with Summary Action Plan (SAP), filed with the Court on May 18, 2016. The SAP committed CHS to full compliance by February 21, 2017.

As noted above, this compliance was not achieved.

Medical Care

This was the third on-site compliance tour for the current medical Monitor. The medical Monitor conducted this review with the assistance of Catherine M. Knox, RN, MN, CCHP and Angela Goehring, RN, MSA, CCHP, who were both familiar with the operations of MDCR and CHS through prior compliance reviews.

Since Compliance Tour #8, CHS has made some demonstrable improvements in some of the required medical areas: intake screening, health assessment, access timeliness, medication administration and management, medical record keeping, acute care and detoxification/withdrawal.

Morbidity and mortality reviews are more specific than previously, with better analysis and focused corrective action plans that are tracked over time. However, the findings and corrective action plans are not yet integrated into the quality management program. CHS has developed chronic care guidelines; performance has improved. Data analysis has improved and corrective action plans are focused and specific. Care surrounding use of force has improved, but documentation has not improved. The biannual report has data that is insufficiently analyzed to tell a story. As measured through focused review of medical records, health assessments are being done, but not all are timely. Discharge planning has not improved.

The peer review program has been repaired.

CHS has transitioned to a data-driven quality management program. This is a vast improvement. The implementation of an effective quality management program has assisted the CHS management and clinical leadership teams to identify opportunities for improvement; develop action plans with clear accountabilities for specific personnel. A new grievance task force is collecting data; during our tour we discussed opportunities for better classification and analysis of the data. The quality management committee minutes do not reflect integration of various functions, including clinical performance measurement, morbidity and mortality, training, pharmacy and therapeutics, grievance, etc. There is a new quality management plan and an intent to improve the biannual evaluation of the program.

Mental Health Care

Specific to the timeline outlined in the Summary Action Plan, the Mental Health (MH)

Monitor conducted this review with the assistance of the Asst. MH Monitor, Adam Chidekel, Ph.D., CCHP who is familiar with the operations of MDCR and CHS through prior compliance reviews. We focused our review on Intake, MH Leveling, SMI patients (especially those who underwent disciplinary reviews or are housed in segregated/restrictive housing), access to constitutionally appropriate activities (e.g., recreation and care) for SMI patients in segregated/restrictive housing and the mental health treatment center, safety checks, staffing, discharge planning, continuity of care, use of force in MH patients, and CQI audits.

Since the last tour the County has improved its review and analysis of data and this was most apparent in the corrective action plans to address concerns with referrals, leveling, and ongoing quality improvement. The mental health caseload for the jails has slightly increased to 58% since the last tour. Reasons for the increase are unclear and may reflect improved screening during intake. Despite the increase in the mental health case load, there appears to have been a decrease in custodial staffing in the MHTC which clinical staff reports has impacted the delivery of care. There have been no suicides since the last tour and incidents of NSSI have been closely followed, reviewed, analyzed, and the data trended for preliminary interventions to improve outcomes.

However, as during the last tour, persons on the mental health caseload, especially those on Level 1, continue to constitute a significant percentage of the those involved in uses of force. CHS believes this may be due to medication non-adherence. Nevertheless, effective and sustained use of crisis intervention training skills should also positively impact the use of force. ETOs are being reviewed to ascertain whether use of force was required during the administration.

Mental health levels continue to be appropriate as defined. However, ways to further clarify criteria for advancing to or discharging from respective levels have been identified as practical areas of improvement.

Prior to and during the tour, serious concerns arose about the handling of SMI patients who are housed in segregated housing. We found that they have limited to no regular access to out of cell activities such as recreation, and for some, showers. SMI patients have remained on segregated status despite decompensation and have remained in segregated housing far beyond the 14 days or less indicated to avoid long-term segregation. Several have remained in segregated housing, due to being high risk, for over 200 days.

Discharge planning efforts have improved despite room for improvement in continuity of care and documentation of partnerships and referral to community resources. Leadership and staff are knowledgeable and conversant about resources yet despite ongoing utilization of community resources, verifiable documentation remains wanting.

MDCR and CHS have continued to significantly improve communication and cooperation. This was evident during the tour in the interactions of facility staff (e.g., morning treatment planning huddles), to the interaction and cooperation of CHS and MDCR leadership at headquarters.

Summary of Status of Compliance - Consent Agreement

Tour #9[4]

Yellow = Collaboration - Medical (Med) and Mental Health (MH)
Purple = Collaboration with Protection from Harm
Orange = Medical Only
Green = Mental Health Only

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments: Implement recommendations by
A. MEDICAL AND MENTAL HEALTH CARE				
1. Intake Screening				
III.A.1.a.	Med; MH			
III. A. 1. b.		MH		
III. A. 1. c.		MH		
III.A.1.d.	Med; MH			
III.A.1.e.		Med; MH		.
III.A.1.f.	Med; MH			
III.A.1.g.	Med; MH			
2. Health Assessments				
III. A. 2. a.		Med		
III. A. 2. b.	MH			
III. A. 2. c.	MH			
III. A. 2. d.		MH		
III.A.2.e.		Med		

[4] For the historic profile of compliance, by paragraph, for the Compliance Agreement – see Appendix B.

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments: Implement recommendations by
III.A.2.f. (See (IIIA1a) and C. (IIIA2e))		Med; MH		
III.A.2.g.	Med; MH			
3. Access to Med and Mental Health Care				
III.A.3.a.(1)	Med; MH			
III.A.3.a.(2)	Med; MH			
III.A.3.a.(3)	Med; MH			
III.A.3.a.(4)		Med; MH		
III.A.3.b.		Med; MH		
4. Medication Administration and Management				
III.A.4.a.		Med; MH		
III.A.4.b(1)	Med; MH			
III.A.4.b(2)		Med; MH		
III. A. 4. c.	MH			
III. A. 4. d.		MH		
IIIA.4.e.		Med; MH		
III.A.4.f. (See (III.A.4.a.)	Med; MH			
5. Record Keeping				
III.A.5.a.	Med	MH		
III.A.5 b.		MH		
III.A.5.c. (See III.A.5.a.)	Med; MH			See III.A.5.a.
III.A.5.d.		Med; MH		

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments: Implement recommendations by
6. Discharge Planning				
III.A.6.a.(1)		MH	Med	
III.A.6.a.(2)		MH	Med	
III.A.6.a.(3)		Med; MH		
7. Mortality and Morbidity Reviews				
III.A.7.a.	Med; MH			
III.A.7.b.	Med; MH			See III.A.7.a.
III.A.7.c.		Med; MH		
B. MEDICAL CARE				
1. Acute Care and Detoxification				
III.B.1.a.		Med		
III.B.1.b. (Covered in (III.B.1.a.)		Med		See III.B.1 a. and III A.3.a.(4)
III.B.1.c.	Med			
2. Chronic Care				
III.B.2.a.		Med		
III.B.2.b. (Covered in (III.B.2.a.)		Med		See III.B.2.a.
3. Use of Force Care				
III.B.3.a.	Med; MH			
III.B.3.b.	Med			
III.B.3.c. (1) (2) (3)	Med			

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments:
C. MENTAL HEALTH CARE AND SUICIDE PREVENTION				
1. Referral Process and Access to Care				
III. C. 1. a. (1) (2) (3)		MH		
III. C. 1. b.	MH			
2. Mental health treatment				
III. C. 2. a.		MH		
III. C. 2. b.		MH		
III. C. 2. c.	MH			
III. C. 2. d.	MH			
III. C. 2. e. (1) (2)		MH		
III. C. 2. f.		MH		
III. C. 2. g.	MH			
III. C. 2. g. (1)	MH			
III. C. 2. g. (2)	MH			
III. C. 2. g. (3)	MH			
III. C. 2. g. (4)	MH			
III. C. 2. h.		MH		
III. C. 2. i.	MH			
III. C. 2. j.		MH		
III. C. 2. k.		MH		
3. Suicide Assessment and Prevention				
III. C. 3. a. (1) (2) (3) (4) (5)		MH		
III. C. 3. b.		MH		
III. C. 3. c.		MH		
III. C. 3. d.	MH			
III. C. 3. e.		MH		
III. C. 3. f.	MH			
III. C. 3. g.	Med; MH			
III. C. 3. h.		MH		

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments: Implement recommendations by
4. Review of Disciplinary Measures				
III. C. 4. a. (1) (2) and b.		MH		
5. Mental Health Care Housing				
III. C. 5. a.	MH			
III. C. 5. b.		MH		
III. C. 5. c.		MH		
III. C. 5. d.		MH		
III. C. 5. e.	MH			
6. Custodial Segregation				
III. C. 6. a. (1a)		MH		
III. C. 6. a. (1b)		MH		
III. C. 6. a. (2)		MH		
III. C. 6. a. (3)		MH		See III.C.6.a.(2)
III. C. 6. a. (4) i		MH		
III. C. 6. a. (4) ii			MH	
III. C. 6. a. (5)		MH		
III. C. 6. a. (6)			MH	
III. C. 6. a. (7)			MH	See III.C.6.a. (6)
III. C. 6. a. (8)			MH	See III.C.6.a. (6)
III. C. 6. a. (9)		MH		
III. C. 6. a. (10)	Med	MH		
III. C. 6. a. (11)			MH	
7. Staffing and Training				
III. C. 7. a.	MH			
III. C. 7. b.	MH			
III. C. 7. c.	MH			

Subsection of Agreement	Compliance	Partial Compliance		
	MH			
	MH			
	MH			
III. C. 7. g. (1)(2)(3)	MH			
III. C. 7. h.		MH		
8. Suicide Prevention Training				
III. C. 8. a. (1 – 9)	MH			
III. C. 8. b.	MH			
III. C. 8. c.	MH			
III. C. 8. d.		MH		
9. Risk Management				
III. C. 9. a.		MH		
III. C. 9. b. (1)(2)(3)(4)		MH		
III. C. 9. c. (1)(2)(3)(4)(5)	MH			
III. C. 9. d. (1)(2)(3)(4)(5)(6)		MH		

D. AUDITS AND CONTINUOUS IMPROVEMENT				
1. Self Audits				
III. D. 1. b.		Med; MH		
III. D. 1. c.		Med; MH		
2. Bi-annual Reports				
III. D. 2. a. (1)(2)		Med; MH		
III. D. 2. a. (3)		MH		See III.D.2.a.
III. D. 2. a. (4)		MH		See III.D.2.a.
III. D. 2. a. (5)		MH		See III.D.2.a.
III. D. 2. a.(6)		Med; MH		
III. D. 2. b. (Covered in III. D. 1. c.)		Med; MH		See III.D.1.c.
IV. COMPLIANCE AND QUALITY IMPROVEMENT				
IV. A.		Med; MH		
IV. B.	Med; MH			See III. A. 7. a.
IV. C.	Med; MH			
IV. D.	Med; MH			

A. MEDICAL AND MENTAL HEALTH CARE

1. Intake Screening

Paragraph Authors: Greifinger and Johnson	III. A. 1. a. Qualified Medical Staff shall sustain implementation of the County Pre-Booking policy, revised May 2012, and the County Intake Procedures, adopted May 2012, which require, inter alia, staff to conduct intake screenings in a confidential setting as soon as possible upon inmates' admission to the Jail, before being transferred from the intake area, and no later than 24 hours after admission. Qualified Nursing Staff shall sustain implementation of the Jail and CHS' Intake Procedures, implemented May 2012, and the Mental Health Screening and Evaluation form, revised May 2012, which require, inter alia, staff to identify and record observable and non-observable medical and mental health needs, and seek the inmate's cooperation to provide information.		
Medical Care: Compliance Status:	Compliance: 7/18	Partial Compliance: 7/13; 10/14; 5/15; 1/16; 7/29/16; 3/3/2017; 12/7/17	Non-Compliance: 3/14 (NR)
Mental Health Care: Compliance Status:	Compliance: 5/15; 7/18	Partial Compliance: 3/14; 10/14; 1/16; 7/29/16; 3/3/2017; 12/7/17	Non-Compliance: 7/13 (NR)
Measures of Compliance:	Medical Care: 1. Observation of process 2. Medical record review 3. 24-hour threshold 4. Review of nursing orientation and in-service education Mental Health Care, as above and: 1. Record review that qualified mental health staff are conducting mental health screening and evaluation 2. Results of internal audits 3. Review for policies, procedures, practices 4. Review of in-service training 5. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	Medical Care: Intake screening is performed by RNs. Nurses do their best to provide confidentiality in a physical space that is not especially conducive to privacy. Nurses have received additional training on the criteria for referral of inmates with emergent/urgent conditions. The physician assigned to intake reports better utilization of his time as referrals are more accurate. The Cerner electronic system also includes information that tracks timeliness and priority of individuals going through health screening which greatly facilitates accountability and timeliness. Screening for sexually-transmitted infection (syphilis, gonorrhea, Chlamydia) is ongoing. Mental Health Care: Patients are being interviewed and screened for mental health issues during intake by an RN. The Intake RN has been trained to screen for MH issues. In conjunction with MDCR, CHS has continued to track and analyze throughput time in intake. CHS indicated they plan to implement a "routine referral" that schedules the patient to see a QMHP within 5 days of intake.		

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s):	• Practice with sick call protocols and demonstration of competency in performing a physical exam • Admission and discharge to the infirmary, medical observation and housing process • Development of nursing care plans for infirmary and medical observation care • Hands on experience with contents of the crash cart, back board, oxygen, and other emergency response equipment • Response to man down calls • Response to mass disasters • Preparation of the medication cart, pharmacy management i.e., formulary vs. non-formulary, medication re-orders, returns, and perpetual inventory • Response to traumatic injury i.e., officer abuse • Professional boundaries specific to corrections • Recognition of withdrawal symptoms • Patient safety • PREA • Discharge planning and bridge medications The curriculum for alcohol/drug withdrawal in-service has improved. Records of 13 inmates who were admitted between January through April 2018 were reviewed. Records were selected from lists of inmates on medications for insulin dependent diabetics and coagulation disorders provided by CHS. Findings: • Intake screening is accomplished within 5 hours and completed by registered nurses. • Inmates identified as having medical or mental health problems are referred for additional evaluation by qualified medical and mental health professionals. Ten of 13 were seen within the required timeframe. • All 13 inmates had treatment continued and the first dose of medication was given within 24 hours. • Medical histories on intake are scanty. • Labs and the first chronic disease appointment are consistently being ordered at intake. According to recent data, 70% of intake assessments are occurring within eight hours, which is an improvement. The process improvements for the medical and MH screening have been notable, with a reduction in the medical care time from 5.43 hours to 3.33 hours. <u>Mental Health Care:</u> The internal audit tool (reported in the Mental Health Review Committee [MHRC] minutes) being utilized for evaluation of mental health screening and referral at intake indicated that of 60 charts reviewed, 98% received a quality nursing assessment and that 78% were appropriately referred to a QMHP. However, the timeliness of the QMHP evaluation was appropriate in 68% of charts reviewed (as compared to a 40% result in Question #1 of CHS Audit Tool #2 in May 2018). CHS theorized that the untimeliness of some QMHP evaluations was "…likely due to inappropriate referrals and decreased QMHP staffing." CHS plans to implement a 5-day Routine QMHP referral at Intake as well as develop an algorithm for QMHP/Psychiatrist referral and at intake. There was no mention of efforts to adequately staff QMHPs in Intake. CHS now refers approximately 70% of the population screened at intake for mental health evaluation. Of the patients seen for mental health evaluation, ~50% are actually given a level. At the time of this report the mental health population (2,434) was 58% of the total population (4,170). This is up from 50-55% of the population at the time of the last report. While there is minimal difference since last year the mental health population remains high. CHS was not able to provide an

	explanation for why the mental health population is increasing.
Monitors' Recommendations:	Medical Care: 1. Improve documentation of medical history and continuity of care. 2. Include the medical intake process in the clinical performance measurement component of the QI Plan, paying special attention to improving adequate medical and behavioral health histories and timely accomplishment of referrals to practitioners. 3. Evaluate and remedy the orders for laboratory tests and referrals to clinicians that "fall through the cracks." 4. Continue to work on decreasing the total intake time to five hours, or less. Mental Health Care: 1. The County should streamline its intake procedure with a focus on reducing total intake time to ≤5 hours. 2. Continue to analyze intake data to identify areas for opportunity to improve throughput in intake and establish clear and consistent criteria to define measurement points in conjunction with MDCR. 3. Make measurable efforts to ensure there is adequate QMHP staffing for Intake.

Paragraph Author: Johnson	III. A. 1. b. Intake Screening: CHS shall sustain its policy and procedure implemented in May 2012 in which all inmates received a mental health screening and evaluation meeting all compliance indicators of National Commission on Correctional Health Care J-E-05. This screening shall be conducted as part of the intake screening process upon admission. All inmates who screen positively shall be referred to qualified mental health professionals (psychiatrist, psychologist, psychiatric social worker, and psychiatric nurse) for further evaluation.		
Compliance Status this tour:	Compliance: 5/15; 1/16; 7/29/16; 3/3/2017	Partial Compliance: 3/14; 10/14; 12/7/17; 7/18	Non-Compliance:
Measures of Compliance:	<u>Mental Health:</u> Results of internal audits demonstrating compliance with NCCHC indicator J-E-05 Results of internal audits demonstrating completion of intake screening upon admission Result of internal audit demonstrating 90% or more of inmates who screen positively shall be referred to qualified mental health professionals for further evaluation Record review Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	CHS has revised policy CHS-033: Mental Health Screening and Evaluation. Use of internal and external audits to track this requirement with the results being reported in the MHRC minutes and in CHS Audit tool #2.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Prior internal audits for this measure at intake consistently indicated that 100% of patients receive mental health screening on intake. Of those who screen positively, between 40-68% (internal audit and Audit tool #2) that were referred to a QMHP were seen within the current referral time frames of 2 hours for emergent and 4 hours for urgent. There was no measure of referrals to QMHPs for those inmates who screened positive. This is overall similar to what was found in the last report. Analysis by CHS suggest this is due to them not utilizing the routine referral as defined in the Consent Agreement, and, confusion about referrals. CHS plans to implement a 5-day Routine QMHP referral at Intake and develop an algorithm that will decrease confusion around referrals at intake (and consults that occur after intake). They believe use of Routine referrals may help their referral fulfillment time frame improve so that it appropriately falls within the established parameters.		
Monitor's Recommendations:	Continue to analyze intake data to identify areas for opportunity to improve throughput in intake. Please review the percentage of positive MH screens at intake that are being referred to the QMHP. Make measurable efforts to ensure there is adequate QMHP staffing for Intake. Proceed with training of Intake RNs with the algorithm to be developed to reduce confusion surrounding referrals. Proceed with creating a Routine 5-day referral for patients that don't require emergent or urgent MH referrals at Intake.		

Paragraph Author: Johnson	III. A. 1. c. Medical and Mental Health Care, Intake Screening: Inmates identified as in need of constant observation, emergent and urgent mental health care shall be referred immediately to Qualified Mental Health Professionals for evaluation, when clinically indicated. The Jail shall house incoming inmates at risk of suicide in suicide-resistant housing unless and until a Qualified Mental Health Professional clears them in writing for other housing.		
Compliance Status this tour:	Compliance:	Partial Compliance: 5/15; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14; 10/14; 1/16; 7/29/16
Measures of Compliance:	<u>Mental Health:</u> Record review of adherence to screening, assessment, and trigger events as described in Appendix A Review of CHS Constant Observation order spread sheet for February to April 2018 for patients placed on suicide precaution Review of CHS Audit Tool #1 results Review of adverse events and deaths of inmates with mental health and substance misuse issues		
Steps taken by the County to Implement this paragraph:	The County revised its policy on basic mental health care. The County revised its policy on suicide prevention. The County is self-auditing this provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Reviewed data provided in the CHS Constant Observation Order spread sheet provided in the pre-tour data set as well as several months of CHS Audit Tool #1. The former was provided by the County due to prior discussion during which the County agreed to track use of the observation cells for inmates that are identified to be at risk for suicide during intake. At that time the County explained that inmates are either placed in an observation cell (suicide resistant housing per this provision), or are handcuffed to a chair in the open area of intake where they are directly observed by Custody. Observations are documented every 15 minutes in the watch system by Custody. Per Custody, use of the Observation Cells for suicidal patients is limited by the cells also being used to house agitated patients. The data provided in the CHS Observation Order spread sheet was a list of orders placed in patient's EMR neither indicated which patients were placed in the observation cell or in the open area of intake, nor provided any explanation or analysis of the data. Audit results for this provision indicated that 100% of patients are being placed on suicide precautions after being leveled as a 1A (despite 30% not entering an order in the EMR). An appropriate corrective action of retraining QMHPs in intake on appropriate documentation was provided in April 2018. Future measurements will indicate the impact of the retraining.		
Monitor's Recommendations:	The Mental Health Monitor recommends the County implement definitions and systems for the following: Per this provision and as previously agreed, please provide an internal audit of Observation Cell use for Level 1A patients in Intake prior to them seeing the QMHP. The Observation Cells should be used, when available, to house suicidal patients in Intake "unless and until a Qualified Mental Health Professional clears them in writing for other housing." Reassess impact of Refresher training on QMHPs documentation for level 1A patients placed on constant observation. Continue self-audits on Suicide Risk Assessment.		

Paragraph Authors: Greifinger and Johnson	III. A. 1. d. Inmates identified as "emergency referral" for mental health or medical care shall be under constant observation by staff until they are seen by the Qualified Mental Health or Medical Professional.		
Medical Care: Compliance Status:	Compliance: 7/13; 5/15; 1/16; 12/17; 7/18	Partial Compliance: 3/3/17, 7/29/16,	Non-Compliance: 3/14 (NR); 10/14
Mental Health Care: Compliance Status:	Compliance: 12/7/17; 7/18	Partial Compliance: 7/13; 5/15; 3/3/2017	Non-Compliance: 3/14 (NR); 10/14; 1/16; 7/29/16
Measures of Compliance:	Medical Care: Medical record review <u>Mental Health Care, as above and:</u> Record review of adherence to screening, assessment, and trigger events as described in Appendix A Review of observation logs for patients placed on suicide precaution Interview of staff and inmates Tour of Intake area		
Steps taken by the County to Implement this paragraph:	<u>Medical:</u> Not applicable <u>Mental Health Care:</u> Discussion with the Medical Director of Behavioral Health during the recent site visit indicated that there has been confusion between patients identified as behavioral health emergency referrals and medical emergency referrals. The County plans to utilize PINK wrist bands for behavioral health emergency referrals and GREEN wrist bands for medical emergency referrals to begin in July 2018.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care:</u> The intake process is currently timely for the identification of serious medical needs and risk of harm. <u>Mental Health Care</u> This provision is currently being met by the county. The county has identified that it is unlikely that a bridge between the EMR and the Black Creek Watch system will occur. Until a new Offender Management System is put in place that can interface with the current EMR, RNs in Intake have been given access to the Black Creek System to input data, but with limited data access and inability to print reports. Review of real time data is slow and limited by accessibility concerns per CHS.		
Monitors' Recommendations:	<u>Medical Care:</u> <u>Mental Health Care:</u> 1. Make the Physical Sight Check Sheet data consistently available to CHS and/or bridge the data into Cerner for active analysis, if appropriate, improvement on the process.		

Paragraph Authors: Greifinger and Johnson	III. A. 1. e. CHS shall obtain previous medical records to include any off-site specialty or inpatient care as determined clinically necessary by the qualified health care professionals conducting the intake screening.		
Medical Care: Compliance Status:	Compliance: 5/15	Partial Compliance: 1/16; 7/29/16, 3/3/17; 12/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 5/14; 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR);
Measures of Compliance:	Medical Care: Medical record review: Necessary previous medical records are ordered in Intake and are in the chart (or there is evidence of reasonable effort to obtain the records). Mental Health Care, as above and: Policy regarding obtaining collateral information and previous psychiatric and medical records Review of records, and an Audit of this provision		
Steps taken by the County to Implement this paragraph:	Medical Care: Prior medical care through JHS is available through the EHR. Other medical records are rarely sought. CHS clinicians are not documenting review of prior records, however. Mental Health Care: The electronic health record (EHR) contained records from Jackson. The County has added an IT enhancement that now allows QMHPs to indicate they reviewed the patients past medical records. The county also developed an internal audit tool (#39) that reviewed compliance with this provision.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Few progress notes reflected review of prior records. Mental Health Care: Internal audit tool #39 reviewed 10 charts of both medical and mental health providers. The audit found that all the mental health charts reviewed indicated (with the IT enhancement) that the prior CHS medical records had been reviewed. This is an improvement from the last tour. However, review of charts for unrelated reasons (e.g., segregation) evidenced that meaningful review of the past medical records and integration of past information into discussion of current functioning and/or professional decision making is still inconsistently occurring based on actual documentation by QMHPs. This was ascertained based on providers failing to reference, rule out, or explain how meaningful information from past treatment with CHS (e.g., prior medication or diagnoses) impacts current clinical presentation. CHS continues to consistently reference the outside hospital medical records of patients who recently returned from forensic hospitalizations (e.g., patients sent out for restoration of competency). QMHPs continue to verbalize that they review the JHS records of patients, but it appears their rationale for not referencing or utilizing that information in clinical decision making is lacking. They do not explain or reconcile conflicting diagnoses or varied symptoms across treatment encounters or treatment episodes.		

Monitors' Recommendations:	Medical Care: 1. Monitor clinical performance in this area and implement effective remedies. Mental Health Care: 1. Practitioners should document their review of available medical records by incorporating the relevant findings into their documentation and by explaining their decisions to rule out or change diagnoses. Incorporating this information is important in the QMHP's decision-making process and can significantly impact diagnostic and treatment choices (i.e., suicidality, mental illness, etc.) as well as forensic decision making (i.e. disciplinary and segregation decisions).

Paragraph Authors: Greifinger and Johnson	III. A. 1. f. CHS shall sustain implementation of the intake screening form and mental health screening and evaluation form revised in May 2012, which assesses drug or alcohol use and withdrawal. New admissions determined to be in withdrawal or at risk for withdrawal shall be referred immediately to the practitioner for further evaluation and placement in Detox.		
	May 2012, which assesses drug or alcohol use and withdrawal. New admissions determined to be in withdrawal or at risk for withdrawal shall be referred immediately to the practitioner for further evaluation and placement in Detox.		
Medical Care: Compliance Status:	Compliance: 12/17; 7/18	Partial Compliance: 7/13; 10/14; 5/15; 1/16; 7/29/16, 3/3/17	Non-Compliance: 3/14 (NR)
Mental Health Care: Compliance Status:	Compliance: 12/7/17; 7/18	Partial Compliance: 7/13; 3/14; 10/14; 5/15; 1/16; 7/29/16; 3/3/2017	Non-Compliance: 3/14 (NR)
Measures of Compliance:	<u>Medical Care:</u> Medical record review Interview <u>Mental Health Care:</u> Review policy Review cases Review referrals to the emergency department		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> Behavioral health staff now operates the evaluation and treatment for withdrawal/detoxification. <u>Mental Health Care:</u> The County has implemented an intake screening which broadly screens for withdrawal. Per policy, mental health is not permitted to directly refer to detox, and all clients must be referred to the medical provider to be cleared for detox prior to placement.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care and Mental Health Care:</u> Diagnosis and treatment of withdrawal has improved substantially. Patients in active withdrawal are monitored with CIWA and COWS and are treated appropriately. CHS has no provision for methadone maintenance for pregnant inmates who have been enrolled in a methadone maintenance program in the community. Pregnant patients who have been on methadone are monitored and treated with medication assisted therapy, as medically appropriate.		
Monitors' Recommendations:	No additional recommendations at this time.		

Paragraph Authors: Greifinger and Johnson	III. A. 1. g. (See also III.A.1.a.) CHS shall ensure that all Qualified Nursing Staff performing intake screenings receive comprehensive training concerning the policies, procedures, and practices for the screening and referral processes.		
Medical Care: Compliance Status:	Compliance: 12/7/17; 7/18	Partial Compliance: 10/14; 5/15; 1/16; 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR), 3/3/17
Mental Health Care: Compliance Status:	Compliance: 12/7/17; 7/18	Partial Compliance: 10/14; 5/15; 1/16; 7/29/16; 3/3/2017	Non-Compliance: 7/13 (NR); 3/14 (NR)
Measures of Compliance:	Medical Care: Review training materials Mental Health Care: Review training materials		
Steps taken by the County to Implement this paragraph:	Revision of training materials so that they conform to the correctional environment.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: CHS developed new employee training curriculum that is specific to the provision of health care in correctional settings since the last site visit. The curriculum for nurses includes training in the intake policy with discussion about the purpose of screening, how to best elicit information during the encounter and ways to address challenges in getting intake screening done timely. The session concludes with a case scenario discussion to assist nurses in making decisions about referral and follow up care with an inmate in withdrawal. This training meets the requirements for this item. Mental Health Care: CHS has improved its intake screening training curriculum for nurses that includes: corrections specific instruction, direction on the purpose of screening, effective information gathering, and case review/discussion about referral and follow-up for an inmate experiencing withdrawal. Discussion with Asst. Medical Director identified continued improvements since the last tour that indicates CHS is continues to remain in compliance with this paragraph.		
Monitor's Recommendations:	No additional recommendations at this time.		

2. Health Assessments

Paragraph Author: Greifinger	III. A. 2. a. Qualified Medical Staff shall sustain implementation of CHS Policy J-E-04 (Initial Health assessment), revised May 2012, which requires, inter alia, staff to use standard diagnostic tools to administer preventive care to inmates within 14 days of entering the program. [NB: This requirement is not about diagnostic tools or prevention – it is about the entirety of the health assessment. It was driven by detainees not getting, or getting inadequate initial health assessments. /MS]		
Compliance Status:	Compliance:	Partial Compliance: 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16; 3/3/2017; 12/7/17
Measures of Compliance:	*The measures of compliance from the Settlement Agreement and/or Consent Agreement and/or what you will use to measure compliance* Medical record review		
Steps taken by the County to Implement this paragraph:	The County initiated a policy and procedure to perform initial health assessments and has implemented the policy. The County plans to use nurse practitioners for the health assessment.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	In a review of 13 records of patients in custody for 14 or more days (intakes January – April 2018), only one had a documented health assessment. .		
Monitor's Recommendations:	Improve scheduling so that health assessments occur within the 14-day standard.		

Paragraph Author: Johnson	III. A. 2. b. Health Assessments: Qualified Mental Health Staff will complete all mental health assessments incorporating, at a minimum, the assessment factors described in Appendix A.		
Compliance Status this tour:	Compliance: 7/18	Partial Compliance: 3/14; 12/7/17	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16; 3/3/2017
Measures of Compliance:	Mental Health: Review of policy regarding mental health evaluation and screening and suicide risk assessment and planning Record review for adherence to screening, assessment and trigger events as described in Appendix A Interview of staff and inmates Review of audits		
Steps taken by the County to Implement this paragraph:	Interagency Policy 003 "Inmate Suicide Prevention and Response Plan has been updated since the last tour. Training on the Suicide Risk Assessment tool (Columbia-Suicide Severity Rating Scale [C-SSR]).		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Per prior audits, 100% of patients are receiving a Behavioral Health screen on intake by an RN that has been trained to work with MH patients. Suicide screening by the RN is also occurring during intake. All mental health assessments (vs. screening) are being performed by a QMHP (or QMHS). Therefore, this provision is being fulfilled appropriately. As of an April 2018 audit (Tool #1) of 10 patients, the Suicide Risk Screen was only appropriately completed in 30% of cases. The Suicide Screening tool does not address all of the assessment factors described in Appendix A. CHS decided to focus on the QMHP Suicide Risk Assessment (which addresses the assessment risk factors in Appendix A) and they provided training to all QMHPs on the C-SSR with 100% completion by staff (completion certificates provided in June Deliverables). A post-training audit of 4 patients who were leveled as 1A twenty-four hours after all QMHPs had completed the training resulted in 75% of patients had received a complete Suicide Risk Assessment. CHS expects that compliance with this measure will increase due to the training and expect to see improvements in the next quarterly audit.		
Monitor's Recommendations:	Follow through with all identified steps in the corrective action plan to ensure provision of suitable access to follow-up care is obtained by patients discharged from suicide precautions.		

Paragraph Author: Johnson	III. A. 2. c. Health Assessments: Qualified Mental Health Professionals shall perform a mental health assessment following any adverse triggering event while an inmate remains in the MDCR Jail facilities' custody, as set forth in Appendix A.		
Compliance Status this tour:	Compliance: 7/18	Partial Compliance: 3/14; 3/3/2017; 12/7/17	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16
Measures of Compliance:	Mental Health: Review of policies regarding mental health evaluation and screening and suicide risk and prevention Record review for adherence to trigger events, referral and assessment as described in Appendix A Interview of staff and inmates Review of all adverse events involving inmates with mental health and substance misuse issues.		
Steps taken by the County to Implement this paragraph:	The County finalized the Suicide Risk and Prevention Plan policy IP-003. QMHPs have been trained on the appropriate use of the Suicide Risk Assessment Performed audits of suicide attempts, suicides, and Non-Suicidal Self-Injury (NSSI) events		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Per this provision, mental health assessments, including a suicide risk assessment, continue to occur after triggering events. Triggering events have been analyzed by the County in the Avoidable Suicide and Self-harm Analysis and the Mental Health Review Committee's (MHRC) Risk Management NSSI and Self-harm reviews. After a triggering event (e.g., suicide attempt or self-harm) patients receive a mental health assessment including a suicide risk assessment (C-SSR). The event is classified by the Medical Director of Behavioral Health and further analyzed by the Risk Management and MHRCs. While the County has taken steps to improve this process the changes have not been fully implemented. Clinical staff continue to perform unstructured suicide risk assessments in lieu of the standardized C-SSR, in part due to IT problems negotiating data fields that require information that could not be obtained from the patient. The County will need to decide how staff should handle these situations and provide training so that the C-SSR is used instead of unstructured interview.		
Monitor's Recommendations:	To maintain compliance please provide a list of patients involved in triggering events for monitor verification that evals are actually occurring for the next tour.		

Paragraph Author: Johnson	III. A. 2. d. Health Assessment: Qualified Mental Health Professionals, as part of the inmate's interdisciplinary treatment team (outlined in the "Risk Management" Section, *infra*), will maintain a risk profile for each inmate based on the Assessment Factors identified in Appendix A and will develop and implement interventions to minimize the risk of harm to each inmate.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14, 7/29/16; 12/7/17; 7/18	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR); 3/3/2017
Measures of Compliance:	Mental Health: 1. Review of policy regarding mental health evaluation, risk management and documentation Record review for adherence to screening, trigger events, referral and assessment as described in Appendix A Review of Mental Health Review Committee minutes from 5/2018		
Steps taken by the County to Implement this paragraph:	nternal audits reported in the MHRC of this provision Establishment of MH Team Leaders Manual tracking by MH Team Leaders of when initial or follow-up IDTTs are due.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The 'risk profile' is the CHS Suicide Risk Assessment (SRA). The SRA takes into account the assessment factors identified in Appendix A including the patients' strengths and weaknesses, and the patient's support systems to assess the patient's risk for self-harm. While CHS is now auditing the completion of SRAs and reporting this data ~monthly at the MHRC meetings there are patients who present with symptoms described in Appendix A who are leveled up prior to needing an IDTT. While the patient's condition may have improved, and the releveling is appropriate the clinical need for monitoring suicide risk remains. It is just less acute. An IDTT or follow up should be completed at the new level to insure continuity of care and to address the remaining risk factors. This is not always demonstrated in the materials presented and chart review. Additionally, Appendix A including Suicidal Ideation as a factor to be addressed. Chart review of level 1A patients did not consistently find clear Risk Assessments when instances of S/I were reported. There were also instances where patients did remain at level 1A/1B to have an IDTT but the IDTP created did not clearly include a safety plan to address the factors listed in Appendix A as part of the treatment plan or the measurable treatment goals. Nevertheless the audit tool and the reporting in MHRC are important steps forward. The MHRC minutes from 5/2018, reported that 153 patients were due for an IDTT and that 100% of them received an IDTT in the month of May. Only 3% (N=5) of the IDTTs occurred late. This is a great improvement since the last report. The CAP included the need to track IDTTs on level 3 and 4 patients (e.g., patients placed on IDTT after a self-harming event) and that a Procedural Directive will be created to specify when an IDTT will be initiated. Review of charts revealed that most IDTTs and interventions therein were not patient specific; though a few were notably very specific (e.g., a high utilization patient who repeatedly submits grievances in segregation).		
Monitor's Recommendations:	Specificity to the patient who is the focus of the IDTT, including use of the risk profile and a safety plan, should be the norm and not the exception regardless of what level the patient is currently treated at. Demonstration that this is happening and verifiable consistently over time will be required to obtain full compliance.		

Paragraph Author: Greifinger	III. A. 2. e. An inmate assessed with chronic disease shall [be] seen by a practitioner as soon as possible but no later than 24-hours after admission as a part of the Initial Health Assessment, when clinically indicated. At that time medication and appropriate labs, as determined by the practitioner, shall be ordered. The inmate will then be enrolled in the chronic care program, including scheduling of an initial chronic disease clinic visit.		
Medical Care Compliance Status:	Compliance: 7/16	Partial Compliance: 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 3/3/2017; 12/7/17
Measures of Compliance:	Medical Care: Medical record review for timeliness and scope		
By policy, patients with identified chronic disease are provided with medication within 24 hours and enrolled in a chronic disease clinic.	By policy, patients with identified chronic disease are provided with medication within 24 hours and enrolled in a chronic disease clinic. Policy does not require a practitioner visit.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Nurses see patients who report a history of medication for chronic disease on intake. Nurses consult with prescribing practitioners for medication orders. Inmates are not seen by the practitioner for the first chronic care appointment within the first 14 days. Only 1 of ten chronic care charts reviewed documented the first chronic care visit in 14 days although all were scheduled within that timeframe. Not all chronic care follow-up appointments are scheduled timely and the frequency of appointments is not based upon the patient's condition. Patients whose condition is poor are seen at the same frequency interval as those whose condition is in good control. Chronic care appointments are not scheduled to coincide with the time medication needs to be renewed resulting in discontinuity of care. Failure to provide timely, clinically appropriate chronic care results in preventable emergency room visits and hospitalization CHS clinical performance monitoring for chronic disease is much more reliable.		
Monitor's Recommendations:	Clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time.		

Paragraph Authors: Greifinger and Johnson	III. A. 2. f. (Covered in III.A.1.a.) and (III.A.2.e.) All new admissions will receive an intake screening and mental health screening and evaluation upon arrival. If clinically indicated, the inmate will be referred as soon as possible, but no longer than 24-hours, to be seen by a practitioner as a part of the Initial Health Assessment. At that time, medication and appropriate labs as determined by the practitioner are ordered.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16; 12/7/17; 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR), 3/3/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Medical Care: • Medical record review Mental Health Care: Record review that QMHP are conducting mental health screening and evaluation Results of internal audits Review of policies, procedures, practices. Review of in-service training. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	Medical Care: By policy, inmates identified as having medical or mental health problems are referred for additional evaluation by qualified medical and mental health professionals. Mental Health Care: See medical section above		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Of 13 inmates identified as having emergent or urgent health care needs by the screening nurse all were seen by nurses within the required timeframe and received their first dose of medication within 24 hours. All but three of the 13 were seen by practitioners within four hours of referral. Mental Health Care: The records reviewed and the data provided demonstrate continued improvement since the last tour. Patients continue to receive their first dose of medication within 24 hours and the majority are being seen within 24 hours by a provider. Labs are being ordered in a timely manner. However, timely completion of lab orders continues to be problematic due to an IT issue. In Cerner only 1 pending set of labs can exist at any given time. This means that if the patient is seen by the QMHP and labs are ordered; those same labs may be removed or cancelled by the next provider (e.g., medical) who sees the pt. CHS plans to inquire about an IT enhancement that will allow more than one set of pending labs to avoid cancellation of labs that have already been ordered. Delay of lab order completion can result in missed data that impacts treatment decisions (e.g., increased risk of morbidity in patients who are withdrawing from illicit drugs or alcohol due to electrolyte abnormalities). Lab results are being reviewed once received.		

Monitor's Recommendations:	Medical Care: 1. Clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time. Mental Health Care: Follow through on the IT enhancement to prevent pending lab orders from being cancelled when new labs are ordered. In the interim, consider work arounds for this issue (e.g., adding labs to the current pending order vs. cancelling it). Stability overtime in this measure is needed to obtain compliance.

Paragraph Authors: Greifinger and Johnson	III. A. 2. g. All individuals performing health assessments shall receive comprehensive training concerning the policies, procedures, and practices for medical and mental health assessments and referrals.		
Medical Care: Compliance Status:	Compliance: 12/17; 7/18	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16, 3/3/17
Mental Health Care: Compliance Status:	Compliance: 7/18	Partial Compliance: 12/7/17	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16; 3/3/2017
Measures of Compliance:	Medical Care: Applies to RN's and mid-level practitioners Review lesson plan Review training records Assure training by appropriate level of professionals Demonstrate proficiencies Mental Health Care, as above and: Review of policy regarding mental health and mental health staff training Review of records, including sign-in sheets, for any training performed Review of training materials, including power point slides and the training of the presenters		
Steps taken by the County to Implement this paragraph:	Medical and Mental Health Care: The County has implemented the required training.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: CHS developed a three-day training for nurses to conduct health assessments. The first day is classroom based physical assessment training and review of policy and procedure. The next two days nurses perform assessments under the supervision of selected physician preceptors, which includes demonstration of competency. Health assessments that were reviewed are complete and well-documented. Mental Health Care: Since the last tour Nursing has updated training (as described above) and further specialized it to the role of the staff performing the assessment (MA, LPN, or RN), including post-testing. Results of post-tests where provided including the name, role, whether they completed the training, and the final test score of the staff. Copies of post-test were also reviewed and were appropriate for the subject matter, though short in some cases (e.g., only 5 questions for MAs).		
Monitor's Recommendations:	Medical Care and Mental Health Care: 1. Supervise through clinical performance measurement.		

3. Access to Medical and Mental Health Care

Paragraph Authors: Greifinger and Johnson	III. A. 3. a. (1) The sick call process shall include… written medical and mental health care slips available in English, Spanish, and Creole.		
Medical Care: Compliance Status:	Compliance: 7/13; 10/14; 7/29/16, 3/3/17; 12/7/17; 7/18	Partial Compliance:	Non-Compliance: 3/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance: 3/14; 10/14; 7/29/16; 3/3/2017; 12/7/17; 7/18	Partial Compliance: 7/13	Non-Compliance: 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • Health care slips on the living units are available in English, Spanish, and Creole. Mental Health Care: • Availability of mental health care slips in English, Spanish and Creole • Availability of writing implements to fill out mental health care slips • Evidence of culturally-sensitive policies and procedures for ADA inmates with cognitive disabilities • Presence and implementation of confidential collection method for mental health slips daily • Review of logs of sick call slips, appointments, for appropriate triage • Review of Mental Health grievances		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):			
Monitor's Recommendations:	No additional recommendations at this time.		

Paragraph Authors: Greifinger and Johnson	III. A. 3. a. (2) The sick call process shall include…opportunity for illiterate inmates and inmates who have physical or cognitive disabilities to confidentially access medical and mental health care.		
Medical Care: Compliance Status:	Compliance: 10/14; 7/29/16, 3/3/17; 12/7/17; 7/18	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance: 7/18	Partial Compliance: 7/13; 12/7/17	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16; 3/3/2017
Measures of Compliance:	Medical Care: Interviewed COs report a confidential way for detainees with impaired communication skills to access care. Mental Health Care: Interview with inmates with cognitive or physical disabilities Interview with staff Review of medical record to assess access to care		
Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health Care: No information or data was provided prior to the tour that indicated the County has provided a way for detainees with impaired communication to access care. However, during site tours Correctional Officers and MH Staff verbally indicated that illiterate or disabled patients were receiving assistance with sick call.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Language lines are available and used for patients who do not speak English or Spanish. The TGK medication nurse reported accepting verbal sick call requests for illiterate patients or disabled patients. Mental Health Care: See Medical Care above. However, the data is not being internally audited in a way that allows CHS to assess if the processes in place are being followed. Sick call requests, both medical and BH, are currently being audited with BH results being reported by Nursing at the MHRC. CHS has created a log of cognitively disabled patients which will present an opportunity to document how they are being assisted with sick call and to assess outcomes. I interviewed a physically disabled patient who is also SMI who reported that he receives assistance with completing sick call request by the correctional case workers, social workers, and nursing. CO's verified that the patient, and other similar patients, received assistance with sick call as the patient described. It appears this provision is being met but remains difficult to verify due to lack of data.		
Monitors' Recommendations:	Medical Care: Mental Health Care: Consider performing a time-limited internal audit of ADA patient access and fulfillment of sick call requests to maintain MH compliance with this provision.		

Paragraph Authors: Greifinger and Johnson	III. A. 3. a. (3) The sick call process shall include…a confidential collection method in which designated members of the Qualified Medical and Qualified Mental Health staff collects the request slips every day;		
Medical Care: Compliance Status:	Compliance: 10/14; 7/29/16, 3/3/17; 12/7/17; 7/18	Partial Compliance: 7/13	Non-Compliance:3/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance: 10/14; 7/29/16; 3/3/2017; 12/7/17; 7/18	Partial Compliance: 7/13	Non-Compliance: 3/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	<u>Medical Care:</u> Inspection and interview <u>Mental Health Care:</u> Review of policy and procedure for sick call Review of log tracking sick call requests and referral for care Review of medical records to assess access and implementation of adequate care Interview of staff Interview of inmates		
Steps taken by the County to Implement this paragraph:			
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical and Mental Health Care:</u> Nurses receive sick call requests directly from inmates during medication pass and use a key to open a specifically designated sick call box on each unit and pick up any requests that have been put there. Nurses scan receipt of the sick call request to initiate the sick call appointment. Once collected they are classified based on their focus area (i.e., medical, BH, etc.). Nurses also distribute sick call request forms to individual inmates upon request and leave a supply at the officer's desk as necessary.		
Monitor's Recommendations:	No additional recommendations at this time.		

Paragraph Author: Greifinger and Johnson	III. A. 3. a. (4) The sick call process shall include…an effective system for screening and prioritizing medical and mental health requests within 24 hours of submission and priority review for inmate grievances identified as emergency medical or mental health care.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16, 3/3/17; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	<u>Medical Care:</u> • Medical record review • Observation <u>Mental Health Care, as above and:</u> 1. Review of policy and procedure 2. Review of number of mental health grievances 3. Review of submitted sick call slips for evidence of triage 4. Review of emergency grievances and mental health grievances 5. Review if audits		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> CHS now has a staff member assigned to indexing and monitoring medical grievances, so longitudinal data are being collected. <u>Mental Health Care:</u> Sick call and Grievances are now being audited and the County has recently expanded the audit to include Urgent Sick call issues to begin to be tracked in the next audit in September 2018. Grievances, including mental health grievances, are discussed during MAC. The mental health grievances continue to make up a small percentage of the total grievances.		
Monitors' analysis	This is a shared issue with the sick call and grievance processes in both medical and mental health. Medical Care: Auditory privacy is not always available, with clinical encounters conducted with open doors and an officer and waiting patients proximate to the door. Though officers interviewed seemed to know to respect auditory privacy, this is not always possible when waiting patients are close to the open door of examination rooms. On the detox unit, practitioners are not allowed to enter the patient's room; patients are expected to come out of the room and sit in a chair, thereby bringing the encounter into a public space. <u>Mental Health Care:</u> Review of audits for Sick Call and Grievances as well as raw data that was included in the data set sent prior to the tour showed that patients are being seen for sick call usually within 24-48 hours of sick call being ordered and the appointment being scheduled. However, while Grievances are being time stamped (which is being tracked), when the sick call is received is not. It is unclear if the 24-48-hour follow-up window is solely from when the sick call visit was ordered/scheduled or from when it was received. Review of the raw data did not indicate when the sick call was		

	received. MH grievances have significantly improved regarding responses addressing the complaint and this is reflected in the audit as well. However, the CHS is still streamlining the process to ensure the patient receives a written response within 7-days. Inadequate time to address responses for the psychiatrist assigned this role was identified as the reason for the delayed responses. CHS plans to assign this duty to one psychiatrist *per facility* rather than to just one psychiatrist.
Monitors' Recommendations:	<u>Medical Care:</u> 1. Provide auditory (and visual) privacy during clinical encounters. Such privacy should always be provided vis-à-vis other inmates. It is recognized that, at times in a jail setting, such privacy cannot be provided vis-a- vis custody staff. However, on those occasions, breaching of privacy should be based on a patient-specific need-to-know, or need-to-be-present. 2. Reduce the lag time between a request for care and the delivery of definitive care. 3. Revise the system for classification of grievances such that emergency grievances are addressed in a timely manner. <u>Mental Health Care:</u> 1. Please include the date/time the sick call was received to ensure medical and mental health sick call requests are being screened and prioritized within 24 hours of submission. 2. Continue efforts to improve patient response time for MH Grievances.

Paragraph Authors: Greifinger and Johnson	III. A. 3. b. CHS shall continue to ensure all medical and mental health care staff are adequately trained to identify inmates in need of acute or chronic care, and medical and mental health care staff shall provide treatment or referrals for such inmates.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 7/29/16; 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR), 3/3/17; 12/7/17
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13; 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16**;** 3/3/2017; 12/7/17
Measures of Compliance:	<u>Medical Care:</u> Observation and chart review <u>Mental Health Care:</u> Review of policies and procedures for mental health training. Review of documentation and lesson plans related to mental health care staff training. Review of mental health records for assessment of treatment of inmates with SMI.		
Steps taken by the County to Implement this paragraph:	A training on referral for Chronic Care services was provided by the former CHS Medical Director during the April 2018. Chronic care guidelines were revised and issued in July 2018, along with relevant revisions to the clinical performance measurement tools for chronic care. Psychiatry Provider Meeting and was recorded in the minutes from that month. Details or an outline of the training were not included nor provided.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care:</u> <u>Mental Health Care:</u> CHS informed the monitors that they have medical staff come to the mental health housing units to provide chronic care services to mental health patients. This was not observed at the time of the tour. However, correctional, medical, and mental health staff where able to describe how the referral process works for patients to be seen by medical or mental health providers. Chart review reflects that patients are being seen for chronic care who have mental health diagnoses. Officers and most providers were aware of ways to maintain HIPAA appropriate privacy during appointments in the MHTC, PTDC, and MW.		
Monitors' Recommendations:	<u>Medical Care:</u> Continue corrective action plans regarding clinical performance for chronic care. <u>Mental Health Care:</u> Access to chronic care for mental health patients with SMI should be tracked and audited quarterly to ensure appropriate access to services is happening.		

4. Medication Administration and Management

Paragraph Authors: Greifinger and Johnson	III. A. 4. a. CHS shall develop and implement policies and procedures to ensure the accurate administration of medication and maintenance of medication records.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 7/29/16; 12/7/17; 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR), 3/3/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR);
Measures of Compliance:	Medical Care: Inspect policies and procedures Mental Health Care: Policy regarding medication administration and documentation Review of medication error reports. Interview of inmates and staff. Review of medication administration records (MARs).		
Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health Care: CHS has developed a plan to transition to an e-MAR in the EMR (Cerner). The MAR is in a separate EMR and hinders fluid review of a patient's medication adherence. Cerner and Sapphire (MAR) do not communicate with each other.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Medications written for treatment of ongoing conditions routinely expire before the next provider appointment. Inmates are expected to submit a request to renew the medication via sick call resulting in discontinuity and delay in care. Notifications of missed medication are being sent in a manner that overwhelms clinicians' mailboxes. Mental Health Care: The policy requires CHS to notify the psychiatrist of medication after repeated refusals and counseling by a Nurse. CHS now notifies the Psychiatrist/ARNP when a patient has refused clinically significant amounts of his or her medication. Percent adherence is included in these communications but is not always relevant (e.g., 100% adherent one day and 71% adherent the next for a daily medication). Providers are now inundated with refusals (e.g., Level 1A who is refusing medications daily receives several notices a day). Despite the over notification this change has allowed for non-adherence issues to be addressed in a timelier manner since the last tour. Bubble packing for some psychotropic medications is also occurring but it is not patient specific (e.g., all of a patient's meds are in the same package) due to short jail stay, and cost and capacity restrictions per CHS. Med delivery has improved per Assistant Medical Monitor's observations during the tour and is now happening per policy.		

Monitors' Recommendations:	Medical Care: Consider the cost and safety benefits to implement patient specific packaging when converting to the Cerner EMAR. Continue auditing medication administration to ensure that actual practices are consistent with policy and procedure. Maintain a perpetual inventory of medications. Mental Health Care: Continue to streamline the notification process for QMHPs to address the issues of med refusals. Follow through with plan to implement Cerner e-MAR to ease provider access to the MAR during visits.

Paragraph Authors: Greifinger and Johnson	III. A. 4. b. (1) Within eight months of the Effective Date…Upon an inmate's entry to the Jail, a Qualified Medical or Mental Health Professional shall decide and document the clinical justification to continue, discontinue, or change an inmate's reported medication for serious medical or mental health needs, and the inmate shall receive the first dose of any prescribed medication within 24 hours of entering the Jail;		
Medical Care: Compliance Status:	Compliance: 12/7/17; 7/18	Partial Compliance: 7/13 (Not yet due); 7/29/16, 3/3/17	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance: 12/7/17; 7/18	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16; 3/3/2017
Measures of Compliance:	Medical Care: Medical record review Mental Health Care: Review policy Review intake screening Review medication continuity Review sample of medical records		
Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health Care: This measure is audited by CHS every quarter and they have repeatedly met this measure at 100%.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Medication is currently given within 24 hours of the order, based medical record reviews. Mental Health Care: Medication is currently given within 24 hours of the order, based on a review of medical records.		
Monitor's Recommendations:	Medical Care: 1. Measure performance in this area on a regular basis and implement remedies where appropriate. Mental Health Care: 1. Measure performance in this area on a regular basis and implement remedies where appropriate.		

Paragraph Authors: Greifinger and Johnson	III. A. 4. b. (2) Within eight months of the Effective Date… A medical doctor or psychiatrist shall evaluate, in person, inmates with serious medical or mental health needs, within 48 hours of entry to the Jail.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13 (Not yet due); 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16, 3/3/17; 12/7/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16; 3/3/2017
Measures of Compliance:	Medical Care: duplicate III.A.2.e. Mental Health Care: Review policy Review intake screening Review audits Review of medical records		
Steps taken by the County to Implement this paragraph:	Medical Care: See III. A. 2. a. Mental Health Care: CHS-033 update and audits.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: See III. A. 2. a. Mental Health Care: Quarterly audits reviewed since the last tour indicated that CHS was last at 86% in February 2018 from 20% at baseline measure in March 2017. This question was recently changed to reflect psychiatric follow-up within 30-days based on the assigned level of care for the patient. This went into effect in May 2018. This yielded 5 N/As due to release before 30-days. However, 100% of the other 5/10 patients were seen within 30-days. CHS now plans to measure whether psychiatric evaluation occurred after referral in the time frames specified in the consent agreement (e.g., Emergent referral within 24 hours, or Urgent referral Within 48 hours, or Routine Referral within 48hrs). CHS is not consistently meeting this provision based on their audits.		
Monitor's Recommendations:	Medical Care: See III. A. 2. a. Mental Health Care: Please adjust audit to the language as stated in the CAP for the May 2018 Tool #2. This should appropriately measure if CHS is adhering to this provision. Once the provision is met the results should continue to be sustained over time.		

Paragraph Author: Johnson	III. A. 4. c. Medication Administration and Management Psychiatrists shall conduct reviews of the use of psychotropic medications to ensure that each inmate's prescribed regimen is appropriate and effective for his or her condition. These reviews should occur on a regular basis, according to how often the Level of Care requires the psychiatrist to see the inmate. CHS shall document this review in the inmate's unified medical and mental health record.		
Compliance Status this tour:	Compliance: 7/18	Partial Compliance: 7/13; 3/3/2017; 12/7/17	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16
Measures of Compliance:	<u>Mental Health:</u> Policy/procedure to track, analyze data, and review Levels of Care and access to care Review of records to assess psychiatrist-patient visits Interviews with staff and inmates		
Steps taken by the County to Implement this paragraph:	CHS is now internally auditing of the appropriateness of leveling.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Appropriateness of psychotropic medications regimen and effectiveness for the patient's condition(s) is not currently being audited. However, CHS has several audits (some internal) that directly or indirectly address aspects of this provision (i.e., tools 23, 31, and 32-37) A review of 10 patients' records who have been prescribed psychotropic medication(s) that 100% were appropriate for the patient's condition(s), despite level of care. Decision making continues to include review and adjustment of prescribed psychotropic medications. However, there continue to be inconsistencies in leveling that have been identified in the CHS' internal audits due to lack of specificity on how many criteria for each level are required for a patient to be assigned a new level, or taken off of their current level. In many cases patients had criteria for more than one level (e.g., level 1B and 2). This does not appear to have affected appropriate prescription of psychotropic medication(s), nor level of effectiveness, for patient(s) conditions.		
Monitor's Recommendations:	A pilot internal audit for this provision should be considered to assess and ensure ongoing compliance. Clarifying and assigning clearer criteria for leveling, including discharge from the patient's current level, will help to better assess the appropriateness of releveling including the frequency of psychiatry follow-up, and psychotropic prescribing review.		

Paragraph Author: Johnson	III. A. 4. d. Medication Administration and Management CHS shall ensure nursing staff pre-sets psychotropic medications in unit doses or bubble packs before delivery. If an inmate housed in a designated mental health special management unit refuses to take his or her psychotropic medication for more than 24 hours, the medication administering staff must provide notice to the psychiatrist. A Qualified Mental Health Professional must see the inmate within 24 hours of this notice.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 12/7/17; 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16; 3/3/2017
Measures of Compliance:	Mental Health: Policy regarding medication administration and reporting Review of Medication Administration Records Review of reports to Qualified Mental Health Professionals Review of Audit tool		
Steps taken by the County to Implement this paragraph:	CHS implemented bubble packs for some psychotropic medications Medication Refusal Audit Tool #11 Procedural Directive (April 2018), outlining Medication Refusal Notification		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Results from audit tool #11 from June 2017 (baseline), March 2018, and June 2018 were reviewed. The audit reviews 20 charts of patients who have refused medication and meet policy specifications for notification of the QMHP. At baseline the results were 0% for documentation of refusal in the EHR and appropriate response. They slightly improved to 15% and 0% in March 2018, and to 45% and 30% respectively in the June 2018 audit. The results have consistently improved since baseline. CHS is now notifying providers, per policy, by utilizing their internal messaging center. Anecdotal complaints from providers are that they receive too many notifications from the message center. The CAP in place for the latest Audit tool 11 findings plans to: (1) "provide a refresher training to the nursing staff on the use of the message center in Cerner"; (2) "The Medical Director will provide a refresher training reviewing the utilization of the message center and the expectations related to documentation of clinician response to medication refusal;" and, (3) CHS "will conduct focused audits of physician documentation to review the early impact of these education efforts, as well as the efficacy of the Medication Refusal Notification process implemented in the E.H.R."		
Monitor's Recommendations:	Agree with measures as outlined in the June 2018 CAP for Tool 11 as appropriate measures to move towards meeting the requirements of this provision. Consider including whether "A Qualified Mental Health Professional [saw] the inmate within 24 hours of…notice" of medication refusal.		

Paragraph Authors: Greifinger and Johnson	III. A. 4. e. CHS shall implement physician orders for medication and laboratory tests within three days of the order, unless the inmate is an "emergency referral," which requires immediately implementing orders. [NB: Lab tests in this measure are only those related to medications. Email DOJ 8/27/13]		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR), 3/3/17; 12/7/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/3/2017; 12/7/17; 7/18	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16
Measures of Compliance:	<u>Medical Care:</u> Medical record review Laboratory logs Interview with staff <u>Mental Health Care:</u> Policy regarding physician orders, laboratories and reporting Review of medical and mental health records Interviews with staff Audits		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> Focused review of the accomplishment of laboratory orders to determine the barriers and opportunities. <u>Mental Health Care:</u> Audits of laboratory order completion		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care:</u> As described elsewhere in this report, orders for lab tests continue to fall through the cracks. <u>Mental Health Care:</u> CHS is now auditing laboratory order completion. Completion rates were last at 90%. However, CHS has encountered technical difficulty because the HER can only hold on pending lab order at a time (Tool #14) . When another non-mental health provider orders labs the prior order is erased. This prevents timely completion of lab		
Monitor's Recommendations:	<u>Medical Care:</u> Repair the systems described in this paragraph of the CA. Monitor performance and implement remedies, as appropriate. <u>Mental Health Care:</u> Follow through on IT enhancements to prevent pending lab orders from being removed from the system when any other provider enters a new lab order.		

Paragraph Authors: Greifinger and Johnson	III. A. 4. f. (See III.A.4.a.) Within 120 days of the Effective Date, CHS shall provide its medical and mental health staff with documented training on proper medication administration practices. This training shall become part of annual training for medical and mental health staff.		
Medical Care Compliance Status:	Compliance: 12/7/17; 7/18	Partial Compliance: 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR), 3/3/17
Mental Health Care: Compliance Status:	Compliance: 12/7/17; 7/18	Partial Compliance: 7/29/16; 3/3/2017	Non-Compliance: 7/13 (NR); 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: Lesson plans and annual training records Mental Health Care: Review of policy and procedure related to medication administration Review of training related to medication administration		
Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health Care: CHS provided information on nurses who attended medication administration training.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Please see comments in III. A. 4. a. Mental Health Care: This provision is being met currently by the County.		
Monitor's Recommendations:	Medical Care and Mental Health Care: Continue audits of medication administration. Provide periodic coaching and targeted re-training based upon audit results and supervisor observations.		

5. Record Keeping

Paragraph Authors: Greifinger and Johnson	III. A. 5. a. CHS shall ensure that medical and mental health records are adequate to assist in providing and managing the medical and mental health needs of inmates. CHS shall fully implement an Electronic Medical Records System to ensure records are centralized, complete, accurate, legible, readily accessible by all medical and mental health staff, and systematically organized. [NB: Specific aspects of medical record documentation are addressed elsewhere, e.g. medication administration. This paragraph, then, applies to all aspects of medical records not addressed elsewhere. Thus, these various paragraphs are independent and MDCR may reach compliance with this paragraph, for example, despite non-compliance with other aspects of medical record keeping.]		
Medical Care: Compliance Status:	Compliance: 7/18	Partial Compliance: 7/13; 10/14; 7/29/16, 3/3/17; 12/7/17	Non-Compliance: 3/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14; 10/14; 7/29/16; 3/3/2017; 12/7/17;7/18	Non-Compliance: 7/13; 5/15 (NR); 1/16 (NR)
Measures of Compliance:	<u>Medical Care:</u> Medical record review <u>Mental Health Care:</u> Policy regarding medical records and documentation Review of medical and mental health records for organization and legibility Review of medical record indicates it is adequate, including necessary components such as intake screening, mental health evaluation, progress notes, orders, updated problem list, individualized treatment plan and collateral information, as needed.		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> The County continues to make improvements to the EHR and will integrate the medication module with the EHR (Cerner). <u>Mental Health Care:</u> The majority of functions are completed through the EHR. There is a plan to convert the e-MAR from Sapphire to Cerner.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care:</u> Complex diagnostic radiological testing not available at Metro West such as CT, MRI, etc. are ordered by the provider on a paper form. The form is given to the same administrative assistant who then gives it to the facility medical director for approval. The medical director approves the test and the administrative assistant then sends it to the Jackson Health System radiology department where an ARNP reviews it and either approves or defers the test. There is no documentation in the health record about this process so again, the facility providers are blind to the process and the status of their order. When there is a medical emergency the documentation is now done on a CHS rapid response sheet which is scanned into the record timely after de-briefing. The use of paper forms to communicate to Corrections is phasing out with more information communicated electronically. <u>Mental Health Care:</u> 1) The e-MAR remains separate from the Cerner, the EHR system. This is a barrier to ease of access during BH		
	evaluations.		

Monitors' Recommendations:	Medical Care: Eliminate paper systems for ordering x-rays and other diagnostics. Train and supervise staff to document encounters contemporaneously Mental Health Care: 1. Implement e-MAR per the CHS Pharmacy Insourcing Proposal Timeline.

Paragraph Author: Johnson	III. A. 5. b. Record Keeping CHS shall implement an electronic scheduling system to provide an adequate scheduling system to ensure that mental health professionals see mentally ill inmates as clinically appropriate, in accordance with this Agreement's requirements, regardless of whether the inmate is prescribed psychotropic medications.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14; 10/14; 7/29/16; 12/7/17; 7/18	Non-Compliance: 7/13; 5/15 (NR); 1/16 (NR) 3/3/2017
Measures of Compliance:	Mental Health: Policy regarding scheduling and documentation Review of mental health records Review of scheduling system		
Steps taken by the County to Implement this paragraph:	The County has instituted the use of No Show Reports produced by their IT departments and started to analyze the data. They have hired additional staff ("5.5 FTE") to assist with scheduling.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS has an electronic scheduling system and is now requiring providers to input why the appointment was missed (i.e., refusal, overbooking, etc.). They produced SMART Plans for each facility using data collected from April 2018 that included analysis of No Show Report data and CAPs. Their analysis showed that there is a substantial problem with "overbooking/scheduling," with them taking notice of the impact it had on the SMU population located at TGK. Of the No Shows from each facility, the majority of them were due to overbooking and ranged from 32-61%; refusals were the second most common cause. This is very high percentage of the No Shows. CAPs included solutions ranging from improving Nursing education on scheduling and adjusting staffing to including a new No Show code for "Facility Malfunction" (due to elevator malfunction at PTDC). There is a separate schedule of groups that is not in the EHR and group attendance is still on a drop-in. Group attendance is starting to be regularly tracked and logs for recent groups were produced during the site visit. They do not track their attendance or reasons for refusals for groups. The electronic scheduling system does not track wait times, and automatically reschedules patients who have missed their appointments once a reason is entered per CHS. Patients are being seen as clinically appropriate.		
Monitor's Recommendations:	Continue to audit and track this issue with implementation of CAPs as already defined. Group should be scheduled, and attendance tracked with appropriate analysis of findings to improve No Shows, for those patients who have groups as part of their treatment plan.		

Paragraph Authors: Greifinger and Johnson	III. A. 5. c. (See III.A.5.a.) CHS shall document all clinical encounters in the inmates' health records, including intake health screening, intake health assessments, and reviews of inmates.		
Medical Care Compliance Status:	Compliance: 7/18	Partial Compliance: 7/13; 10/14; 7/29/16, 3/3/17; 12/7/17	Non-Compliance: 3/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Compliance Status:	Compliance: 7/18	Partial Compliance: 7/13; 3/14; 10/14; 7/29/16; 3/3/2017; 12/7/17	Non-Compliance: 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • Duplicate III.A.5.a. Mental Health Care: • Review of policy and procedure related to documentation • Review of medical record • Review of EHR, once implemented		
Steps taken by the County to Implement this paragraph:	Medical Care: See III.A.5.a. Mental Health Care: CHS has streamlined the forms used in the EHR for MH documentation as well as the names of the forms		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: See SA III.A.5.a. Mental Health Care: Streamlining of EHR MH forms has made tracking of appointment types and thus chart review more consistent and simpler. CHS is meeting this provision.		
Monitors' Recommendations:	Medical Care: See SA III.A.5.a.		

Paragraph Authors: Greifinger and Johnson	III. A. 5. d. CHS shall submit medical and mental health information to outside providers when inmates are sent out of the Jail for health care. CHS shall obtain records of care, reports, and diagnostic tests received during outside appointments and timely implement specialist recommendations (or a physician should properly document appropriate clinical reasons for non-implementation).		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 7/29/16, 3/3/17; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14; 10/14; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: Medical record review Mental Health Care: Review of policy relevant to collateral information and implementation of recommended treatment. Review of medical records. Interview of staff and inmates.		
Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health Care: CHS developed: (1) a paper Transfer Summary form that summarizes relevant health information and is sent with patients when they leave the facility for outside care; (2) Return from Off-Site visit type in their EHR Nurse Evaluation Tool; (3) an IT enhancement to document during patient visits that outside records were reviewed; and, (4) Audits of use of Transfer Summary and of outside record review.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: When patients return from outside visits, including specialist appointments, ER trips, and hospitalizations, practitioners are routinely notified. However, there is great variation in the documentation by nurses about the results and recommendations. The recommendations of outside physicians were followed in seven of 10 charts reviewed by the monitors of patients sent to the ED. In two of the charts there was no documentation by the provider of the rationale for not following the recommendations. CHS performance data, reported in June 2018, demonstrates continuing opportunities for improvement in preventing ED visits, inbound nursing documentation and acknowledgement of ED physician's recommendations. There was evidence that records from hospital EDs other than JHS were received and reviewed by providers to inform their clinical decisions. Mental Health Care: CHS has made significant efforts to address this provision. Review of the baseline June 2018 audit results for use of the transfer summary returned at 0%. The CAP involves education of staff with further tracking. CHS continues to consistently reference the outside hospital medical records of patients who recently returned from forensic hospitalizations (e.g., patients sent out for restoration of competency). QMHPs are indicating in records that they have reviewed patients outside records, but their findings are not always evident in the chart or in their decision making. They continue to report that they review the JHS and		

	prior CHS records. This is most evident during the initial QMHP visits; less so during later evaluations (e.g., after a triggering event). The latter may be due to variation in time frames of when documentation actually occurred.
Monitors' Recommendations:	Medical Care: Suggest development of a template or power form for nurses to use in documenting consistent information about patients upon return from off-site care and communication with providers about continuation of care. Mental Health Care: Practitioners should document their review of available medical records by incorporating the relevant findings into their documentation. Incorporating this important in the QMHP's decision-making process can significantly impact diagnostic and treatment choices (i.e., suicidality, mental illness, choice of medication, etc.). Continue to track and audit with implementation of CAPs.

6. Discharge Planning

Paragraph Authors: Greifinger and Johnson	III. A. 6. a. (1) CHS shall provide discharge/transfer planning…Arranging referrals for inmates with chronic medical health problems or serious mental illness. All referrals will be made to Jackson Memorial Hospital where each inmate/patient has an open medical record.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 1/16; 10/14; 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 5/15 (NR); 3/3/2017; 12/7/17; 7/18
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14; 5/15 (NR)
Measures of Compliance:	Medical Care: Medical record review Interview Mental Health Care, as above and: Policy and procedure regarding discharge planning Referrals for inmates with chronic medical health problems or serious mental illness. Evidence of providing a bridge supply of medications of up to 7 days to inmates upon release including receipt of medication as appropriate Provision of an inmate handbook at admission indicating they may request bridge medications and community referral upon release.		
Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health Care: The County updated its policy on Discharge Planning. Provision of bridge medication is now being audited Inmate handbook instructions for bridge medication and discharge has been updated.		

Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: There are signs posted in the jail about the availability of discharge medications. There was scant documentation in the charts reviewed of discharge planning or discharge medications provided to inmates with medical problems. There is no connectivity between the jail management system or CHS to communicate about discharge dates or to identify those inmates who would benefit from either discharge plans or medications. There is no documentation of a functioning system for continuity of care on discharge. Mental Health Care: CHS audits of Continuity of Care on Discharge showed that of 20 charts reviewed, 65% had a discharge plan completed and 10% received a bridge supply of medication (down from 40% in April 2018). The CAP includes a plan to hire more Social Work (SW) staff to assist with discharge planning, exploration of ways to improve notification of need for bridge med prescriptions to providers and to corrections for patients to pick up their medications. SW staff interviews in the MHTC at TGK implied reduced officer staffing and restrictions on when patients can be seen for discharge planning as additional possible reasons discharge planning may not occur more often. Providers default to JHS for referrals. Tracking of continuity of care in regard to if visits were actually attended or interventions were effective are not happening. There was no evidence provided of other referral sources other than verbal descriptions (e.g., referrals to substance use rehabilitation). Community partnerships are a potential rich source for referrals. Other than grant data and support letters for that grant, no evidence (i.e., documentation of referral, follow-up data, etc.) was produced for community partnerships as a possible referral source at the time of discharge. Staff and leadership were conversant on community partnership resources.
Monitor's Recommendations:	Medical Care Implement effective discharge planning including medication and referral to community resources. Track data on results. Mental Health Care: Continue efforts to establish discharge planning consistent with this provision including, bridge medication and referral to community resources/partners. This should improve continuity of care on discharge including for patients who may not seek all of their medical services at a Jackson Health System facility.

Paragraph Authors: Greifinger and Johnson	III. A. 6. a. (2) Providing a bridge supply of medications of up to 7 days to inmates upon release until inmates can reasonably arrange for continuity of care in the community or until they receive initial dosages at transfer facilities. Upon intake admission, all inmates will be informed in writing and in the inmate handbook they may request bridge medications and community referral upon release.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 5/15 (NR); 1/16; 3/3/2017; 12/7/17; 7/18
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14; 5/15 (NR)
Measures of Compliance:	Medical Care: Medical record review Mental Health Care, as above and: Policy regarding discharge planning Referrals for inmates with chronic medical health problems or serious mental illness. Providing a bridge supply of medications of up to 7 days to inmates upon release as noted by log review or other method Provision of an inmate handbook at admission indicating they may request bridge medications and community referral upon release.		
Steps taken by the County to Implement this paragraph:	Medical Care: N/A Mental Health Care: Please see III. A. 6. A. 1.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Please see III. A. 6. A. 1. Mental Health Care: Please see III. A. 6. A. 1.		
Monitor's Recommendations:	Medical Care: Please see III. A. 6. A. 1. Mental Health Care: Please see III. A. 6. A. 1.		

Paragraph Authors: Greifinger and Johnson	III. A. 6. a. (3) Adequate discharge planning is contingent on timely notification by custody for those inmates with planned released dates. For those inmates released by court or bail with no opportunity for CHS to discuss discharge planning, bridge medication and referral assistance will be provided to those released inmates who request assistance within 24-hours of release. Information will be available in the handbook and intake admission awareness paper. CHS will follow released inmates with seriously critical illness or communicable diseases within seven days of release by notification to last previous address.		
Medical Care: Compliance Status:	Compliance: 1/16	Partial Compliance: 10/14; 7/29/16; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 5/15 (NR) 3/3/2017
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14; 5/15 (NR)
Measures of Compliance:	Medical Care: Medical record review Mental Health Care: Policy regarding discharge planning Evidence of referrals for inmates with chronic medical health problems or serious mental illness. Evidence of providing a bridge supply of medications of up to 7 days to inmates upon release Provision of an inmate handbook at admission indicating they may request bridge medications and community referral upon release.		
Steps taken by the County to Implement this paragraph:	Medical Care: Please see III. A. 6. A. 1. Mental Health Care: Please see III. A. 6. A. 1.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: CHS is planning to implement an effective discharge planning process. Mental Health Care: Please see III. A. 6. A. 1.		
Monitor's Recommendations:	Medical Care: Please see III. A. 6. A. 1. Mental Health Care: Please see III. A. 6. A. 1.		

7. Mortality and Morbidity Reviews

Paragraph Authors: Greifinger and Johnson	III. A. 7. a. Defendants shall sustain implementation of the MDCR Mortality and Morbidity "Procedures in the Event of an Inmate Death," updated February 2012, which requires, inter alia, a team of interdisciplinary staff to conduct a comprehensive mortality review and corrective action plan for each inmate's death and a comprehensive morbidity review and corrective action plan for all serious suicide attempts or other incidents in which an inmate was at high risk for death. Defendants shall provide results of all mortality and morbidity reviews to the Monitor and the United States, within 45 days of each death or serious suicide attempt. In cases where the final medical examiner report and toxicology takes longer than 45 days, a final mortality and morbidity review will be provided to the Monitor and United States upon receipt.		
Medical Care: Compliance Status:	Compliance: 7/18	Partial Compliance: 7/13; 1/16; 7/29/16; 12/7/17	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 3/3/2017
Mental Health Compliance Status:	Compliance: 7/18	Partial Compliance: 3/14; 7/29/16; 12/7/17	Non-Compliance: 7/13; 10/14 (NR); 5/15 (NR); 1/16; 3/3/2017
Measures of Compliance:	<u>Medical Care:</u> Medical record review Review of M&M and quality management committee minutes <u>Mental Health Care, as above and:</u> Ongoing review of comprehensive mortality reviews and corrective action plans for each inmate's death Within 45 days of each death or serious suicide attempt, provide report for review to Monitor and United State In cases where the final medical examiner report and toxicology takes longer than 45 days, a final mortality and morbidity review will be provided to the Monitor and United States upon receipt. Interviews with staff. Review of the Psychological Autopsies. Review of M&M and quality management committee minutes		
Steps taken by the County to Implement this paragraph:	With technical assistance from the monitors, CHS is working to improve their self-critical analysis		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical and Mental Health:</u> M&M reviews are much timelier and self-critical. Corrective action plans are clear and are tracked with a new system to assure follow-through. The reviews are updated when further information is received, e.g., toxicology reports.		
Monitors' Recommendations:			

Paragraph Authors: Greifinger and Johnson	III. A. 7. b. Defendants shall address any problems identified during mortality reviews through training, policy revision, and any other developed measures within 90 days of each death or serious suicide attempt.		
Medical Care: Compliance Status:	Compliance: 7/18	Partial Compliance: 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16; 3/3/2017; 12/7/17
Mental Health Care: Compliance Status:	Compliance: 7/18	Partial Compliance: 3/14	Non-Compliance: 7/13; 10/14 (NR); 5/15 (NR); 1/16; 7/29/16; 3/3/2017; 12/7/17
Measures of Compliance:	Medical Care: Review of M&M reports and committee minutes Mental Health Care: Review mortality reviews and corrective action plans for each inmate's death Review of comprehensive morbidity review and corrective action plan for all serious suicide attempts or other incidents in which an inmate was at high risk for death. Within 90 days of each death or serious suicide attempt, provide evidence of implementation of plans to address issues identified in mortality reviews		
Steps taken by the County to Implement this paragraph:	Medical Care: See Comments in III.A.7.a. Mental Health Care: See Comments in III.A.7.a.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: See Comments in III.A.7.a. Mental Health Care: See Comments in III. A. 7. a.		
Monitors' Recommendations:	See III.B.1 a. and III A.3.a.(4) Medical Care: See Comments in III.A.7.a. Mental Health Care: 1. See Comments in III.A.7.a.		

Paragraph Authors: Greifinger and Johnson	III. A. 7. c. Defendants will review mortality and morbidity reports and corrective action plans bi-annually. Defendants shall implement recommendations regarding the risk management system or other necessary changes in policy based on this review. Defendants will document the review and corrective action and provide it to the Monitor.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16; 3/3/2017; 12/7/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/18	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR);1/16; 7/29/16; 3/3/2017; 12/7/17
Measures of Compliance:	Medical Care: Review bi-annual reports Mental Health Care: Review bi-annual reports Review risk management system Review corrective action plans provided for each serious suicide attempt or inmate death		
Steps taken by the County to Implement this paragraph:	Medical Care One bi-annual report was produced Mental Health Care: The County provided a bi-annual report of M&M with CAPs.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: The reports were produced. Mental Health Care: The biannual reports were produced. Review of the CAPs demonstrated that they are updating them as they receive new information and closing them out once all steps in a CAP are met. How conclusions were arrived upon from analyses was not always clear (e.g., reasons for differences by facility of trigger events). However, whether the CAPs were effective was not always clear nor how the changes made have been integrated into the larger service/system of care.		
Monitors' Recommendations:	Medical Care: Produce bi-annual reports include categorization of critical incidents, findings, clear analysis of data, corrective action plans that are consistent with findings, follow-up to update and determine if action plans have been implemented, were effective, and if larger system changes are needed moving forward. Mental Health Care: Continue to provide bi-annual reports to the monitors per this requirement and include categorization of critical incidents, findings, clear analysis of data, corrective action plans that are consistent with findings, follow-up to update and determine if action plans have been implemented, were effective, and if larger system changes are needed moving forward.		

B. MEDICAL CARE

1. Acute Care and Detoxification

Paragraph Author: Greifinger	III. B. 1. a. CHS shall ensure that inmates' acute health needs are identified to provide adequate and timely acute medical care.		
Compliance Status:	Compliance:	Partial Compliance: 7/29/16; 7/18	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 3/3/2017; 12/7/17
Measures of Compliance:	Medical Care: Medical record review Inspection Interview		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	There is no review of over or under utilization of infirmary or medical housing. There is no delineation between infirmary, observation, and medical housing beds. All patients, regardless of acuity, are admitted under the same process. The nurse conducts an assessment one time per shift, or every eight hours. Nurses that were interviewed in the medical housing unit indicated they check on the patients every two hours but nothing is documented in the health record. There is no "leveling" of acuity, so that all patients get vital signs once each shift, independent of the medical need. The report sheets used to pass patient plans of care from one shift to the next were inadequate. Nurses interviewed shared they report "by exception". If the oncoming nurse wants to be informed of each patient's plan of care, they are required to review each patient's health record summary. This process is too timely for the nurse to be prepared to assume responsibility for the care of each patient in the unit, prior to the departure of the off going nurse. In the event of a patient emergency, at the beginning of the shift, the nurse very likely would be assessing the patient's condition without the benefit of medical history, medications, current orders, etc. Nursing staff in the infirmary reported that patients placed in the unit are under constant observation via camera, as there are no call lights available to the patients should they need to get the attention of the nurse. Observation of the desk and cameras over several days duration found several times where no one was watching the cameras.		
Monitor's Recommendations:	Stratify levels of care for patients in medical housing and implement risk-based nursing monitoring.		

Paragraph Author: Greifinger	III. B. 1. b. (See III.B.1.a.) CHS shall address serious medical needs of inmates immediately upon notification by the inmate or a member of the MDCR Jail facilities' staff or CHS staff, providing acute care for inmates with serious and life-threatening conditions by a Qualified Medical Professional.		
Compliance Status:	Compliance:	Partial Compliance: 7/29/16, 3/3/17; 12/7/17; 7/18	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	duplicate III.A.3.a.(4) duplicate III.B.1.a.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	See III. B. 1. a. & III.A.3.a.(4)		
Monitor's Recommendations:	See III. B. 1. a. & III.A.3.a.(4)		

Paragraph Author: Greifinger	III. B. 1. c. CHS shall sustain implementation of the Detoxification Unit and the Intoxication Withdrawal policy, adopted on July 2012, which requires, inter alia, County to provide treatment, housing, and medical supervision for inmates suffering from drug and alcohol withdrawal.		
Compliance Status:	Compliance: 12/7/17; 7/18	Partial Compliance: 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR), 3/3/17
Measures of Compliance:	*The measures of compliance from the Settlement Agreement and/or Consent Agreement and/or what you will use to measure compliance* Inspection		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Vastly improved monitoring, documentation, and treatment.		
Monitor's Recommendations:	No additional recommendations at this time.		

2. Chronic Care

Paragraph Author: Greifinger	III. B. 2. a. CHS shall sustain implementation of the Corrections Health Service ("CHS") Policy J-G-01 (Chronic Disease Program), which requires, inter alia, that Qualified Medical Staff perform assessments of, and monitor, inmates' chronic illnesses, pursuant to written protocols.		
Compliance Status:	Compliance:	Partial Compliance: 7/29/16; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR), 3/3/17
Measures of Compliance:	Policy review Medical record review Interview		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Chronic care currently follows nationally-accepted guidelines. Enrollment in chronic care occurs more often than it used to, however, patients are not seen in a timely manner by a practitioner. Chronic care follow-up appointments are not scheduled timely and the frequency of appointments is not based upon the patient's condition. Patients whose condition is poor are seen at the same frequency interval as those whose condition is in good control. Chronic care appointments are not scheduled to coincide with the time medication needs to be renewed resulting in discontinuity of care. According to CHS' data, only one in ten patients with chronic disease was seen within 14 days and patients with elevated blood pressures did not always have follow-up BP evaluations. Performance was good for patients on anticoagulant medication. Chronic care guidelines are being updated. Note: As of 12/7/17, only 0.05% of MDCR inmates were vaccinated against influenza.		
Monitor's Recommendations:	Measure clinical performance as part of the quality management program, identify deficiencies, implement remedies and re-measure over time. Improve rates of vaccination against influenza for general health purposes, not the least of which is employee healthand public health.		

Paragraph Author: Greifinger	III. B. 2. b. (See III. B. 2. a.) Per policy, physicians shall routinely see inmates with chronic conditions to evaluate the status of their health and the effectiveness of the medication administered for their chronic conditions. [NB: The Medical Monitor will interpret "see" in this particular requirement as meaning physicians play a leadership and oversight role in the management of patients with chronic conditions; Qualified Medical Staff may perform key functions consistent with their licensure, training, and abilities. This interpretation was approved by DOJ during the telephone conference of 8/19/13.]		
Compliance Status:	Compliance:	Partial Compliance: 7/29/16; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR), 3/3/17
Measures of Compliance:	duplicate III.B.2. a.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	See III. B. 2. a.		
Monitor's Recommendations:	See III. B. 2. a.		

3. Use of Force Care

Paragraph Authors: Greifinger and Johnson	III. B. 3. a. The Jail shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15-minute in-person visual observation by trained custody. Qualified Medical Staff shall perform 15-minute checks on an inmate in restraints. For any custody-ordered restraints, Qualified Medical Staff shall be notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.		
Medical Care: Compliance Status:	Compliance: 3/3/17; 7/29/16; 7/18	Partial Compliance: 12/7/17	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14; 5/15 (NR); 1/16 (NR}
Mental Health: Compliance Status	Compliance: 7/18	Partial Compliance: 3/3/2017; 12/7/17	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14; 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	Medical Care: Review of logs Medical record review Policy review Mental Health Care, as above and: Review of adequate care provided for patients placed in restraint, including chemical restraint or involuntary intramuscular injection. Adequate documentation shall include evidence of attempts to de-escalate the incident and attempts at lesser restrictive means of treatment. Review of mental health care provided to patients repeatedly involved in episodes of restraint for assessment of possible co-morbid mental health conditions Review of differentiation between custody vs. clinical restraint in patients with mental health conditions, as noted by proper utilization of a medical order before initiation		
Steps taken by the County to Implement this paragraph:	<u>Medical Care</u> A policy is in place. <u>Mental Health Care:</u> Restraint Policy completed CHS implemented a Restraint Order set for tracking purposes and has audited restraint use.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care</u> <u>Mental Health Care:</u> There were no incidents of clinical (physical) restraint reported since the last tour. Due to there being no use of restraints that occurred since the last tour I was unable to review any new data since the restraint policy was updated. The recommendation from the last report was met and based on the new order set restraint use will be reflected in the EHR when used.		
Monitor's Recommendations:	<u>Mental Health Care:</u> Bi-annual (internal) audits of restraint use should be conducted to ensure compliance with this provision and appropriate use of restraints per CHS policy.		

Paragraph Author: Greifinger	III. B. 3. b. The Jail shall ensure that inmates receive adequate medical care immediately following a use of force.		
Compliance Status:	Compliance: 7/18	Partial Compliance: 7/29/16; 12/7/17	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 3/3/2017
Measures of Compliance:	Review of logs Medical record review		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	In only seven out of 15 records reviewed was it possible to ascertain if inmates were seen immediately following use of force. There is no documentation that the medical evaluation of the inmate is outside the hearing of officers or other inmates. In none of the 15 incidents reviewed was any suspicion raised that the injury could have been a result of staff-on-inmate abuse. There is no evidence that medical staff understands or know how to report a suspicion of staff-on-inmate abuse as required by the Settlement Agreement. Medical evaluation and care provided was adequate in all but one case. In 12 of 15 incidents a CHS Incident Addendum was completed. It appears that completing the form is at the request of custody staff rather than as described in the Settlement Agreement, which is more limited in its requirement.		
Monitor's Recommendations:			

Paragraph Author: Greifinger	III. B. 3. c. Qualified Medical Staff shall question, outside the hearing of other inmates or correctional officers, each inmate who reports for medical care with an injury, regarding the cause of the injury. If a health care provider suspects staff-on- inmate abuse, in the course of the inmate's medical encounter, that health care provider shall immediately: 1) take all practical steps to preserve evidence of the injury (e.g., photograph the injury and any other physical evidence); 2) report the suspected abuse to the appropriate Jail administrator; and 3) complete a Health Services Incident Addendum describing the incident.		
Compliance Status:	Compliance: 7/18	Partial Compliance: 10/14; 12/7/17	Non-Compliance:7/13 (NR); 3/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16, 3/3/17; 12
7M17easures of Compliance:	Interviews Medical record review		
Steps taken by the County to Implement this paragraph:	The County provides an internal telephone number, available to inmates at no charge, to report inappropriate uses of force. This telephone number is posted visibly.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	See III. B. 3. b.		
Monitor's Recommendations:			

C. MENTAL HEALTH CARE AND SUICIDE PREVENTION

1. Referral Process and Access to Care

Paragraph Author: Johnson	III. C. 1. a. Referral Process and Access to Care Defendants shall ensure constitutional mental health treatment and protection of inmates at risk for suicide or self-injurious behavior. Defendants' efforts to achieve this constitutionally adequate mental health treatment and protection from self- harm will include the following remedial measures regarding… CHS shall develop and implement written policies and procedures governing the levels of referrals to a Qualified Mental Health Professional. Levels of referrals are based on acuteness of need and must include "emergency referrals," "urgent referrals," and "routine referrals," as follows: "Emergency referrals" shall include inmates identified as at risk of harming themselves or others, and placed on constant observation. These referrals also include inmates determined as severely decompensated, or at risk of severe decompensation. A Qualified Mental Health Professional must see inmates designated "emergency referrals" within two hours, and a psychiatrist within 24 hours (or the next Business day), or sooner, if clinically indicated. "Urgent referrals" shall include inmates that Qualified Mental Health Staff must see within 24 hours, and a psychiatrist within 48 hours (or two business days), or sooner, if clinically indicated. "Routine referrals" shall include inmates that Qualified Mental Health Staff must see within five days, and a psychiatrist within the following 48 hours, when indicated for medication and/or diagnosis assessment, orsooner, if clinically indicated.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR);
Measures of Compliance:	Mental Health: Review of medical records for implementation of policy. Review of internal audits.		
Steps taken by the County to Implement this paragraph:	Referral to a QMHP is occurring at the time of initial screening. Self-referral can occur via the sick call process. The relevant policy was also updated. CHS has plans to utilize the routine referral and to audit follow-up by a psychiatrist within 48 hours for Urgent and Routine referrals. The baseline audit results for this provision were provided during the time the report was being written. A power point presentation of the training on referrals was provided as well as the 5-question post-test was also provided.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	QMHPs are being referred70% of patients screened during intake; 50% are subsequently assigned a MH level (some are referred for detox). Patients are not always seen by the QMHP during the allocated time frame per referral. Psychiatrist follow-up within the allocated time frame commonly occurred for level 1A and 1B patients but was neither consistently occurring for patients who have been leveled higher; nor after being level down from 1A. Baseline audit results show a 30% finding for patients being seen by the QMHP in the allocated referral time frame, documenting a progress note that described the assessment process, and whether the appropriate level of care was assigned per their documentation. CHS plans to add questions to review if the QMHP ordered referral to a psychiatrist, and if the psychiatrist completed the referral within the time frames of this provision. CAPs were put in place to address deficiencies that were found to contribute to these low findings. While onsite, CHS discussed		

	with the MH Monitor recognition of the quality of assessments provided by the APRNs in Intake including diagnosis and psychotropic prescribing. CHS plans to extend the time for psychiatrist follow-up by recognizing that evaluation by an APRN (vs. SW) in intake allows for what the psychiatrist would have done at the time the CA was written. Concerns were raised by the MH Monitor given the variety of APRNs working in Intake (e.g., Psych and Family APRN) and the differences in their respective training. Therefore, this change will be tracked for quality along with meeting all other requirements of this provision (e.g., time to evaluation). Training on this provision with the changes had occurred for 54% of relevant staff at the time of this report. CHS predicted completion of training for all relevant staff within the month of July.
Monitor's Recommendations:	For the next tour, please provide: Records demonstrating completion of training to the policy for relevant staff. Continue audit this provision and follow through on CAPs to move this provision towards full, sustained, compliance.

Paragraph Author: Johnson	III. C. 1. b. Referral Process and Access to Care CHS will ensure referrals to a Qualified Mental Health Professional can occur: At the time of initial screening; At the 14-day assessment; or At any time by inmate self-referral or by staff referral.		
Compliance Status this tour:	Compliance: 7/18	Partial Compliance: 7/13; 7/29/16; 3/3/2017; 12/7/17	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR);
Measures of Compliance:	<u>Mental Health Care:</u> Review manual of mental health policies and procedures Results of internal audits Review of medical records		
Steps taken by the County to Implement this paragraph:	CHS is providing a continuum of care services, has hired new staff to meet staffing needs, and collect data relevant to the provision of mental health care.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s):	Referrals to the QMHP can occur at the time of initial screening, during later assessments by clinical staff, and by self-referral via sick call requests. However, CHS is only currently auditing referrals/follow through at intake and for sick call. Referrals from other providers are not being tracked. Medical staff understood referral process for patients to be seen by a QMHP. Correctional officers also were able to explain the processes in place for them to have a patient evaluated by the QMHP.		
Monitor's Recommendations:	Continue to streamline data collection, analysis, and the development of corrective action plans that are regularly updated and followed through to completion. Please include referrals that do not originate during intake or via sick call in your audits.		

2. Mental Health Treatment

Paragraph Author: Johnson	III. C. 2. a. Mental Health Treatment CHS shall develop and implement a policy for the delivery of mental health services that includes a continuum of services; provides for necessary and appropriate mental health staff; includes treatment plans for inmates with serious mental illness; collects data; and contains mechanisms sufficient to measure whether CHS is providing constitutionally adequate care.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14;10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: Review of manual of mental health policies and procedures Level of care and provision of mental health services including medication management, group therapy and discharge planning Review of mental health staffing vs. mental health population Review of internal audits Review implementation of projected changes in mental health services including: Medical Appointment Scheduling System (MASS), Sapphire (Physician Order Entry System and Electronic Drug Monitoring) and the Electronic Medical Record, Cerner, all projected in August 2014.		
Steps taken by the County to Implement this paragraph:	The County continues to streamline the delivery of care by self-analysis and by its efforts to meet the provisions within the consent agreement.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is providing a continuum of care across various mental health levels with the previously mentioned difficulties when leveling patients to a higher or lower level of care. Staffing has improved with ongoing identification of staffing changes needed to implement quality care (i.e., discharge planning, weekend coverage, etc.); close analysis of clinical work product (both quantity and quality) in conjunction with other non-clinical duties needs to be improved. Treatment plans have improved but should be patient specific as the norm, beyond medication management. Data collection and associated analysis and corrective action plans have significantly improved.		
Monitor's Recommendations:	Continue to streamline data collection, analysis, and the development of corrective action plans that are regularly updated and followed through to completion for the requirements of this provision and as appropriate to ensure the delivery of constitutionally appropriate care.		

Paragraph Author: Johnson	III. C. 2. b. Mental Health Treatment CHS shall ensure adequate and timely treatment for inmates, whose assessments reveal mental illness and/or suicidal ideation, including timely and appropriate referrals for specialty care and visits with Qualified Mental Health Professionals, as clinically appropriate.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: Review of mental health policies and procedures Review medical records, screenings, and referrals for concordance with Appendix A CHS anticipates "100% achievement of compliance" for a minimum of 4 (four) consecutive quarters of retrospective random chart reviews.		
Steps taken by the County to Implement this paragraph:	The CHS policy for Behavioral Health Services was updated.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Timely treatment for patients remains an issue despite improvements in the thoroughness of initial evaluations by APRNs in Intake. Continued inadequacy of evaluation and treatments provided (i.e., lack of evidence that medical records were reviewed, delay in lab draws due to cancellations by orders from other providers, or follow-up after notification of medication refusals). CHS reports an improvement in overall time for intake. However, they are still not below their own measure of 5 hours or less for throughput but are generally meeting 24 hours or less required by the CA for completion of intake.		
Monitor's Recommendations:	Continue to focus on improving identified factors that impact the timeliness of care of patients (i.e., review of medical records and use of relevant data in treatment planning, missed lab draws, medication refusal notification, complications with leveling, etc.).		

Paragraph Author: Johnson	III. C. 2. c. Mental Health Treatment Each inmate on the mental health caseload will receive a written initial treatment plan at the time of evaluation, to be implemented and updated during the psychiatric appointments dictated by the Level of Care. CHS shall keep the treatment plan in the inmate's mental health and medical record.		
Compliance Status this tour:	Compliance: 7/18	Partial Compliance: 7/13; 7/29/16; 3/3/2017; 12/7/17	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	Mental Health: Review of manual of mental health policies and procedures Results of internal audits Review of medical records for presence of treatment plans and evidence of their implementation		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS how has the ARNP at intake and the Psychiatrist in the first contact write a treatment plan as part of their initial services. This enables CHS to technically meet this provision as written. Unfortunately, the *quality* of the plan is often poor and contains little more than a description of the services available to a patient based on his or her level of care. The treatment plans are distinct from IDTP and when a patient remains at a level long enough to have an IDTP the IDTP Treatment Plan and the ARNP/Psychiatry Note Treatment Plans are not in congruence. As a whole the quality of the work reflected in this area is essentially unchanged since the last tour. EHR Clinical forms pull documentation of the initial treatment plan to the MH notes that follow. Many times, the medication adjustments are the only significant change in the plan. While the treatment plans continue to be patient centered, there is substantial space to specify need/referral to many of the non-MD treatment services (e.g., individual therapy or anger management group). Patients who are high utilizers (e.g., SMI with a repeated grievance history) typically had very specific treatment plans due to IDTTs.		
Monitor's Recommendations:	All treatment plans (those created by individual providers and those created by the IDTT) should include concrete, measurable, and observable goals that are individualized for each patient to maintain compliance. Treatment plans created in IDTP should incorporate and build on treatment plans created earlier in the course of treatment to demonstrate continuity of care.		

Paragraph Author: Johnson	III. C. 2. d. Mental Health Treatment CHS shall provide each inmate on the mental health caseload who is a Level I or Level II mental health inmate and who remains in the Jail for 30 days with a written interdisciplinary treatment plan within 30 days following evaluation. CHS shall keep the treatment plan in the inmate's mental health and medical record.		
Compliance Status this tour:	Compliance: 12/7/17; 7/18	Partial Compliance: 7/13; 7/29/16; 3/3/2017	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> Manual of mental health policies and procedures Results of internal audits in MHRC monthly meeting minutes Review of medical records for presence of treatment plans and evidence of their implementation		
Steps taken by the County to Implement this paragraph:	Completion of IDTTs are being audited		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Review of MHRC minutes from March to June 2018 showed that IDTT audits were reported in the April and May MHRC minutes. Both months reported 100% compliance with this measure. Limited onsite chart review by the Asst. MH Monitor in conjunction with the Director of Psychology corroborated those findings during the site visit.		
Monitor's Recommendations:	No additional recommendations at this time.		

Paragraph Author: Johnson	C. 2. e. Mental Health Treatment In the housing unit where Level I inmates are housed (9C) (or equivalent housing) for seven continuous days or longer will have an interdisciplinary plan of care within the next seven days and every 30 days thereafter. In addition, the County shall initiate documented contact and follow-up with the mental health coordinators in the State of Florida's criminal justice system to facilitate the inmate's movement through the criminal justice competency determination process and placement in an appropriate forensic mental health facility. The interdisciplinary team will: (1) Include the treating psychiatrist, a custody representative, and medical and nursing staff. Whenever clinically appropriate, the inmate should participate in the treatment plan. (2) Meet to discuss and review the inmate's treatment no less than once every 45 days for the first 90 days of care, and once every 90 days thereafter, or more frequently if clinically indicated; with the exception being inmates housed on 9C (or equivalent housing) who will have an interdisciplinary plan of care at least every 30 days.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> Review of manual of mental health policies and procedures Results of internal audits Review of medical records for presence of interdisciplinary treatment plans and evidence of their implementation for patients in 9C who have been housed for seven continuous days or longer to see if individualized treatment plans are provided at 7 days and at 30 days Evidence of contact with mental health coordinators in the State of Florida's criminal justice system to facilitate the inmate's movement through the criminal justice competency determination process and placement in an appropriate forensic mental health facility. Review of the interdisciplinary treatment team notes for evidence of individualized plans Evidence of care meetings for patients at intervals no less than 45 days Interview staff and inmates.		
Steps taken by the County to Implement this paragraph:	Jail Diversion program work and IDTT audits are being reported in the MHRC monthly meeting minutes.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s):	See III. C. 2. d. regarding IDTTs. Per Asst. MH Monitor, review of sign in sheets for IDTTs does not consistently reflect all who attended. However, interviews of MH and custody staff reflect knowledge of the process and all parties report regular attendance and input. Patients are usually releveled prior to an IDTT review occurring. The County reports they "initiate documented contact and follow-up with the mental health coordinators in the State of Florida's criminal justice system to facilitate the inmate's movement through the criminal justice competency determination process and placement in an appropriate forensic mental health facility" for patients whose competence to stand trial has been called into question. This process is facilitated by the Jail Diversion program. Per CHS, the Jail Diversion Program is grant based (25% grant, 75% CHS) and focuses on removing incompetent patients from the jail and placing them in the community or other more appropriate environment for treatment. Complex grant funding documents and several verbal explanations were provided to explain this process but they did not clearly delineate the process nor identify the relationship between the county and the grantee for the state of Florida.		

Monitor's Recommendations:	Please provide summarized documentation that explains how the Jail Diversion grant program meets the requirement of this provision. As this was also identified as a form of community partnerships, please explain how the grant facilitates partnerships with other community entities for continuity of care services after discharge (release).

Paragraph Author: Johnson	III. C. 2. f. Mental Health Treatment CHS will classify inmates diagnosed with mental illness according to the level of mental health care required to appropriately treat them. Level of care classifications will include Level I, Level II, Level III, and Level IV. Levels I through IV are described in Definitions (Section II.). Level of care will be classified in two stages: Stage I and Stage II.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: 1. Mental health policies and procedures 2. Review of medical records for evidence of implementation of policies 3. Review of internal audits		
Steps taken by the County to Implement this paragraph:	Psychiatric level of care and follow-up is outlined in CHS policy 058B.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Internal audits identified the need for clarity on the criteria for each level and when a patient can be releveled to a less acute level of care.		
Monitor's Recommendations:	Please proceed with clarification of requirements for leveling and releveling based on the criteria for each level. Once established, the changes will need to be audited for compliance.		

Paragraph Author: Johnson	III. C. 2. g. Mental Health Treatment Stage I is defined as the period of time until the Mental Health Treatment Center is operational. In Stage I, group-counseling sessions targeting education and coping skills will be provided, as clinically indicated, by the treating psychiatrist. In addition, individual counseling will be provided, as clinically indicated, by the treating **psychiatrist.**		
Compliance Status this tour:	Compliance: 3/3/17; 12/7/17; 7/18	Partial Compliance:	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16
Measures of Compliance:	Mental Health: Manual of mental health policies and procedures. Results of internal audits, if any Review of medical records for implementation of policies consistent with appropriate treatment in Stage I, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	Since the last tour CHS has hired more mental health staff including social workers, psychologists, and psychiatrist. Individual and group psychotherapy continues to be provided at all facilities and attendance is tracked by sign-in sheets.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS remains compliant with this requirement. CHS now has a system in place for tracking the reasons for missed appointments.		
Monitor's Recommendations:	It is recommended that CHS track and document patient participation in group therapy services.		

Paragraph Author: Johnson	C. 2. g. (1) Mental Health Treatment Inmates classified as requiring Level IV level of care will receive: Managed care in the general population; Psychotropic medication, as clinically appropriate; Individual counseling and group counseling, as deemed clinically appropriate, by the treating psychiatrist; and Evaluation and assessment by a psychiatrist at a frequency of no less than once every 90 days.		
Compliance Status this tour:	Compliance: 3/3/2017; 7/18	Partial Compliance: 12/7/17	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	<u>Mental Health:</u> Manual of mental health policies and procedures Results of internal audits, if any Review of medical records for implementation of policies consistent with appropriate treatment in Stage I, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	Internal audits of leveling and associated services		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is providing appropriate mental health care to the level 4 population. CHS has started to audit attendance of group and individual therapy with the results being reported in the MHRC monthly meeting minutes. Difficulties arose due to variation in the type of notes used to document group and individual sessions as well as inability to know the type of group session attended without opening the note. Data found from chart reviews was were inconsistent based on how the search occurred and by month. While this indicates group and individual counseling are being provided to patients (level 3 and 4), it does not indicate how many nor how often. Another internal audit tool of level 4 criteria found that only 20% of charts (2/10) reflected they were receiving psychotherapy services. In the audits some notes that should have been therapy notes were not therapy notes. Chart review demonstrated that patients who are elevated to level 4 are seen as required per policy the majority of the time and that many are discharged before they need to be seen by the psychiatrist.		
Monitor's Recommendations:	Please continue efforts to improve tracking of group and individual therapy documentation and attendance.		

Paragraph Author: Johnson	C. 2. g. (2) Mental Health Treatment Inmates classified as requiring Level III level of care will receive: i. Evaluation and stabilizing in the appropriate setting; ii. Psychotropic medication, as clinically appropriate; iii. Evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; iv. Individual counseling and group counseling, as deemed clinically appropriate by the treating psychiatrist; and v. Access to at least one group counseling session per month or more, as clinically indicated.		
Compliance Status this tour:	Compliance: 12/7/17; 7/18	Partial Compliance: 3/3/2017	Non-Compliance: 7/13;3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	Mental Health: Manual of mental health policies and procedures Results of internal audits, if any Review of medical records for implementation of policies consistent with appropriate treatment in Level III, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	Internal audits of leveling and associated treatment services.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is providing appropriate mental health care to the level 3 population. CHS has started to audit attendance of group and individual therapy with the results being reported in the MHRC monthly meeting minutes. Difficulties arose due to variation in the type of notes used to document group and individual sessions as well as inability to know the type of group session attended without opening the note. Data found from chart reviews was were inconsistent based on how the search occurred and by month. While this indicates group and individual counseling are being provided to patients (level 4 and otherwise), it does not indicate how many nor how often. Another internal audit tool found that only 10% of charts (1/10) reflected they were receiving psychotherapy services. In the audits some notes that should have been therapy notes were not therapy notes. Chart review demonstrated that patients who are elevated to level 3 are seen as required per policy the majority of the time and that many are discharged before they need to be seen by the psychiatrist.		
Monitor's Recommendations:	See recommendation for III. C. 2. g. (1).		

Paragraph Author: Johnson	III. C. 2. g. (3) Mental Health Treatment Inmates classified as requiring Level II level of care will receive: i. evaluation and stabilizing in the appropriate setting; ii. psychotropic medication, as clinically appropriate; iii. private assessment with a Qualified Mental Health Professional on a daily basis for the first five days and then once every seven days for two weeks; iv. evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; and v. access to individual counseling and group counseling as deemed clinically appropriate by the treating psychiatrist.		
Compliance Status this tour:	Compliance: 12/7/17; 7/18	Partial Compliance: 7/13; 1/16; 7/29/16; 3/3/2017	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: Manual of mental health policies and procedures Results of internal audits, if any Review of medical records for implementation of policies consistent with appropriate treatment in Level II, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	Internal audits of leveling and associated treatment services.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is providing appropriate mental health care to the level 2 population. Chart review demonstrated that patients who are elevated to level 2 are seen as required per policy. Internal audits demonstrated that only 30% of patients assessed to be level 2 were appropriate based on leveling criteria. So although patients are receiving appropriate treatment per level, they may have been more appropriate for level 3 or 4. CHS is in the process of clarifying the criteria for each level and when a patient can be releveled to a less acute level of care. Assigning the most appropriate level and then the appropriate care will save resources and presumably improve outcomes. It was discovered that the level 2 patients in medical housing units were not being given sheets for their beds. This was found to be a mistake due to custody staff not knowing the appropriate criteria. Patients also complained of not being given access to religious materials when requested. Custody indicated there may be restrictions on patients having books but that religious materials should have been made available by other means.		
Monitor's Recommendations:	Please proceed with clarification of requirements for leveling and releveling based on the criteria for each level. Once established, the changes will need to be audited for adherence. Please ensure patients have access to appropriate items (e.g., sheets and access to religious materials). Inappropriate restriction of these items should be investigated by the County.		

Paragraph Author: Johnson	III. C. 2. g. (4) Mental Health Treatment Inmates classified as requiring Level I level of care will receive: i. evaluation and stabilizing in the appropriate setting; ii. immediate constant observation or suicide precautions; iii. Qualified Mental Health Professional in-person assessment within four hours, iv. psychiatrist in-person assessment within 24 hours of being placed at a crisis level of care and daily thereafter v. psychotropic medication, as clinically appropriate; and vi. individual counseling and group counseling, as deemed clinically appropriate by the treating psychiatrist.		
Compliance Status this tour:	Compliance: 3/3/2017; 12/7/17; 7/18	Partial Compliance: 7/13; 1/16; 7/29/16;	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: Manual of mental health policies and procedures Results of internal audits, if any Review of medical records for implementation of policies consistent with appropriate treatment in Level I, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	Internal audits of leveling and associated treatment services.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is providing appropriate mental health care to the level 1 population. Chart review demonstrated that patients who are elevated to level 1 are seen as required per policy. Internal audits demonstrated that only 100% of patients assessed to be level 1A were appropriate based on leveling criteria; and, 50% of patients assessed to be level 1B. The latter was explained by overlap between level 1B and level 2 patients with some providers selecting level 1B instead of level 2 despite patients meeting criteria. So although level 1B patients are receiving appropriate treatment per level, they may have been more appropriate for level 2. CHS is in the process of clarifying the criteria for each level and when a patient can be releveled to a less acute level of care. Assigning the most appropriate level and then the appropriate care will save resources and presumably improve outcomes. It was discovered that the level 1 patients in the MHTC have limited access to recreation and that it was not being tracked. MDCR has applied an IT enhancement to the Black Creek Watch system and plans to now track "out of cell time" for patients which will include recreation. Staff on the unit also reported restrictions on patients' access to materials to write. CHS added 3 questions to their audit tool #1 that will address: reasoning for restricting patient access to custodial activities; whether specific property and privileges were given to the patient; and, whether an order was entered for clothing and bedding for the patient.		
Monitor's Recommendations:	Continue audits for this provision (internal and tool #1) with additional focus on access to level appropriate recreation privileges, services, and property (e.g., clothing and bedding).		

Paragraph Author: Johnson	III. C. 2. h. Mental Health Treatment Stage II will include an expansion of mental health care and transition services, a more therapeutic environment, collaboration with other governmental agencies and community organizations, and an enhanced level of care, which will be provided once the Mental Health Treatment Center is opened. The County and CHS will consult regularly with the United States and the Monitor to formulate a more specific plan for implementation of Stage II.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16; 12/7/17; 7/18	Non-Compliance: Pending 10/14; 5/15 (NR); 3/3/17
Measures of Compliance:	<u>Mental Health:</u> Manual of correctional and mental health policies and procedures Site tour of the Mental Health Treatment Center (MHTC), which according to CHS/MDCR is the 2nd floor of TGK, to assess compliance with this requirement. Review of audits of use of force in MH patients		
Steps taken by the County to Implement this paragraph:	The Mental Health Treatment Center (MHTC) was officially identified by CHS/MDCR as the 2nd floor of the TGK facility.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Patients on Levels I and II remain at TGK in the MHTC which was visited during the site tour. The unit and services provided were reviewed while onsite. The services provided on the mental health unit are "enhanced" in comparison to the general population in accordance with the higher level of acuity of the patients housed there (e.g., suicidal patients). Outstanding issues include: Discussion with the MD-BH indicates that collaborations with community organizations are in place but that only proof provided was complex grant funding documents and several verbal explanations to explain this process. Per CHS, the grant funds the Jail Diversion Program (25% grant, 75% CHS) and focuses on removing incompetent patients from the jail and placing them in the community or other more appropriate environment for treatment. They also reported several community partnerships through the grant with letters of support for the grant written to another agency other than MDCR/CHS provided as proof. Complex grant funding documents and several verbal explanations were provided to explain this process but they did not clearly delineate the process nor identify the relationship between the county and the grantee for the state of Florida.		
Monitor's Recommendations:	Please provide summarized documentation that explains how the Jail Diversion grant program meets the requirement of this provision. As this was also identified as a form of community partnerships, please explain how the grant facilitates partnerships with other community entities for continuity of care services after discharge (release). Show proof of those partnerships.		

Paragraph Author: Johnson	III. C. 2. i. Mental Health Treatment CHS will provide clinically appropriate follow-up care for inmates discharged from Level I consisting of daily clinical contact with Qualified Mental Health Staff. CHS will provide Level II level of care to inmates discharged from crisis level of care (Level I) until such time as a psychiatrist or interdisciplinary treatment team makes a clinical determination that a lower level of care is appropriate.		
Compliance Status this tour:	Compliance: 12/7/17; 7/18	Partial Compliance: 3/3/2017; 7/13; 7/29/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	Mental Health: 1. Manual of mental health policies and procedures. 2. Results of internal audits, if any. 3. Review of medical records for implementation of policies including a five-day step-down and meeting with the psychiatrist a minimum of every 30 days or as clinically necessary. 4. Review of mental health records		
Steps taken by the County to Implement this paragraph:	Audits of 5-day follow-ups after discharge from level 1. Procedural Directive that addresses the way to ensure 5-day follow-up for patients discharged from level 1 who change facilities.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is now auditing 5-Day Follow-Up Services (for patients who are levelled down from Level 1). An audit of 10 charts in April 2018 found that 40% of patients completed their 5-day follow-up rounds; an audit of 15 charts in May 2018 showed that 60% of 5-day follow-up rounds were completed. This is a decrease from findings reported during the last tour. CHS has identified patients changing facilities once they are discharged from level 1 as an issue. They have instituted a new process that requires that a referral be ordered whenever a patient is discharged from level 1. Referrals cause the EHR to create an appointment for patients so they can be monitored for 5-days regardless of which facility they go to. The estimated this process will be in place by August 2018.		
Monitor's Recommendations:	To maintain compliance with this measure, CHS will need to meet the requirements of this provision before the next tour. Audits should be ongoing once the new process of using referrals for tracking is in place.		

Paragraph Author: Johnson	III. C. 2. j. Mental Health Treatment CHS shall ensure Level I services and acute care are available in a therapeutic environment, including access to beds in a health care setting for short-term treatment (usually less than ten days) and regular, consistent therapy and counseling, as clinically indicated.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14;10/14 (NR); 5/15 (NR);
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of correctional and mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of Level I care in therapeutic environment, including evidence of immediate suicide precautions and meeting with psychiatry within 24 hours		
Steps taken by the County to Implement this paragraph:	Since the last tour, TGK was established as the MHTC for acute Level I and Level II mental health care. A therapeutic environment has been established with access to counseling in a private setting and access to group therapy. Constant observation cells have been added to the medical housing units at TGK.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Non-pharmacologic treatment options for Level I patients housed on in the MHTC and on medical units are available but continue to remain limited, The reasoning for decision making regarding restricting access to interventions will not be audited and analyzed. Uses of force against MH patients remains high with over 50% of case involving patients on the MH case load. The number of uses of force against Level 1 patients vs. other MH levels is disproportionately high.		
Monitor's Recommendations:	See III. C. 2. g. (4) Please audit and review use of force in MH patients for effective interventions to decrease RTRs, including effective use of CIT skill sets in during incidents to assess their effectiveness and if further training is needed when dealing with this population.		

Paragraph Author: Johnson	III. C. 2. k. Mental Health Care and Suicide Prevention: CHS shall conduct and provide to the Monitor and DOJ a documented quarterly review of a reliable and representative sample of inmate records demonstrating alignment among screening, assessment, diagnosis, counseling, medication management, and frequency of psychiatric interventions.		
Compliance Status this tour:	Compliance:	Partial Compliance: 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16; 7/29/16; 3/3/2017
Measures of Compliance:	<u>Mental Health:</u> 1. Review of representative sample dashboards and internal audits. 2. Review of medical records for concordance of data		
Steps taken by the County to Implement this paragraph:	Ongoing audits of MH screening, assessment, diagnosis, counseling, medication management, and frequency of psychiatric interventions is occurring (some internally).		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	A *documented quarterly review* of a reliable and representative sample of inmate records demonstrating alignment among screening, assessment, diagnosis, counseling, medication management, and frequency of psychiatric interventions was not provided before the site visit or before the report was submitted. CHS has developed several sound QI Tools that have been or are in the process of being implemented, with rolling analysis of the results. Not all tools reflecting full adherence to their respective consent agreement provisions and therefore have not been shown to be in alignment.		
Monitor's Recommendations:	Please provided a *Quarterly Review* per this provision to demonstrate alignment among screening, assessment, diagnosis, counseling, medication management, and frequency of psychiatric interventions.		

3. Suicide Assessment and Prevention

Paragraph Author: Johnson	III. C. 3. a. Suicide Assessment and Prevention: Defendants shall develop and implement a policy to ensure that inmates at risk of self-harm are identified, protected, and treated in a manner consistent with the Constitution. At a minimum, the policy shall: (1) Grant property and privileges to acutely mentally ill and suicidal inmates upon clinical determination by signed orders of Qualified Mental Health Staff. (2) Ensure clinical staff makes decisions regarding clothing, bedding, and other property given to suicidal inmates on a case-by-case basis and supported by signed orders of Qualified Mental Health Staff. (3) Ensure that each inmate on suicide watch has a bed and a suicide-resistant mattress, and does not have to sleep on the floor. (4) Ensure Qualified Mental Health Staff provide quality private suicide risk assessments of each suicidal inmate on a daily basis. (5) Ensure that staff does not retaliate against inmates by sending them to suicide watch cells. Qualified Mental Health Staff shall be involved in a documented decision to place inmates in suicide watch cells.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 3/14; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	Mental Health: 1. Review suicide prevention policy and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies including review of the following: - Property granted to inmates upon clinical determination of QMHS - Inmates have suicide resistant mattresses - Inmates have proper suicide resistant clothing - Quality suicide risk assessments are conducted - Staff do not retaliate against inmates by sending them to suicide watch cells		
Steps taken by the County to Implement this paragraph:	The interagency policy on Suicide Prevention was completed.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Access to custodial activities (i.e., chapel visits, recreation time, etc.) on a consistent basis continues to be an issue per staff reports and was not being tracked at the time of this site visit. Auditing of documentation of the rationale behind restriction of access is planned but had yet to be implemented at the time of the tour.		
Monitor's Recommendations:	See III. C. 2. g. (4)		

Paragraph Author: Johnson	III. C. 3. b. Suicide Assessment and Prevention When inmates present symptoms of risk of suicide and self-harm, a Qualified Mental Health Professional shall conduct a suicide risk screening **and assessment** instrument that includes the factors described in Appendix A. The suicide risk screening and assessment instrument will be validated within 180 days of the Effective Date and every 24 months thereafter.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16; 12/7/17; 7/18	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR); 7/29/16; 3/3/2017
Measures of Compliance:	<u>Mental Health:</u> Suicide prevention policy and procedures Results of internal audits. CHS anticipates "100% compliance for a minimum of 4 (four) consecutive quarters." Review of medical records for implementation of policies, in accordance with triggers found in Appendix A. Review of adverse events and screening to audit against false negatives.		
Steps taken by the County to Implement this paragraph:	This County has implemented a suicide screening tool and suicide risk assessment. Clinical staff completed training on the C-SSR for suicide risk assessments.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is currently only tracking suicide risk assessments completed at intake (Audit Tool #1) but plans to begin to review suicide risk assessment completed at other times (e.g., after a triggering event). It is unclear if this is consistently happening based on the documents provided by CHS. See III. A. 2. b.		
Monitor's Recommendations:	Reassess impact of Refresher training on QMHPs documentation for level 1A patients placed on constant observation. Continue self-audits on Suicide Risk Assessment.		

Paragraph Author: Johnson	III. C. 3. c. Suicide Assessment and Prevention County shall revise its Suicide Prevention policy to implement individualized levels of observation of suicidal inmates as clinically indicated, including constant observation or interval visual checks. The MDCR Jail facilities' supervisory staff shall regularly check to ensure that corrections officers implement the ordered levels of observation.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 3/14; 12/7/17; 7/18	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16; 7/29/16; 3/3/2017
Measures of Compliance:	Mental Health: Review of suicide prevention policies and procedures to include observations of inmates at risk of suicide at staggered checks every 15 minutes and constant observation as clinically necessary. Results of internal audits, reports, and adverse events, including MDCR audits of custody observation checks Review of medical records for implementation of policies		
Steps taken by the County to Implement this paragraph:	CHS interagency suicide policy completed.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This requirement was witnessed during the intake process. MDCR is documenting in the Black Creek Watch System. The system is not able to interface with Cerner. MDCR is in the process of identifying a new Offender Management System that will interface with Cerner. MDCR indicated that results are available to CHS upon request and Nursing has been given limited access to the Watch System (does not include report production). Reports from the watch system were provided for one of the mental health units. The 15-minute checks were not happening on a consistent basis based on times in the report. A summary of the findings from the Facility Check Procedures Audit performed by MDCR in May 2018 was also reviewed. Its findings were c/w the findings from review of the watch system reports with several potential contributors being identified and a CAP was put in place. Decreases in custody staffing may have also contributed to this finding per staff reports in the MHTC (e.g., Officers performing 15-minute checks also are escorting the med nurse). The latter was not verified. However, custody staffing has decreased in the MHTC since the last tour per discussion with MDCR.		
Monitor's Recommendations:	The County should track, audit, and analyzing data on observation of suicidal patients, and complete all CAPs to improve monitoring and performance to demonstrate adherence to this provision.		

Paragraph Author: Johnson	III. C. 3. d. Suicide Assessment and Prevention: CHS shall sustain implementation of its Intake Procedures adopted in May 2012, which specifies when the screening and suicide risk assessment instrument will be utilized.		
Compliance Status this tour:	Compliance: 7/18	Partial Compliance: 7/13; 3/14; 1/16; 7/29/16; 3/3/2017; 12/7/17	Non-Compliance: 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> Manual of mental health policies and procedures Results of internal audits, if any Review of medical records for implementation of policies, including screening and suicide risk assessments.		
Steps taken by the County to Implement this paragraph:	CHS/MDCR have implemented IP-003 including appropriately compliant suicide prevention training.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Suicide screening and suicide risk assessments are being utilized per policy. Validation of full completion of the assessment is still process due to poor sampling during the May 2018 audit for tool #1. However, the screening is happening *when* indicated per intake procedures.		
Monitor's Recommendations:	Continue audits of intake screening and suicide risk assessments to ensure appropriate completion of screening and assessment is occurring.		

Paragraph Author: Johnson	III. C. 3. e. Suicide Assessment and Prevention: CHS shall ensure individualized treatment plans for suicidal inmates that include signs, symptoms, and preventive measures for suicide risk.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 7/29/16; 12/7/17; 7/18	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR); 1/16; 3/3/2017
Measures of Compliance:	<u>Mental Health:</u> Manual of mental health policies and procedures Results of internal audits, if any Review of medical records for implementation of policies and training reflecting preventive measures, signs and symptoms in individualized treatment plans.		
Steps taken by the County to Implement this paragraph:	IDTTs are being audited		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Medical records reviewed continue to demonstrate consideration of the relevant suicide risk and protective factors but did not consistently specify how they would be addressed/mitigated in a safety plan. Instead many of the treatment plans focused medication management of the underlying illness (e.g., depression).		
Monitor's Recommendations:	Treatment plans for suicide patients should include concrete and measurable individualized treatment goals for patients with the goal of: increasing protective factors, reducing and/or mitigating known and modifiable risk factors, and acting on and bolstering treatment interventions.		

Paragraph Author: Johnson	III. C. 3. f. Suicide Assessment and Prevention Cut-down tools will continue to be immediately available to all Jail staff that may be first responders to suicide attempts.		
Compliance Status this tour:	Compliance: 7/18	Partial Compliance: 7/13; 3/14; 1/16; 7/29/16; 3/3/2017; 12/7/17	Non-Compliance: 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> On-site check for cut-down tool. Manual of mental health policies and procedures Results of internal audits or on-site inspections, if any Incident reports documenting use of cut-down tool		
Steps taken by the County to Implement this paragraph:	Cut-down tools are located outside the units in the emergency response bag. Cut-down tools were removed from the unit. Training on the location of the cut-down tools is happening as part of the Suicide Prevention Training process.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	During the tour inspection of emergency bags demonstrated that each contained a cut down tool at all facilities. However, due to what appears to be an over interpretation of previous recommendations, cut-down tools were removed from the housing units. This may impact them being *immediately available* per the requirements of this provision. At present, staff may have to wait for additional staff to arrive at the unit and bring in the emergency bag before they can access the cut-down tool.		
Monitor's Recommendations:	The County should evaluate whether having a cutdown tool on the unit, as well as in the emergency response bag outside the units, will allow for the tool to be *immediately available* in case of emergency.		

Paragraph Authors: Greifinger and Johnson	III. C. 3. g. Suicide Assessment and Prevention The Jail will keep an emergency response bag that includes appropriate equipment, including a first aid kit, CPR mask or Ambu bag, and emergency rescue tool in close proximity to all housing units. All custodial and medical staff shall know the location of this emergency response bag and the Jail will train staff how to use its contents.		
Medical Care: Compliance Status:	Compliance: 3/3/17; 7/18	Partial Compliance: 5/15; 1/16; 7/29/16; 12/7/17	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR)
Mental Health Care: Compliance Status:	Compliance: 7/18	Partial Compliance: 5/15; 1/16; 7/29/16; 3/3/2017; 12/7/17	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR)
Measures of Compliance:	Medical Care: Interviews Observation Mental Health Care: On-site review of first aid kit and resources. Review of record of education / training to CHS and officers in emergency response Review of adverse events		
Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health Care: Emergency response bags were present (outside of the housing units).		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: "Crash carts" in the clinic were observed with contents labeled, cart locked and tagged with a number and evidence of every shift checks documented on the log. Naloxone is now available on each housing unit and in the crash carts. It is being used appropriately. The County reports that each officer carries a key to the emergency response bags. During the tour, some staff reported that keys are only carried by supervising officers. Mental Health Care: As above in medical care; and, emergency response bags were located outside housing units with the key being held by officers.		
Monitors' Recommendations:	The County should clarify to the monitors, prior to the next tour, as to both the policy and actual practices for access to the keys for the emergency response bags.		

Paragraph Author: Johnson	III. C. 3. h. Mental Health Care and Suicide Prevention: County shall conduct and provide to the Monitor and DOJ a documented quarterly review of a reliable and representative sample of inmate records demonstrating*:* (1) adequate suicide screening upon intake, and (2) adequate suicide screening in response to suicidal and self-harming behaviors and other suicidal ideation.		
Compliance Status this tour:	Compliance:	Partial Compliance: 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14; 10/14 (NR); 5/15 (NR); 1/16; 7/29/16; 3/3/2017
Measures of Compliance:	<u>Mental Health:</u> Result of internal quarterly review and dashboard with key performance indicators Review of morbidity and mortality reports from inmate death Representative sample of inmate records.		
Steps taken by the County to Implement this paragraph:	CHS is monitoring the requirements of this section as part of the CQI process.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Review of Audit Tool #1 results from May 2018 show that suicide screens are not being completed fully by Nursing and that assessment had yet to be fully assessed at intake, or at other times. CHS plans to reassess completion of assessment at intake and otherwise moving forward. A spot audit in June 2018 immediately after refresher training and IT enhancements demonstrated improvement. However, the next audit cycle for tool #1 will provide a representative sample to see if the improvements were sustained.		
Monitor's Recommendations:	Continue audits of this provision to demonstrate sustained improvement in findings.		

4. Review of Disciplinary Measures

Paragraph Author: Johnson	C. 4. Review of Disciplinary Measures a. The Jail shall develop and implement written policies for the use of disciplinary measures with regard to inmates with mental illness or suspected mental illness, incorporating the following (1) The MDCR Jail facilities' staff shall consult with Qualified Mental Health Staff to determine whether initiating disciplinary procedures is appropriate for inmates exhibiting recognizable signs/symptoms of mental illness or identified with mental illness; and (2) If a Qualified Mental Health Staff determines the inmate's actions that are the subject of the disciplinary proceedings are symptomatic of mental illness, no disciplinary measure will be taken. A staff assistant must be available to assist mentally ill inmates with the disciplinary review process if an inmate is not able to understand or meaningfully participate in the process without assistance.		
Compliance Status this tour:	Compliance: 3/2017	Partial Compliance: 7/13; 1/16; 7/29/16; 12/7/17; 7/18	Non-Compliance: 3/14;10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: MDCR and CHS policies and procedures Review of tracking mechanism reflecting inmates for whom mental health has provided opinion in disciplinary proceeding and final decision. Review of medical records for inmates involved in disciplinary actions with mental health history, including possible notation or evidence of consultation with Qualified Mental Health Staff.		
Steps taken by the County to Implement this paragraph:	CHS has collaborated with MDCR and produced policy CHS-008A.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Review of 3 consecutive months of internal audit data demonstrated that >95% of the time CHS has provided QMHP consultation and decided as to the appropriateness of a patient being disciplined; and that ~90% of patients evaluated were cleared for disciplinary action. There was no assessment of the quality of the assessment and if the decision was valid. There was no indication that a "staff assistant" was made available to assist patients with the disciplinary review process. However, during the site tour both the Medical Director of Behavioral Health and the Director of Psychology said that any patient who is "not able to understand or meaningfully participate in the process without assistance" with not be cleared for disciplinary action. A new process to determine capacity has been implemented and a flow chart of the process and training materials were provided as part of the monthly deliverables.		
Monitor's Recommendations:	Continue to track data and conduct internal analyses to assess the quality of the evaluation method (decisional capacity when warranted) proceeding the DR process.		

5. Mental Health Care Housing

Paragraph Author: Johnson	III. C. 5. a. Mental Health Care and Suicide Prevention: The Jail shall maintain a chronic care and/or special needs unit with an appropriate therapeutic environment, for inmates who cannot function in the general population.		
Compliance Status this tour:	Compliance: 7/18	Partial Compliance: 1/16, 7/29/16, 3/3/2017; NR 12/7/17	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health Care: Manual of MDCR and mental health policies and procedures Review of medical records for implementation of policies, including evidence of a separate housing unit for patients with chronic care or with special needs.		
Steps taken by the County to Implement this paragraph:	CHS Policy 044A. Constant observation beds have been provided on the medical units and medical providers are going to the MH housing units to see patients at TGK.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Sheets are being restricted to level 2 patients in medical housing. Two suicide resistant cells are in the TGK medical clinic for patients who have cleared booking but not yet been assigned to a unit, as well as for medically ill patients who may need Level 1A/1B care. Access to therapeutic activities in the chronic care and special needs units is not being tracked but MDCR has implemented IT enhancements to its Black Creek Watch Tour system and is now tracking access. However, the environment of both the chronic are and special needs units are generally more therapeutic than general population due to more frequent contact with medical and mental health providers.		
Monitor's Recommendations:	Please track MH patient visits with chronic care and access to therapeutic activities (and recreation) to assess that this requirement is being met.		

Paragraph Author: Johnson	III. C. 5. b. Mental Health Care Housing: The Jail shall remove suicide hazards from all areas housing suicidal inmates or place all suicidal inmates on constant observation.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/18	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR); 1/16, 7/29/16; 3/3/17; 12/7/17
Measures of Compliance:	<u>Mental Health Care:</u> On-site inspection of facility, including inspection of tie-off points that may pose risk for suicidal inmates, areas with low visibility and low supervision. Manual of mental health policies and procedures Review of medical records and observation logs for implementation of policies, including results of adverse events and suicides, if any.		
Steps taken by the County to Implement this paragraph:	Several housing units have been retrofitted with updated suicide resistant safety measures since the last tour.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Since the last tour, MDCR has implemented suicide resistant safety measures to several housing units. For example, during the tour the monitor visualized where MDCR bolted shower plates to the wall and reduced the size of shower buttons in the MWDC. MDCR said they are reviewing adding webbing to at least one (due to funding) of the second tiers of a unit outside of the MHTC at TGK. In another suicide a patient broke away from officers and jumped off the stairs of a general population housing unit. Suicidal inmates are placed on constant observation but in Intake are not regularly placed in an observation cell in preference for seating patients in the open area. MDCR agreed to track use of the observation cell for suicidal patients as the IP-003 indicates that suicidal patients should be placed in a holding cell unless one is not available. The audit of use of the observation cells for suicidal inmates in Intake was neither produced before nor during the tour.		
Monitor's Recommendations:	Continue to retrofit housing units to be suicide resistant and utilize constant observation in an observation cell (e.g., in Intake) until a patient can be appropriately placed on a housing unit on suicide precaution. Provide updates on plans to add mesh or another means to block inmates from jumping from the upper tiers of non-mental health housing units.		

Paragraph Author: Johnson	III. C. 5. c. Mental Health Care Housing The Jail shall allow suicidal inmates to leave their cells for recreation, showers, and mental health treatment, as clinically appropriate. If inmates are unable to leave their cells to participate in these activities, a Qualified Medical or Mental Health Professional shall document the individualized clinical reason and the duration in the inmate's mental health record. The Qualified Medical or Mental Health Professional shall conduct a documented re-evaluation of this decision on a daily basis when the clinical duration is not specified.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16; 7/29/16; 3/3/17; 12/7/17; 7/18	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health Care:</u> Manual of mental health policies and procedures Review of log or forms documenting individual recreation / activity while on the unit Medical record review to assess medical decision making of QMHPs and psychiatrists regarding patient recreation and individualized treatment planning		
Steps taken by the County to Implement this paragraph:	MHTC was established.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This provision is now being audited quarterly as part of Tool #1. Refresher training that included this provision was provided and a spot audit immediately after the training showed 100% compliance (providers are now documenting why the decided to restrict access). This provision was not being audited prior to June 2018. The next regularly scheduled quarterly audit for Tool #1 will be in August 2018 and will reflect if the immediate improvements have been sustained.		
Monitor's Recommendations:	In ongoing audits, it will be important for any analyses to assess if a duration for restriction was initially provided, or if the decision to restrict was reevaluated on a daily basis if the duration was not specified.		

Paragraph Author: Johnson	III. C. 5. d. Mental Health Care Housing County shall provide quarterly reports to the Monitor and the United States regarding its status in developing the Mental Health Treatment Center. The Mental Health Treatment Center will commence operations by the end of 2014. Once opened, County shall conduct and report to the United States and the Monitor quarterly reviews of the capacity of the Mental Health Treatment Center as compared to the need for beds. The Parties will work together and with any appropriate non-Parties to expand the capacity to provide mental health care to inmates, if needed.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14; 10/14; 1/16; 7/29/16; 3/3/17; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 5/15 (NR);
Measures of Compliance:	<u>Mental Health Care:</u> 1. Review of designed staffing matrix 2. Review of timeline of Mental Health Treatment Center. 3. Interview with appropriate parties and non-parties, including CHS, MDCR and other stakeholders 4. Review of building plans		
Steps taken by the County to Implement this paragraph:	Patients on Levels I and II are now at TGK; patients on Levels III are at Metro West; and patients on Level IV are housed at all facilities. Space for face-to- face QMHP visits has been established and group therapy is occurring. MHTC bed space has expanded to include 2 more units per the County.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	No quarterly reviews of the capacity of the Mental Health Treatment Center as compared to the need for beds have been received or provided by CHS to this monitor. MDCR provided a 7-day review of the daily census for and bed space needs for the MHTC which showed a consistent deficit during the review period. However, data previously reported for one day of the week reviewed was inconsistent with the later report. The earlier report showed lower bed space needs whereas the later report showed a bed space deficit for level 1 patients in the MHTC. It is unclear why there was a discrepancy. Per the County. Custody staffing has been reduced in the MHTC due to budgetary reasons.		
Monitor's Recommendations:	1. Please ensure that quarterly reviews of the capacity of the Mental Health Treatment Center as compared to the need for beds are being conducted and shared with the monitors. Please review the data for internal consistency before it is submitted.		

Paragraph Author: Johnson	III. C. 5. e. Mental Health Care Housing Any inmates with SMI who remain on 9C (or equivalent housing) for seven continuous days or longer will have an interdisciplinary plan of care, as per the Mental Health Treatment section of this Agreement (Section III.C.2.e).		
Compliance Status this tour:	Compliance: 7/18	Partial Compliance: 7/13; 7/29/16; 3/3/2017; 12/7/17	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health Care:</u> Manual of mental health policies and procedure Results of internal audits, if any Review of medical records for implementation of policies, including implementation of timely screening and inter-disciplinary plans of care within seven days of placement on 9C or overflow unit		
Steps taken by the County to Implement this paragraph:	Internal audits of IDTTs		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This is now occurring >95% of the time per internal audits of IDTTs. Onsite chart review during the tour also reflects this is occurring per this provision.		
Monitor's Recommendations:	Implement patient centered individualized treatment planning. Treatment plans should consistently include safety plans.		

6. Custodial Segregation

Paragraph Author: Johnson	III. C. 6. a. (1) Custodial Segregation: The Jail and CHS shall develop and implement policies and procedures to ensure inmates in custodial segregation are housed in an appropriate environment that facilitates staff supervision, treatment, and personal safety in accordance with the following: (Part a) All locked housing decisions for inmates with SMI shall include the documented input of a Qualified Medical and/or Mental Health Staff who has conducted a face-to-face evaluation of the inmate, is familiar with the details of the inmate's available clinical history, and has considered the inmate's mental health needs and history.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: 1. Manual of mental health policies and procedures 2. Results of internal audits, if an 3. Review of medical records for implementation of policies, including results of disciplinary proceedings of persons on the mental health caseload and evidence of consultation with Qualified Mental Health Staff. 4. Review of logs of compliance with initial evaluation of inmate by Medical and QMHS.		
Steps taken by the County to Implement this paragraph:	CHS Policy 044		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Face-to-face evaluations of patients who are going to be placed in segregated housing by QMHPs is occurring most of the time. During the last review period chart reviews did find cases where a patient was cleared by a QMHP without performing a face-to-face interview. Instead, reference to the most recent psychiatry note was used to substantiate the decision to clear the patient for segregation. Per policy, a face-to-face evaluation is required. During the evaluation, the patient's clinical history and mental health needs are reviewed. MDCR is monitoring SMI patients in segregated housing with the Black Creek Watch System. IT enhancements since the last tour will allow them to track out of cell time including for treatment and other activities (e.g., recreation). This was not being tracked prior to the recent IT enhancements. Hand written logs are being kept on segregation units to track out of cell time and movement. This data was also being transcribed into a movement log for CHS by Custody. Documentation in the Custody logs and CHS movement logs varied widely by day and by shift and at times each contained different data, or, no data at all on some patients. Review of logs showed that patients are not consistently being provided recreation time out of their cells. On some days they didn't leave their cells at all. Custody reports barriers to movement for segregation inmates include safety considerations due to separations, staffing, patient refusal, and the recency of the logging process. The reasons have not been formally audited. Custody is looking into ways to provide out of cell time for SMI patients in segregated housing. MDCR identified a list of SMI inmates who have been in segregated housing for longer than 14 days who they deemed "too dangerous" (to others) to allow out of segregated housing. On chart review several of these patients had decompensated at some point during their time in segregation yet remained on segregated status. Length of stay in segregation for these patients ranged from 5-427 days at the time of the tour. Several patients who were considered custodial segregation were housed in the MHTC. For example, one patient had "Disc Seg" on the face sheet outside his cell door. MDCR has		

	indicated this was done in error as the patient was transferred with a "pending disciplinary matter." The monitors were told patients who are housed in the MHTC are no longer segregated until they are releveled to level 4. They have not identified how they plan to provide sufficient out of cell time with access to therapeutic activities and recreation. Custody has indicated they are discussing what other "similarly" sized facilities are doing to meet this requirement. PTDC is still being utilized to house overflow of custodial segregation patients should the need arise.
Monitor's Recommendations:	1. Data and information should be analyzed in real-time to mitigate harm to patients. Review and analyze data and trends relative to mental health status and length of stay of patients in custodial segregation. No patient should be placed in custodial segregation for an excessive period, particularly those with SMI. 2. Out of cell time should be tracked and analyzed with appropriate CAPs put in place to increase what appears to currently be minimal to no out of cell time for SMI patients in segregated housing. 3. Immediate efforts should be made to remove SMI patients from segregated housing who have been there for longer than 14 days (long term seg patients) so that they can be placed in an appropriate environment per this provision. 4. If a long term seg patient is "too dangerous" to remove from segregation, then an appropriately documented amount of out of cell time should be provided to as best possible help to prevent decompensation of this vulnerable population.

Paragraph Author: Johnson	III. C. 6. a. (1) Mental Health Care and Suicide Prevention: (Part b) If at the time of custodial segregation Qualified Medical Staff has concerns about mental health needs, the inmate will be placed with visual checks every 15 minutes until the inmate can be evaluated by Qualified Mental Health Staff.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health Care:</u> 1. Review of policy mental health policies and procedures 2. Review of medical records and observation logs for SHUs for staggered 15-minute checks 3. Review of internal audits		
Steps taken by the County to Implement this paragraph:	CHS Draft Policy 044. Segregation notes are now clearly labeled		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Segregation Notes are now clearly labeled and the contents have been streamlined to clearly address all of the provisions in this section. However, the 15-minute checks are being documented by MDCR in their Black Creek Watch System which does not interface with Cerner. Review of a 7-day report from the Watch System showed that 15-minute checks are not consistently occurring.		
Monitor's Recommendations:	1. Review and analyze data and trends from the Black Creek Watch System and continue to share this data with CHS to allow for collaborative solution finding for this patient population and for purpose of auditing adherence to this provision. 2. Follow through on CAPs to improve adherence to this provision.		

Paragraph Author: Johnson	III. C. 6. a. (2) Custodial Segregation **Prior** to placement in custodial segregation for a period greater than eight hours, all inmates shall be screened by a Qualified Mental Health Staff to determine (1) whether the inmate has SMI, and (2) whether there are any acute medical or mental health contraindications to custodial segregation.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR);
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log of patients placed in custodial segregation with SMI for greater than 8 hours 3. Review of medical records, initial screening evaluations and referral for mental health service slips, including results of adverse events, if any.		
Steps taken by the County to Implement this paragraph:	CHS-044. Development of an internal audit tool for this provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS provided data on a baseline internal audit of this provision and found that of a "total of 23 patients in months of April 1st thru May 12th, [2018] only 43 % were screened and cleared for segregation placement." They hope to improve performance on this provision in future audits. A CAP was put in place to improve performance. See III.C.6.a(1) regarding analysis relevant to this provision. No indication that the above monitor's prior recommendations were met was provided this tour.		
Monitor's Recommendations:	See III.C.6.a(1) Follow through on CAPs for the internal audit from the June Deliverables that is relevant to this provision.		

Paragraph Author: Johnson	III. C. 6. a. (3) Custodial Segregation If a Qualified Mental Health Professional finds that if an inmate has SMI, that inmate shall only be placed in custodial segregation with visual checks every 15 or 30 minutes as determined by the Qualified Medical Health Professional.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health Care: 1. Manual of mental health policies and procedures 2. Review of log of inmates placed in custodial segregation for greater than 8 hours 3. Review of medical records and observation logs for implementation of policies, including results of adverse events and suicides, if any.		
Steps taken by the County to Implement this paragraph:	Please see III. C. 6. A. (1)		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Please see III. C. 6. A. (1)		
Monitor's Recommendations:	Please see III. C. 6. A. (1)		

Paragraph Author: Johnson	III. C. 6. a. (4). i. Custodial Segregation Inmates with SMI who are not diverted or removed from custodial segregation shall be offered a heightened level of care that includes: i. Qualified Mental Health Professionals conducting rounds at least three times a week to assess the mental health status of all inmates in custodial segregation and the effect of custodial segregation on each inmate's mental health to determine whether continued placement in custodial segregation is appropriate. These rounds shall be documented and not function as a substitute for treatment.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16 12/7/17; 7/18	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR), 7/29/16; 3/3/2017
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log documenting that QMHP has rounded on patient three times per week 3. Review of medical records and observation logs for implementation of policies		
Steps taken by the County to Implement this paragraph:	CHS Policy 044 Reasons for missed appointments are now being documented and tracked.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	No audits of this provision were provided for this tour. Chart review and review of segregation unit movement logs (custody and CHS) demonstrated that this provision is being met most of the time. There were several instances were all 3 visits were not documented in the movement log as completed which was consistent with what was in the chart. See III. C. 6. A. (1)		
Monitor's Recommendations:	1. Audit these visits to demonstrate adherence, meaningful analysis of the data, as well as corrective action plans. 2. See III. C. 6. A. (1)		

Paragraph Author: Johnson	III. C. 6. a. (4). ii. Custodial Segregation Inmates with SMI who are not diverted or removed from custodial segregation shall be offered a heightened level of care that includes: ii. Documentation of all out-of-cell time, indicating the type and duration of activity.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 7/29/16; 3/3/2017;12/7/17; 7/18
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of logs documenting that MDCR has permitted recreation and showers at least three times per week 3. Review of log of patient in custodial segregation with SMI		
Steps taken by the County to Implement this paragraph:	See III. C. 6. A. (1)		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III. C. 6. A. (1)		
Monitor's Recommendations:	See III. C. 6. A. (1)		

Paragraph Author: Johnson	III. C. 6. a. (5) Custodial Segregation Inmates with SMI shall not be placed in custodial segregation for more than 24 hours without the written approval of the Facility Supervisor and Director of Mental Health Services or designee.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16; 7/29/16; 12/7/17; 7/18	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR); 3/3/2017
Measures of Compliance:	Mental Health Care: 1. Manual of mental health policies and procedures 2. Review of log of patient in custodial segregation with SMI 3. Review of medical chart for written approval of Facility Supervisor and Director of Mental Health Services for placement		
Steps taken by the County to Implement this paragraph:	CHS policy 044 Form for written approval was provided as an example for review.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Evidence that this requirement is consistently being met was not provided. During the tour a written approval signed by custody and the MD-BH was provided as an example. The County decided to continue to have the Facility "Supervisor" and the evaluating QMHP in the place of the Medical Director of Behavioral Health Services for placement of patients with SMI in custodial segregation. Concerns were raised regarding the quality of review of the process provided by the evaluating QMHP vs. someone in BH administration. In response CHS plans to track the quality of these decisions moving forward to further evaluate this change.		
Monitor's Recommendations:	1. Please track requirement and perform audits demonstrating adherence and include qualitative analysis of the decisions/data. 2. Signed written approvals should be scanned into the EHR.		

Paragraph Author: Johnson	III. C. 6. a. (6) Custodial Segregation Inmates with serious mental illness shall not be placed into long-term custodial segregation, and inmates with serious mental illness currently subject to long-term custodial segregation shall immediately be removed from such confinement and referred for appropriate assessment and treatment.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16; 7/29/16	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR); 3/3/2017; 12/7/17; 7/18
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log of patient in custodial segregation with SMI 3. Review of medical records of patient with SMI in custodial segregation for length of placement in custodial segregation and effect on mental health		
Steps taken by the County to Implement this paragraph:	See III. C. 6. A. (1)		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III. C. 6. A. (1)		
Monitor's Recommendations:	See III. C. 6. A. (1)		

Paragraph Author: Johnson	III. C. 6. a. (7) Custodial Segregation If an inmate on custodial segregation develops symptoms of SMI where such symptoms had not previously been identified or the inmate decompensates, he or she shall immediately be removed from custodial segregation and referred for appropriate assessment and treatment.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 3/3/2017; 12/7/17; 7/18
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log of patients in custodial segregation with SMI 3. Review of referral slips for mental health evaluation for timely triage and access to care 4. Review of medical records for referral to psychiatrist and implementation of treatment plans 5. Review of internal audits		
Steps taken by the County to Implement this paragraph:	See III. C. 6. A. (1)		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s):	See III. C. 6. A. (1)		
Monitor's Recommendations:	See III. C. 6. A. (1)		

Paragraph Author: Johnson	III. C. 6. a. (8) Custodial Segregation If an inmate with SMI in custodial segregation suffers deterioration in his or her mental health, decompensates, engages in self-harm, or develops a heightened risk of suicide, that inmate shall immediately be referred for appropriate assessment and treatment and removed if the custodial segregation is causing the deterioration.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16; 7/29/16	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR); 3/3/2017; 12/7/17; 7/18
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log of patients in custodial segregation with SMI 3. Review of referral slips for mental health evaluation for timely triage and access to care 4. Review of medical records for referral to psychiatrist and implementation of treatment plans 5. Review of internal audits		
Steps taken by the County to Implement this paragraph:	See III. C. 6. A. (1)		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III. C. 6. A. (1)		
Monitor's Recommendations:	See III. C. 6. A. (1)		

Paragraph Author: Johnson	III. C. 6. a. (9) Custodial Segregation MDCR staff will conduct documented rounds of all inmates in custodial segregation at staggered intervals at least once every half hour, to assess and document the inmate's status, using descriptive terms such as "reading," "responded appropriately to questions" or "sleeping but easily aroused."		
Compliance Status this tour:	Compliance: 7/13	Partial Compliance: 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of MDCR and mental health policies and procedures 2. Review of log of patients in custodial segregation with SMI 3. Review of custodial segregation log checks		
Steps taken by the County to Implement this paragraph:	DSOP-12-002 Section VI. A. describes confinement documentation. IT enhancements to the Black Creek Watch System have occurred for improved documentation.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This documentation is entered into the MDCR Black Creek Watch System and Custody and CHS Movement log books. Data from the watch system was provided as well as onsite review of movement logs (Custody and CHS). Findings were inconsistent between the various recording modalities.		
Monitor's Recommendations:	See III. C. 6. A. (1)		

Paragraph Authors: Greifinger and Johnson	III. C. 6. a. (10) Custodial Segregation Inmates in custodial segregation shall have daily opportunities to contact and receive treatment for medical and mental health concerns with Qualified Medical and Mental Health Staff in a setting that affords as much privacy as reasonable security precautions will allow.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 1/16; 7/29/16; 12/7/17; 7/18	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR), 3/3/17
Mental Health Care: Compliance Status:	Compliance: 7/18	Partial Compliance: 7/13; 1/16; 7/29/16; 12/7/17	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR); 3/3/2017
Measures of Compliance:	Medical Care: • Interviews • Review of logs • Presence of logs in medical records Mental Health Care: 1. Manual of MDCR and mental health policies and procedures 2. On-site tour of facility 3. Review of grievances 4. Inspection that mechanism for placement of sick call and access to care is timely		
Steps taken by the County to Implement this paragraph:	Medical Care: MDCR has implemented a scan system to document custody rounds on inmates in segregation. Mental Health Care: Mental health care rounds occur on a once weekly basis in custodial segregation. Medical rounds occur daily.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: 1. The quality of welfare checks for patients in isolation cells who do not receive medications is variable across facilities, within facilities, and even in one case, variable within the same nurse. In some cases where patients are not scheduled to receive medications, the nurse either just looks in the patient's room without any oral interaction, or does not check on the inmate at all. 2. Almost all patients reported that COs summon nurses right away when needed. One problem that exists, however, is that in isolation cell units without in-cell buzzers and where the CO is not stationed within the living unit, patients have to wait for the CO to make rounds in order to request urgent medical care. While those rounds were reported by patients to be regular and predictable, the time between them can be up to 30 minutes. Thus, in the event of an emergency, where time is of the essence (e.g. chest pain), the inability to summon aid immediately would be unsafe. 4. Confidentiality during examination for patients in isolation cells is a moot issue because all examinations are currently conducted in the clinic. There is a plan to begin conducting clinic examinations in a room adjacent to the male and female units at MW. However, the plan includes provisions for visual, and hopefully auditory, confidentiality.		

	5. The relevant policies and training curricula have yet to be developed. Mental Health Care: The referral, sick call process, 30-minute checks from custody, nursing, and social worker rounding (3 days) all allow for this parameter to be met. Chart review and patients that were interviewed indicates these modes of patient contact are being documented in the EHR. However, all provisions are not being regularly audited and due to the variability, this is difficult to track with a simple chart review. Custody staff are aware of the mental health team's schedules and know the providers who work in their facilities (e.g., PTDC). added another medical exam room in unit at PTDC to improve patient provider contact. This reduces the need for custody to escort patients to the clinic. Both QMHPs and Custody indicated that they stand a respectful distance away during evaluations unless there is a safety concern.
Monitors' Recommendations:	To maintain compliance, please work with MDCR to obtain the data to track this requirement and perform audits demonstrating adherence, and include analysis of the data; or, utilize documentation in Cerner (EHR) to capture adherence to this provision.

Paragraph Author: Johnson	III. C. 6. a. (11) Custodial Segregation Mental health referrals of inmates in custodial segregation will be classified, at minimum, as urgent referrals		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 3/3/2017; 12/7/17; 7/18
Measures of Compliance:	Mental Health Care: MDCR, mental health policies and procedures Review of log demonstrating appointment system / triage vs. electronic scheduling system indicating that patients are seen by Mental Health Staff within 24 hours and a psychiatrist within 48 hours or two business days. Review of mental health grievances		
Steps taken by the County to Implement this paragraph:	CHS policy 044 Internal audit tool		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	An internal audit included in the June 2018 Deliverables showed a 0% adherence to this provision. CHS plans to develop and implement an ongoing audit tool for this provision with CAPs. CHS reports that they were not in compliance with this provision due to Officers bypassing taking the patient to the Nurse for referral and taking them MH staff (80% of charts reviewed). This did not allow for referral entry. However, of the patients audited all were evaluated by MH. The referral not being documented complicates verification of patients being seen by MH while in custodial segregation. For instance, CHS reports that patients included in the audit were provided from MDCR Incident Reports.		
Monitor's Recommendations:	Retrain staff on the referral process and continue ongoing audits demonstrating sustained adherence, including analysis of any information specific to the timely referral of patients for SMI during custodial segregation (and assessment by a QMHP).		

7. Staff and Training

Paragraph Author: Johnson	III. C. 7. a. Staffing and Training CHS revised its staffing plan in March 2012 to incorporate a multidisciplinary approach to care continuity and collaborative service operations. The effective approach allows for integrated services and staff to be outcomes-focused to enhance operations.		
Compliance Status this tour:	Compliance: 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Partial Compliance: 3/14	Non-Compliance: 7/13; 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: 1. Review of staffing plan, average census and mental health population. 2. CHS, mental health policies and procedures		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is in the process of hiring an Asst. MD-BH as well as Psychiatrists and Social Workers. Since the last tour they have hired a Director of Psychology as well as a Lead Psychiatrist and Psychologist. FTEs were included in the documentation as well as productivity expectations.		
Monitor's Recommendations:	None.		

Paragraph Author: Johnson	III. C. 7. b. Staffing and Training Within 180 days of the Effective Date, and annually thereafter, CHS shall submit to the Monitor and DOJ for review and comment its detailed mental health staffing analysis and plan for all its facilities.		
Compliance Status this tour:	Compliance: 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Partial Compliance: 3/14	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Review of staffing plan and matrix as it relates to current and projected average census and mental health population. 2. Review mental health policies and procedures 3. Review of training materials for BH that is provided to new hires.		
Steps taken by the County to Implement this paragraph:	See III. C. 7. a.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is adequately staffed from a psychiatric and behavioral health perspective. New hires are receiving corrections specific training.		
Monitor's Recommendations:	None		

Paragraph Author: Johnson	III. C. 7. c. Staffing and Training CHS shall staff the facility based on the staffing plan and analysis, together with any recommended revisions by the Monitor. If the staffing study and/or monitor comments indicate a need for hiring additional staff, the parties shall agree upon the timetable for the hiring of any additional staff.		
Compliance Status this tour:	Compliance: 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Partial Compliance: 3/14	Non-Compliance: 7/13; 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> Review of staffing plan, average census, projected census and mental health population. Review of timetable for hiring, as needed		
Steps taken by the County to Implement this paragraph:	See III. C. 7. a.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is adequately staffed from a psychiatric and behavioral health perspective.		
Monitor's Recommendations:	None		

Paragraph Author: Johnson	III. C. 7. d. Staffing and Training Every 180 days after completion of the first staffing analysis, CHS shall conduct and provide to DOJ and the Monitor staffing analyses examining whether the level of staffing recommended by the initial staffing analysis and plan continues to be adequate to implement the requirements of this Agreement. If they do not, the parties shall re-evaluate and agree upon the timetable for the hiring of any additional staff.		
Compliance Status this tour:	Compliance: 7/18	Partial Compliance: 3/14; 1/16; 7/29/16; 3/3/2017; 12/7/17	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR);
Measures of Compliance:	<u>Mental Health:</u> 1. Review of staffing plan, average census, projected census and mental health population. 2. Review of timetable for hiring, as needed 3. Review of applicable reports		
Steps taken by the County to Implement this paragraph:	FTE allotments and productivity expectation were included in the most recent staffing analysis.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The staffing matrix provided the allotted FTEs for CHS BH, employment status (i.e., FT, PT, etc.) of staff listed, and productivity.		
Monitor's Recommendations:	Consider adjusting productivity appropriately for those providers in leadership who also have both clinical and administrative responsibilities (e.g., 0.7 admin, 0.3 clinical = 1.0 FTE)		

Paragraph Author: Johnson	III. C. 7. e. Staffing and Training The mental health staffing shall include a Board Certified/Board Eligible, licensed chief psychiatrist, whose work includes supervision of other treating psychiatrists at the Jail. In addition, a mental health program director, who is a psychologist, shall supervise the social workers and daily operations of mental health services.		
Compliance Status this tour:	Compliance: 3/3/2017; 12/7/17; 7/18	Partial Compliance: 7/13; 3/14; 1/16; 7/29/16	Non-Compliance: 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: 1. Review of staffing plan 2. Review of meeting minutes 3. Interview of staff 4. MDCR and mental health policies and procedures 5. Review of timetable for hiring, as needed		
Steps taken by the County to Implement this paragraph:	The MD-BH/Chief Psychiatrist, Dr. Patricia Junquera, has hired a Chief Psychologist who reports directly to her and who per this provision supervises the social workers and daily operations of the MH services. She has also hired a Lead Psychiatrist to assist with administrative duties; and, is in the process of hiring an Asst. MD-BH to assist with direct clinical supervision of staff and administrative duties.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Consistent with the prior tour, "Dr. Junquera performs primarily administrative functions." She reports to the Chief Medical Officer of CHS as her supervisor. Through comprehensive review of data, meeting minutes, interviews of staff, discussions of all aspects of clinical care and QI, and direct observation it was ascertained that the parameters of this provision are being met.		
Monitor's Recommendations:	No additional recommendations at this time.		

Paragraph Author: Johnson	III. C. 7. f. Staffing and Training The County shall develop and implement written training protocols for mental health staff, including a pre-service and biennial in-service training on all relevant policies and procedures and the requirements of this Agreement.		
Compliance Status this tour:	Compliance: 3/3/2017; 12/7/17; 7/18	Partial Compliance: 1/16; 7/29/16	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR).
Measures of Compliance:	Mental Health: 1. Review of organizational chart and staffing matrix 2. Review of in-service training sign-in sheets 3. Review of in-service training materials 4. Interview of staff 5. County, MDCR and mental health policies and procedures		
Steps taken by the County to Implement this paragraph:	Training materials were submitted as part of monthly deliverables. Post-training tests were included.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Training materials generally consist of the policy placed in a power-point, with or without a Lesson Plan, now with the addition of relevant cases or examples for some trainings. Training materials submitted prior to the tour included post-training test materials as well as attendance and course completion logs (with scores).		
Monitor's Recommendations:	No additional recommendations at this time.		

Paragraph Author: Johnson	III. C. 7. g. Staffing and Training The Jail and CHS shall develop and implement written training protocols in the area of mental health for correctional officers. A Qualified Mental Health Professional shall conduct the training for corrections officers. This training should include pre-service training, annual training for officers who work in forensic (Levels 1-3) or intake units, and biennial in-service training for all other officers on relevant topics, including: (1) Training on basic mental health information (e.g., recognizing mental illness, specific problematic behaviors, additional areas of concern); (2) identification, timely referral, and proper supervision of inmates with serious mental health needs; and (3) Appropriate responses to behavior symptomatic of mental illness; and suicide prevention.		
Compliance Status this tour:	Compliance: 3/3/2017; 12/7/17; 7/18	Partial Compliance: 1/16, 7/29/16	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: 1. Review of organizational chart and staffing matrix 2. Review of in-service training sign-in sheets 3. Review of in-service training materials for officers in identification of specific mental health needs, as per agreement 4. Interview of staff 5. MDCR and mental health policies and procedures		
Steps taken by the County to Implement this paragraph:	Ongoing updates to training per policy changes (including Procedural Directives/Memos).		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS continues to remain compliant with this provision.		
Monitor's Recommendations:	None.		

Paragraph Author: Johnson	III. C. 7. h. Staffing and Training The County and CHS shall develop and implement written policies and procedures to ensure appropriate and regular communication between mental health staff and correctional officers regarding inmates with mental illness.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 3/14; 7/29/16; 12/7/17; 7/18	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16; 3/3/2017
Measures of Compliance:	Mental Health: 1. Review of MDCR and mental health policies, procedures, and meeting minutes requiring regular communication and reporting between CHS and MDCR 2. Review of adverse events and grievances indicating implementation of policies Interview of CHS and MDCR staff		
Steps taken by the County to Implement this paragraph:	Morning Huddle documentation was provided as well as the shift huddle schedule for the MHTC.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Efforts to improve communication between mental health and correctional officers regarding inmates with mental illness continue via the morning (shift) huddles. Huddle attendance is documented (though not all attendees regularly sign). Both MH and Custody staff speak highly of the benefit of the huddles for treatment and issue planning. Leadership continue to communicate during interagency meetings including the MAC and mini-mac meetings. Since the last tour the Director of MDCR was given responsibility for both correctional as well as medical services within the facility by the County. This has significantly improved communication between MDCR and CHS, including BH. However, interagency communication is far from seamless and should continue to remains an area of focus for improvement to collectively resolve shared challenges in custodial and service delivery (e.g., segregation for SMI patients).		
Monitor's Recommendations:	Continue to develop and implement written policies and procedures to ensure appropriate and regular communication between mental health staff and correctional officers regarding inmates with mental illness.		

8. Suicide Prevention Training

Paragraph Author: Johnson	III. C. 8. a. Suicide Prevention Training The County shall ensure that all staff have the adequate knowledge, skill, and ability to address the needs of inmates at risk for suicide. The County and CHS shall continue its Correctional Crisis Intervention Training a competency-based interdisciplinary suicide prevention training program for all medical, mental health, and corrections staff. The County and CHS shall review and revise its current suicide prevention training curriculum to include the following topics, taught by medical, mental health, and corrections custodial staff: 1. suicide prevention policies and procedures; 2. the suicide screening instrument and the medical intake tool; 3. analysis of facility environments and why they may contribute to suicidal behavior; 4. potential predisposing factors to suicide; 5. high-risk suicide periods; 6. warning signs and symptoms of suicidal behavior; 7. case studies of recent suicides and serious suicide attempts; 8. mock demonstrations regarding the proper response to a suicide attempt; and 9. the proper use of emergency equipment.		
Mental Health Care: Compliance Status:	Compliance: 12/7/17; 7/18	Partial Compliance: 10/14 3/3/2017	Non-Compliance: 7/13; 3/14; 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	1. Review of summary of CIT Training completed as of June 2018 2. Review of training for Correctional Crisis Intervention program for all staff 3. Review of training materials and teaching staff for inclusion of the following items: Suicide prevention policies and procedures; 4. The suicide screening instrument and the medical intake tool; 5. Analysis of facility environments and why they may contribute to suicidal behavior; Potential predisposing factors to suicide; 6. Highs risk suicide periods; 7. Warning signs and symptoms of suicidal behavior; 8. Case studies of recent suicides and serious suicide attempts; 9. Mock demonstrations regarding the proper response to a suicide attempt; and The proper use of emergency equipment. 10. Attendance of Suicide Prevention training		
Steps taken by the County to Implement this paragraph:	Information was provided relative to both CHS and Correctional staff that have completed suicide prevention training and officers that have completed CIT.		

Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Review of the materials provided and follow-up discussions with the MD-BH and Director of Psychology demonstrated that enough persons and percentage of the material required of this provision was completed to render it in full compliance for suicide prevention training. The MH Monitors had the opportunity to attend part of the annual Suicide Prevention training and were very pleased with the content, delivery, and participation that we witnessed. The regularity with which CIT training is completed is concerning. IT was explained that CIT training (initial or refresher) is required annually. However, "annually" was explained to mean that it can be completed "at any point in the next calendar year." Meaning, if an officer completes CIT training in January 2017, they theoretically have until December 2018 to complete their refresher training (up to 23 months later). MDCR reported shifting assignments to units where officers have contact with MH Units due to their bidding system as a reason to have the expanded time frame to complete training.
Monitors' Recommendations:	Completion of CIT training is essential to reduce use of force in vulnerable MH patient populations. Delays in training may worsen an already tenuous situation. Consider prioritizing and expediting completion of this training.

Paragraph Author: Johnson	III. C. 8. b. Suicide Prevention Training All correctional custodial, medical, and mental health staff shall complete training on all of the suicide prevention training curriculum topics at a minimum of eight hours for the initial training and two hours of in- service training annually for officers who work in intake, forensic (Levels 1S3), and custodial segregation units and biannually for all other officers.		
Mental Health Care: Compliance Status:	Compliance: 12/7/17; 7/18	Partial Compliance: 10/14; 3/3/2017	Non-Compliance: 7/13; 3/14; 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	III. C. 8. a.		
Steps taken by the County to Implement this paragraph:	III. C. 8. a.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	This provision is being met.		
Monitors' Recommendations:	None		

Paragraph Author: Johnson	III. C. 8. c. Suicide Prevention Training CHS and the County shall train correctional custodial staff in observing inmates on suicide watch and step- down unit status, one hour initially and one-hour in-service annually for officers who work in intake, forensic (Levels 1S3), and custodial segregation units and biannually for all other officers.		
Mental Health Care: Compliance Status:	Compliance: 3/3/2017; 12/7/17; 7/18	Partial Compliance: 10/14	Non-Compliance: 7/13; 3/14; 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	III. C. 8. a.		
Steps taken by the County to Implement this paragraph:	III. C. 8. a.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	III. C. 8. b.		
Monitors' Recommendations:			

Paragraph Author: Johnson	III. C. 8. d. Suicide Prevention Training CHS and the County shall ensure all correctional custodial staff are certified in cardiopulmonary resuscitation ("CPR").		
Mental Health Care: Compliance Status:	Compliance: 3/3/2017; 12/7/17	Partial Compliance: 10/14; 1/16; 7/29/16; 7/18	Non-Compliance: 7/13; 3/14; 5/15 (NR);
Measures of Compliance:	1. Review of current CPR certification of all staff.		
Steps taken by the County to Implement this paragraph:	The County is training 250 custody staff per month		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	As of April 1, 2018, 1136 of MDCR's 2036 sworn staff (56% not certified, 44% certified) had not received CPR recertification training within the last 2 years. The county put a CAP in place to certify 250 officers per month in CPR with a completion date for October 31, 2018 for full compliance with this provision. This was included in the May Deliverables.		
Monitors' Recommendations:	By November 30th please, provide evidence of completion of this provision.		

9. Risk Management

Paragraph Author: Johnson	III. C. 9. a. Risk Management The County will develop, implement, and maintain a system to ensure that trends and incidents involving avoidable suicides and self-injurious behavior are identified and corrected in a timely manner. Within 90 days of the Effective Date, the County and CHS shall develop and implement a risk management system that identifies levels of risk for suicide and self-injurious behavior and results in intervention at the individual and system levels to prevent or minimize harm to inmates, as set forth by the triggers and thresholds in Appendix A.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14; 7/29/16; 3/3/2017;12/7/17; 7/18	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	1. Review of Risk Management reports 2. Risk Management Training materials 3. MHRC meeting minutes 4. M&M Reviews 5. M&M Training materials 6. CQI Meeting minutes		
Steps taken by the County to Implement this paragraph:	NSSI Presentation Avoidable Suicides and Self-harm Analysis		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	There has been continued improvement in the collection and analysis of data since the last tour. The NSSI Presentation and Avoidable Suicides and Self-harm Analysis reflect effort to identify trends in these incidents and implement interventions to decrease occurrence and improve outcomes. Conclusions did not always logically follow analysis of data. However, the data obtained lead to changes at both the system and individual levels (e.g., Provider being notified by the Incident Reporting System and education on findings at the provider level for improved care).		
Monitor's Recommendations:	Continue to sustain and refine analysis of risk management data and outcomes of interventions.		

Paragraph Author: Johnson	C. 9. b. Risk Management The risk management system shall include the following processes to supplement the mental health screening and assessment processes: (1) Incident reporting, data collection, and data aggregation to capture sufficient information to formulate a reliable risk assessment at the individual and system levels; (2) Identification of at-risk inmates in need of clinical or interdisciplinary assessment or treatment; (3) Identification of situations involving at-risk inmates that require review by an interdisciplinary team and/or systemic review by administrative and professional committees; and (4) Implementation of interventions that minimize and prevent harm in response to identified patterns and trends.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> See III. C. 9. a.		
Steps taken by the County to Implement this paragraph:	See III. C. 9. a.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation provided showed adherence to all sub-parts of this provision. However, conclusions did not always logically follow analysis of data.		
Monitor's Recommendations:	Continue to audit, analyze, and refine Risk Management interventions at the individual and system level.		

Paragraph Author: Johnson	C. 9. c. Risk Management The County shall develop and implement a Mental Health Review Committee that will review, on at least a monthly basis, data on triggering events at the individual and system levels, as set forth in Appendix A. The Mental Health Review Committee shall: (1) Require, at the individual level, that mental health assessments are performed and mental health interventions are developed and implemented; (2) Provide oversight of the implementation of mental health guidelines and support plans; (3) Analyze individual and aggregate mental health data and identify trends that present risk of harm; (4) Refer individuals to the Quality Improvement Committee for review; and (5) Prepare written annual performance assessments and present its findings to the Interdisciplinary Team regarding the following: i. Quality of nursing services regarding inmate assessments and dispositions, and Access to mental health care by inmates, by assessing the process for screening and assessing inmates for mental health needs.		
Compliance Status this tour:	Compliance: 7/18	Partial Compliance: 3/14; 3/3/2017; 12/7/17	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	Mental Health: Review of minutes of monthly meetings and agenda Review of suicides and adverse events Review of referrals process for at risk individuals Review of Quantros reports. Review of internal quality / risk audits		
Steps taken by the County to Implement this paragraph:	The Mental Health Review Committee meets on a regular (~monthly) basis as noted by the minutes submitted. Evidence of the quality of nursing services regarding inmate assessments and dispositions and access to mental health care by inmates, by evaluating the process for screening and assessing inmates for mental health needs was provided in the deliverables and in the documents sent prior to the tour.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The information provided met all elements of the provision which are necessary for compliance as per the Consent Agreement. However, it will need to be continued to sustain compliance.		
Monitor's Recommendations:			

Paragraph Author: Johnson	III. C. 9. d. Risk Management The County shall develop and implement a Quality Improvement Committee that shall: (1) Review and determine whether the screening and suicide risk assessment tool is utilized appropriately and that documented follow-up training is provided to any staff who are not performing screening and assessment in accordance with the requirements of this Agreement; (2) Monitor all risk management activities of the facilities; (3) Review and analyze aggregate risk management data; (4) Identify individual and systemic risk management trends; (5) Make recommendations for further investigation of identified trends and for corrective action, including system changes; and (6) Monitor implementation of recommendations and corrective actions.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14; 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: 1. Review of screenings by psychiatry 2. Review of monthly Quality Meeting minutes 3. Review of suicides and adverse events 4. Review of Quantros reports. 5. Review of internal quality / risk audits		
Steps taken by the County to Implement this paragraph:	See III. C. 9. a. The Quality Improvement Committee meetings		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Quality Improvement Committee is meeting, and has developed a number of QI Tools to monitor provision of care per the CA. During the tour, all CAPs were reviewed with CHS and the Medical Monitor. Analysis of data has significantly improved and CAPs are more specific and inclusive. QI Meeting minute document findings from each of the other committees. However, neither actions nor follow-up were included despite those columns being present. The Quatros system is tracking all CAPs with regular updates by QI staff.		
Monitor's Recommendations:	Improvements must be sustained to obtain substantial compliance.		

D. Audits and Continuous Improvement

1. Self Audits

Paragraph Authors: Greifinger and Johnson	III.D.1.b. Qualified Medical and Mental Health Staff shall review data concerning inmate medical and mental health care to identify potential patterns or trends resulting in harm to inmates in the areas of intake, medication administration, medical record keeping, medical grievances, assessments and treatment.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 1/16; 7/29/16; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 3/3/2017; 12/7/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14; 7/29/16; 7/18	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16; 3/3/2017; 12/7/17
Measures of Compliance:	Medical Care: • Review of Quality Improvement Plan and bi-annual evaluations • QI committee minutes • Clinical performance measurement tracked and trended over time, with remedial action timelines and periodic re-measurement • Review of grievances, responses, and data analysis Mental Health Care: 1. Review of Mental Health Review Committee minutes 2. Review of Quality Assurance Committee minutes 3. Review of any reports or analyses generated by MDCR Medical Compliance		
Steps taken by the County to Implement this paragraph:	Medical Care and Mental Health Care: CHS has completely revised its QI processes, leading to data-driven CAPs.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical and MH Care: A quality improvement plan for 2018 is in place. The QI committee receives trended clinical performance measures, analyses and corrective action plans. The QI Committee minutes do not discuss these data. Mortality reviews are similarly presented, without documented discussion. Grievance data are not collected, though there is little useful analysis. CAPs are data driven, leading to changes in systems of care. Grievance responses are friendlier, except for rather impersonal responses in mental health. Grievances could be investigated more thoroughly.		
Monitor's Recommendations:	Medical and MH Care: Continue to implement the recently-developed, robust, quality management program.		

Paragraph Authors: Greifinger and Johnson	III.D.1.c. The County and CHS shall develop and implement corrective action plans within 30 days of each quarterly review, including changes to policy and changes to and additional training.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16; 3/3/2017
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16; 7/29/16; 3/3/2017
Measures of Compliance:	Medical Care: • Review of relevant documents Mental Health Care: Review of corrective action plans. Corrective plans shall be submitted in a timely manner and shall be qualitative; addressing causes not just symptoms of harm.		
Steps taken by the County to Implement this paragraph:	Medical Care: Please see comments in III.A.7.a., III.A.7.c., and III.D.1.b. Mental Health Care: Please see comments in III.A.7.a., III.A.7.c., and III.D.1.b.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Please see comments in III.A.7.a., III.A.7.c., and III.D.1.b. as well as the Quality Improvement section in the introduction to this section of this report. Mental Health Care: Please see comments in III.A.7.a., III.A.7.c., and III.D.1.b.		
Monitor's Recommendations:	Medical Care: Please see recommendations in III.A.7.a., III.A.7.c. and III.D.1.b. as well as the Quality Improvement section in the introduction to this section of this report, which are included here by reference. Mental Health Care: Please see recommendations in III.A.7.a., III.A.7.c. and III.D.1.b.		

2. Bi-annual Reports

Paragraph Authors: Greifinger and Johnson	III.D.2.a. Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: All psychotropic medications administered by the jail to inmates. All health care delivered by the Jail to inmates to address serious medical concerns. The report will include: i. number of inmates transferred to the emergency room for medical treatment and why; ii. number of inmates admitted to the hospital with the clinical outcome; iii. number of inmates taken to the infirmary for non-emergency treatment; and why; and iv. number of inmates with chronic conditions provided consultation, referrals and treatment, including types of chronic conditions.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/3/2017; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	Medical Care: To be determined Mental Health Care: Review of bi-annual report provided in the June 2018 deliverables		
Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health Care: Provision of a bi-annual report analyzing the data as listed above between January and June 2018.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care and Mental Health Care: The bi-annual report is insufficiently analytical for constructive use.		
Monitor's Recommendations:	Medical and MH Care: For the biannual report, analyze data, report on trends, revise corrective action plans, as appropriate.		

Paragraph Author: Johnson	III.D.2.a. (3) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: All health care delivered by the Jail to inmates to address serious medical concerns. The report will include: i. All suicide-related incidents. The report will include: ii. all suicides; iii. all serious suicide attempts; iv. list of inmates placed on suicide monitoring at all levels, including the duration of monitoring and property allowed (mattress, clothes, footwear); v. all restraint use related to a suicide attempt or precautionary measure; and vi. information on whether inmates were seen within four days after discharge from suicide monitoring.		
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 1/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 10/14 (NR); 5/15 (NR); 7/29/16
Measures of Compliance:	<u>Mental Health:</u> • The Mental Health Monitor receives bi-annual reports of health care delivered to inmates **including the volume of and reason** for episodic clinic visits, follow-up/chronic care clinic visits, ER transfers, and hospitalizations. • Bi-annual reports are being submitted in a timely manner **and to include accurate data supportive of its conclusions**.		
Steps taken by the County to Implement this paragraph:	The Bi-annual report was provided		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	See comments from III.D.2.a.		
Monitor's Recommendations:	See recommendations from III.D.2.a.		

Paragraph Author: Johnson	III.D.2.a. (4) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: Inmate counseling services. The report and review shall include: (4) inmates who are on the mental health caseload, classified by levels of care; (5) inmates who report having participated in general mental health/therapy counseling and group schedules, as well as any waitlists for groups; (6) inmates receiving one-to-one counseling with a psychologist, as well as any **waitlists for such counseling**; and (7) inmates receiving one-to-one counseling with a psychiatrist, as well as any **waitlists for such counseling**.		
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 3/3/2017; 12/7/17; 7/18	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	Mental Health: • The Mental Health Monitor receives bi-annual reports of health care delivered to inmates including the volume of and reason for episodic clinic visits, evidence of timely follow-up/chronic care clinic visits, group therapy and individual therapy. • Bi-annual reports are being submitted in a timely manner and to include accurate data supportive of its conclusions.		
Steps taken by the County to Implement this paragraph:	The Bi-annual report was produced.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	See comments from III.D.2.a.		
Monitor's Recommendations:	See recommendations from III.D.2.a.		

Paragraph Author: Johnson	III.D.2.a. (5) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: The report will include: (8) Total number of inmate disciplinary reports, the number of reports that involved inmates with mental illness, and whether Qualified Mental Health Professionals participated in the disciplinary action.		
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 1/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 10/14 (NR); 5/15 (NR); 7/29/16
Measures of Compliance:	• The Mental Health Monitor receives bi-annual reports of health care delivered regarding inmates involved in disciplinary reports at each level of care, the date of any hearing that may have resulted as a result of the disciplinary hearing, whether a QMHP participated in the disciplinary action, and the outcome. • Bi-annual reports are being submitted in a timely manner and to include accurate data supportive of its conclusions.		
Steps taken by the County to Implement this paragraph:	The County submitted a Biannual report.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	See comments from III.D.2.a.		
Monitor's Recommendations:	See recommendations from III.D.2.a.		

Paragraph Authors: Greifinger and Johnson	III.D.2.a.(6) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following:… [6] Reportable incidents. The report will include: i. a brief summary of all reportable incidents, by type and date; ii. [Joint audit with MH] a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit; and iii. number of grievances referred to IA for investigation.		
Medical Care: Compliance Status:	Compliance: 1/16	Partial Compliance: 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Medical Care: Inspection Mental Health Care: 1. Review of bi-annual reports 2. Review of incident reports 3. Review of inmate deaths, including those which died following transfer from MDCR to Jackson Healthcare		
Steps taken by the County to Implement this paragraph:	Medical and Mental Health Care: Reports are provided. Mental Health Care:		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical and Mental Health Care: The bi-annual report contains only one of the required elements: inmate deaths. All other elements are missing. See comments from III.D.2.a		
Monitors' Recommendations:	Medical and MH Care: Provide a report responsive to all the requirements of this provision. The Monitors recommend, however, that these elements be incorporated into the broader quality improvement program as captured in a comprehensive Mortality and Morbidity Detection and Prevention policy. Indeed, such information as the number of injuries, for example, is information that the County will want to collect and monitor (i.e. report) more often than every 6 months. Further, it will want to augment these raw numbers with analysis of the cause and preventability of these injuries as well as efforts to reduce them.		

Paragraph Authors: Greifinger and Johnson	III.D.2.b. (See also III.D.1.c.) The County and CHS shall develop and implement corrective action plans within 60 days of each quarterly review, including changes to policy and changes to and additional training.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16, 3/3/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR); 1/16; 7/29/16; 3/3/2017
Measures of Compliance:	Medical Care: Duplicate III.D.1.c. Mental Health Care: Review of Quarterly Reviews Review of corrective action plans Review of implementation of CAP Review of policy and procedure, as applicable		
Steps taken by the County to Implement this paragraph:	Medical Care: Same as comments in III.D.1.c. Mental Health Care: Same as comments in III.D.1.c.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical and Mental Health Care: Same as comments in III.D.1.c.		
Monitors' Recommendations:	Medical and Mental Health Care: Same as recommendations in III.D.1.c.		

IV. COMPLIANCE AND QUALITY IMPROVEMENT

Paragraph Authors: Greifinger and Johnson	IV.A Within 180 days of the Effective Date, the County and CHS shall revise and develop policies, procedures, protocols, training curricula, and practices to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement. The County and CHS shall revise and develop, as necessary, other written documents such as screening tools, logs, handbooks, manuals, and forms, to effectuate the provisions of this Agreement. The County and CHS shall send any newly adopted and revised policies and procedures to the Monitor and the United States for review and approval as they are promulgated. The County and CHS shall provide initial and in-service training to all Jail staff in direct contact with inmates, with respect to newly implemented or revised policies and procedures. The County and CHS shall document employee review and training in policies and procedures.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR);1/16
Measures of Compliance:	Medical and Mental Health Care: To be determined		
Steps taken by the County to Implement this paragraph:	Medical and Mental Health Care: This is an over-arching provision; a number of other provisions fall under its umbrella, some of which are compliant or partially compliant. For example, the County has been sending new policies and procedures to the Monitors and has developed some operational documents to implement the Consent Agreement.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical and Mental Health Care: See above. Many policies have only recently been approved.		
Monitor's Recommendations:	Medical and MH Care: See various recommendations throughout this report.		

Paragraph Authors: Greifinger and Johnson	IV. B The County and CHS shall develop and implement written Quality Improvement policies and procedures adequately to identify and address serious deficiencies in medical care, mental health care, and suicide prevention to assess and ensure compliance with the terms of this Agreement on an ongoing basis.		
Compliance Status:	Compliance: 7/18	Partial Compliance: 7/13; 7/29/16;	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 3/3/2017; 12/7/17
Mental Health Care: Compliance Status:	Compliance: 7/18	Partial Compliance: 7/13; 3/14; 7/29/16;	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR); 3/3/2017; 12/7/17
Measures of Compliance:	Medical Care: Inspection of policies and procedures. Mental Health Care: 1. Review of policies and procedures.		
Steps taken by the County to Implement this paragraph:	Medical Care: The County performs a limited number of the activities required under provisions III.D.1.b. and III.D.1.c. that overlap with this provision. For example, they do conduct regular quality improvement meetings. The peer review process has been revised in a constructive manner. Mental Health Care: CHS has scheduled QI and MHRC meetings with minutes that reflect some of the requirements of this provision, and, As above in Medical Care comments.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Vastly improved quality management processes. Mental Health Care: QI review continues to improve.		
Monitors' Recommendations:	Medical Care and Mental Health Care: Please see the comments in provision III. A. 7. a.		

Paragraph Authors: Greifinger and Johnson	IV. C. and D. On an annual basis, the County and CHS shall review all policies and procedures for any changes needed to fully implement the terms of this Agreement and submit to the Monitor and the United States for review any changed policies and procedures.		
Medical Care Compliance Status:	Compliance: 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Partial Compliance: 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Compliance Status:	Compliance: 3/3/2017; 12/7/17; 7/18	Partial Compliance: 3/14; 1/16; 7/29/16	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Medical Care: • Annual review of policies and procedures for any needed changes. Mental Health Care: 1. Review of policies and procedures 2. Review of implementation of policies and procedures, as noted in Medical Care 3. Review of committee meeting minutes and/ or documentation reflecting annual review of policies and updates, as needed.		
Steps taken by the County to Implement this paragraph:	Medical Care: The County is actively reviewing policies, most of which are the subject of provisions within the CA. Mental Health Care: CHS policy updates policies with the monitors on an ongoing basis.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Policy review is ongoing. Mental Health Care: Policy review is an ongoing process.		
Monitor's Recommendations:	No additional recommendations at this time.		

Settlement Agreement Status
August 22, 2018

Appendix A - Settlement Agreement									
Section	**Jul-13**	**May-14**	**Oct-14**	**May-15**	**Jan-16**	**Jul-16**	**Mar-17**	**Dec-17**	**Jul-18**
Safety and Supervision									
III.A.1.a. (1)	pc	pc	pc	nr	pc	c	c	c	c
III.A.1.a. (2)	nc	nc	pc	nr	nr	pc	pc	pc	pc
III.A.1.a. (3)	pc	pc	c	nr	nr	c	c	c	pc
III.A.1.a. (4)	pc	pc	pc	c	nr	c	c	c	c
III.A.1.a. (5)	pc	pc	c	nr	nr	c	c	c	c
III.A.1.a. (6)	pc	c	c	nr	nr	c	c	c	pc
III.A.1.a. (7)	pc	pc	c	nr	nr	c	c	c	pc
III.A.1.a. (8)	nc	nc	pc	nr	c	c	c	c	pc
III.A.1.a. (9)	pc	pc	pc	nr	c	c	c	c	c
III.A.1.a. (10)	pc	pc	pc	nr	nr	pc	c	c	c
III.A.1.a. (11)	pc	pc	pc	nr	nr	pc	c	pc	pc
Security Staffing									
III.A.2. a.	not due	pc	pc	c	nr	c	c	c	c
III.A.2. b.	nc	pc	pc	c	nr	pc	c	c	pc
III.A.2.c.	not due	pc	pc	c	nr	c	c	c	c
III.A.2.d.	not audited	not due	nc	not due	c	c	c	c	c
Sexual Misconduct									
III. A.3.	pc	pc	c	nr	pc	pc	pc	pc	c
Incidents and Referrals									
III. A.4 a.	pc	pc	c	nr	nr	c	c	c	c
III.A.4. b.	nc	nc	c	nr	nr	c	c	c	c
III.A.4.c.	nc	pc	pc	nr	c	c	c	c	c
III.A.4.d.	not due	nc	pc	c	nr	c	c	pc	pc
III.A.4.e.	pc	pc	pc	nr	nr	p	c	c	c
III.A.4.f.	pc	pc	pc	pc	c	pc	c	c	c

Settlement Agreement Status
August 22, 2018

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jul-18
Use of Force by Staff									
III.A. 5 a.(1) (2) (3)	pc	pc	pc	pc	pc	pc	c	pc	c
III.A.5. b.(1), i., ii, iii, iv, v, vi (2)	pc	pc	pc	pc	nr	c	c	pc	c
III.A. 5. c. (1)	nc	c	pc	nr	nr	c	c	c	c
III.A. 5. c. (2)	nc	pc	pc	nr	pc	pc	c	pc	pc
III.A. 5. c. (3)	pc	pc	pc	c	nr	c	c	c	c
III.A. 5. c. (4)	pc	not audited	c	nr	nr	c	c	c	c
III.A. 5. c. (5)	pc	c	c	nr	nr	c	c	c	c
III.A. 5. c. (6)	nc	not audited	pc	c	nr	c	c	pc	c
III.A. 5. c. (7)	pc	c	c	nr	nr	c	c	c	c
III.A. 5. c. (8)	nc	nc	c	nr	c	c	c	c	c
III.A. 5. c. (9)	nc	nc	pc	pc	c	c	c	c	c
III.A. 5. c. (10)	pc	c	c	c	nr	c	c	nc	c
III.A. 5. c. (11)	nc	nc	nc	pc	nr	pc	pc	pc	c
III.A. 5. c. (12)	nc	nc	nc	pc	nr	pc	c	pc	c
III.A. 5. c. (13)	nc	c	c	nr	nr	c	c	c	c
III.A. 5. c. (14)	nc	nc	nc	pc	nr	pc	c	pc	c
III.A.5. d. (1) (2) (3) (4)	pc	pc	pc	nr	nr	pc	c	pc	c
III.A.5. e. (1) (2)	nc	pc	pc	nr	nr	pc	c	pc	c
Early Warning System									
III.A.6. a. (1) (2) (3) (4) (5)	nc	nc	pc	nr	c	pc	c	c	pc
III.A.6.b.	nc	nc	not due	pc	c	pc	c	c	c
III.A.6.c.	nc	nc	no	pc	c	pc	c	pc	pc

Settlement Agreement Status
August 22, 2018

Section	Jul-17	May-17	Oct-17	May-17	Jan-17	Jul-17	Mar-17	Dec-17	Jul-18
Fire and Life Safety									
III.B.1.	pc	pc	pc	nr	nr	pc	c	c	c
III.B.2.	c	c	c	nr	nr	pc	c	c	c
III.B.3.	pc	pc	pc	nr	nr	pc	c	c	c
III.B.4.	pc	pc	pc	pc	pc	pc	c	c	c
III.B. 5.	nc	pc	pc	nr	nr	pc	c	c	c
III.B.6	nc	nc	nc	pc	nr	pc	c	c	c
Inmate Grievances									
III.C. 1.,2.,3.,4.,5.,6.	pc	pc	pc	c	nr	c	c	pc	pc
Audits and Continuous Improvements									
PFH III.D.1. a. b.	nc	nc	pc	nr	nr	pc	c	pc	c
FLS III.D.1. a. b.	nc	nc	pc	nr	nr	pc	c	c	c
PFH III.D. 2.a. b.	not due	nc	pc	pc	pc	pc	c	pc	pc
Compliance and Quality Improvement									
PFH IV. A.	not due	nc	pc	nr	nr	pc	c	c	c
FLS IV. A.	not due	not audited	pc	nr	pc	pc	c	c	c
PFH IV. B.	nc	nc	pc	nr	nr	pc	c	pc	pc
FLS IV.B.	nc	nc	pc	nr	nr	pc	c	c	c
PFH IV.C.	not due	nc	pc	nr	c	c	c	c	c
FLS IV. C.	not due	nc	pc	nr	pc	c	c	c	c
PFH IV. D.	pc	pc	c	nr	nr	c	c	c	c
FLS IV. D.	pc	pc	pc	nr	pc	c	c	c	c

Legend:
nc = noncompliance
pc = partial compliance
c = compliance
nr = not reviewed

PFH - Protection from Harm
FLS - Fire Life Safety

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Consent Agreement C= Compliance; PC=Partial Compliance; NC=Non-Compliance; NR=Not Reviewed									
Section	**Jul-13**	**May-14**	**Oct-14**	**May-15**	**Jan-16**	**Jul-16**	**Mar-17**	**Dec-17**	**Jun-18**
A. Medical and Mental Health Care									
1. Intake Acreening									
III.A.1.a.	Med-PC MH -PC	Med- NR MH - NR	Med-PC MH -PC	Med - PC MH - C	Med-PC MH -PC	Med-PC MH -PC	Med-PC MH -PC	Med-PC MH -PC	Med-C MH C
III. A. 1. b.	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C	MH - PC
III. A. 1. c.	MH - NC	MH - NC	MH - NC	MH - PC	MH - NC	MH - NC	MH - PC	MH - PC	MH - PC
III.A.1.d.	Med - C MH-PC	Med- NR MH - NR	Med - NC MH - NC	Med - C MH - PC	Med - C MH - NC	Med - PC MH - NC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C
III.A.1.e.	Med- NR MH - NR	Med- NR MH - NR	Med - NC MH - PC	Med - C MH - PC	Med - PC MH- PC	Med-PC MH -PC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - PC
III.A.1.f.	Med - PC MH- PC	Med- NR MH - NR	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C
III.A.1.g.	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC	Med - NC MH - PC	Med - C MH - C	Med - C MH - C
2. Health Assessments									
III. A. 2. a.	Med- NR	Med- NR	Med- NR	Med- NR	Med- NR	Med- NR	Med - NC	Med - NC	Med -PC
III. A. 2. b.	MH - NR	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - C
III. A. 2. c.	Not Yet Due	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - C
III. A. 2. d.	Not Yet Due	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC	MH - PC	MH - PC
III.A.2.e.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NR	MH - C	MH - NC	MH - NC	Med - PC
III.A.2.f. (See (IIIA1a) and C. (IIIA2e))	Med - PC MH- PC	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - PC MH- PC	Med - NC MH - PC	Med-PC MH -PC	Med - PC MH -PC
III.A.2.g.	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - NC MH - NC	Med - NC MH - NC	Med-C MH -PC	Med-C MH - C
3. Access to Medical and Mental Health Care									
III.A.3.a.(1)	Med - C MH - PC	Med- NR MH - NR	Med - C MH - C	Med- NR MH - NR	Med- NR MH- NR	Med - C MH - C	Med - C MH - C	Med - C MH - C	Med - C MH - C
III.A.3.a.(2)	Med- NR MH - PC	Med- NR MH - NR	Med - C MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - C MH - NR	Med - C MH - NC	Med - C MH - PC	Med - C MH - C

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III.A.3.a.(3)	Med - PC MH- PC	Med- NR MH - NR	Med - C MH - C	Med- NR MH - NR	Med- NR MH - NR	Med - C MH C	Med - C MH - C	Med - C MH - C	Med - C MH - C
III.A.3.a.(4)	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC
III.A.3.b.	Med - PC MH - PC	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH - NC	Med - NC MH - NC	Med - NC MH - NC	Med - PC MH - PC
4. Medication Administration and Management									
III.A.4.a.	Med - PC MH - PC	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - NC MH - PC	Med - PC MH - PC	Med - PC MH - PC
III.A.4.b(1)	Not Yet Due	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- NC	Med - PC MH - NC	Med - C MH - C	Med - C MH - C
III.A.4.b(2)	Not Yet Due	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - NC MH- NC	Med- NC MH -NC	Med- NC MH -PC	Med- PC MH -PC
III. A. 4. c.	MH - PC	MH- NR	MH- NR	MH- NR	MH- NR	MH - NC	MH- PC	MH- PC	MH- C
III. A. 4. d.	MH - PC	MH- NR	MH- NR	MH- NR	MH- NR	MH - NC	MH- NC	MH- PC	MH- PC
IIIA.4.e.	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH - NC	Med - NC MH - PC	Med - NC MH - PC	Med -PC MH - PC
III.A.4.f. (See (III.A.4.a.)	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - NC MH - PC	Med - C MH - C	Med - C MH - C
5. Record Keeping									
III.A.5.a.	Med - PC MH - NC	Med - NR MH- PC	Med - PC MH- PC	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med-PC MH -PC	Med - PC MH - PC	Med - C MH - PC
III.A.5 b.	MH - NC	MH - PC	MH - PC	MH - NR	MH - NR	MH- PC	MH - NC	MH - PC	MH - PC
III.A.5.c.(See III.A.5.a.)	Med - PC MH- PC	Med- NR MH - NR	Med-PC MH -PC	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med-PC MH -PC	Med - PC MH - PC	Med - C MH - C
III.A.5.d.	Med - PC MH- PC	Med - NR MH- NR	Med-PC MH -PC	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med-PC MH -PC	Med - PC MH - PC	Med - PC MH - PC

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Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18
6. Discharge Planning									
III.A.6.a.(1)	Med - NR MH- PC	Med - NR MH- NC	Med - PC MH - PC	Med- NR MH - NR	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - NC MH - PC
III.A.6.a.(2)	Med - NR MH - PC	Med - NR MH - NC	Med - PC MH - PC	Med- NR MH - NR	Med - NC MH - PC	Med - PC MH - PC	Med - NC MH - PC	Med - NC MH - PC	Med - NC MH - PC
III.A.6.a.(3)	Med - NR MH- PC	Med - NR MH - NC	Med - PC MH - PC	Med- NR MH - NR	Med-PC MH -PC	Med- NR MH - NR	Med - NC MH - PC	Med - PC MH - PC	Med - PC MH - PC
7. Mortality and Morbidity Reviews									
III.A.7.a.	Med - PC MH - PC	Med - NR MH - PC	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - NC	Med - PC MH - PC	Med - NC MH - NC	Med - PC MH - PC	Med - C MH - C
III.A.7.b.	Med - NR MH - NC	Med - NR MH - PC	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - PC MH- NC	Med - NC MH - NC	Med - NC MH - NC	Med - C MH - C
III.A.7.c.	Med - NR MH - NC	Med - NR MH - NC	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - PC MH - NC	Med - NC MH - NC	Med - NC MH - NC	Med - PC MH - PC
B. Medical Care									
1. Acute Care and Detoxification									
III.B.1.a.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - NC	Med - PC
III.B.1.b. (See (III.B.1.a.)	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - PC	Med - PC	Med - PC
III.B.1.c.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - C	Med - C
2. Chronic Care									
III.B.2.a.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC	Med - PC
III.B.2.b. (See (III.B.2	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC	Med - PC
3. Use of Force Care									
III.B.3.a.	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - NR MH- NR	Med - NR MH- NC	Med - C MH - NC	Med-C MH -PC	Med - PC MH -PC	Med - C MH - C
III.B.3.b.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC	Med - C
III.B.3.c. (1) (2) (3)	Med - NR	Med - NR	Med - PC	Med - NR	Med - NR	Med - NC	Med - NC	Med - PC	Med - C

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Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18
C. Mental Health Care and Suicide Prevention									
1. Referral Process and Access to Care									
III. C. 1. a. (1) (2) (3)		MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 1. b.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - C
2. Mental Health Treatment									
III. C. 2. a.	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 2. b.	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 2. c.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 2. d.	MH - PC	MH - PC	MH - PC	MH - NR	MH - NC	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. e. (1) (2)	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 2. f.	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 2. g.	MH - NC	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - C	MH - C	MH - C
III. C. 2. g. (1)	MH - NC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - C	MH - PC	MH - C
III. C. 2. g. (2)	MH - NC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - C	MH - C
III. C. 2. g. (3)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. g. (4)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 2. h.	MH - PC		MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC	MH - PC
III. C. 2. i.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. j.	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 2. k.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC	MH - PC
3. Suicide Assessment and Prevention									
III. C. 3. a. (1) (2) (3) (4) (5)	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 3. b.	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC	MH - PC	MH - PC
III. C. 3. c.	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC	MH - PC
III. C. 3. d.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 3. e.	MH - PC	MH - NC	MH - NR	MH - NR	MH - NC	MH - PC	MH - NC	MH - PC	MH - PC
III. C. 3. f.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 3. g.	Med -NR MH - NC	Med - NR MH - NC	Med - NR MH- NR	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - PC	Med - PC MH - PC	Med - C MH - C
III. C. 3. h.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC	MH - PC

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Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18
4. Review of Disciplinary Measures									
III. C. 4. a. (1) (2) and	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - PC	MH - PC
5. Mental Health Care Housing									
III. C. 5. a.	MH - NC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 5. b.	MH - NC	MH - NC	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - NC	MH - PC
III. C. 5. c.	MH - NC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC	MH - PC
III. C. 5. d.	MH - NR	MH - PC	MH - PC	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 5. e.	MH - PC	MH - NC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - C
6. Custodial Segregation									
III. C. 6. a. (1a)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 6. a. (1b)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 6. a. (2)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 6. a. (3)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 6. a. (4) i	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC	MH - PC	MH - PC
III. C. 6. a. (4) ii	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC	MH - NC	MH - NC
III. C. 6. a. (5)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC	MH - PC
III. C. 6. a. (6)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC
III. C. 6. a. (7)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC
III. C. 6. a. (8)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC
III. C. 6. a. (9)	MH - C	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 6. a.(10)	Med - NC MH - PC	Med - NR MH - NC	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - PC	Med - PC MH - PC	Med - NC MH - NC	Med - PC MH - PC	Med - C MH - PC
III. C. 6. a. (11)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC
7. Staffing and Training									
III. C. 7. a.	MH - PC	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 7. b.	MH - NR	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 7. c.	MH - NC	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 7. d.	MH - NR	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 7. e.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 7. f.	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 7. g. (1)(2)(3)	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 7. h.	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - NC	MH - PC	MH - PC

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Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18
8. Suicide Prevention Training									
III. C. 8. a. (1 – 9)	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - PC	MH - C	MH - C
III. C. 8. b.	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - PC	MH - C	MH - C
III. C. 8. c.	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - C	MH - C	MH - C
III. C. 8. d.	MH - NC	MH - NC	MH - PC	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - PC
9. Risk Management									
III. C. 9. a.	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 9. b. (1)(2)(3)(4)	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 9. c. (1)(2)(3)(4)(5)	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - PC	MH - C
III. C. 9. d. (1)(2)(3)(4)(5)(6)	MH - NR	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
D. Audits an Continuous Improvement									
1. Self Audits									
III. D. 1. b.	Med - NR MH -PC	Med - NR MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - NC	Med - PC MH - PC	Med - NC MH - NC	Med - NC MH - NC	Med - PC MH - PC
III. D. 1. c.	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH- NC	Med - PC MH - NC	Med - NC MH - NC	Med - PC MH - PC	Med - PC MH - PC
2. Bi-annual Reports									
III. D. 2 .a. (1)(2)	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med -NC MH - NC	Med - PC MH - NC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC
III. D. 2. a. (3)			MH - NR	MH - NR	MH - PC	MH - NC	MH - PC	MH - PC	MH - PC
III. D. 2. a. (4)			MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - PC	MH - PC
III. D. 2. a. (5)			MH - NR	MH - NR	MH - PC	MH - NC	MH - PC	MH - PC	MH - PC
III. D. 2. a.(6)	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - C MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC
III. D. 2. b.(See III. D. 1. c.)	Med - NR MH- NR	Med - NR MH- PC	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - PC MH - NC	Med - NC MH - NC	Med - PC MH - PC	Med - PC MH - PC

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IV. Compliance and quality Improvement									
IV. A	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - NC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC
IV. B	Med - PC MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - PC	Med - NC MH - NC	Med - NC MH - NC	Med -C MH - C
IV. C	Med - NR MH- NR	Med - NF MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med-PC MH -PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C	Med - C MH - C
IV. D	Med - NR MH- NR	Med - NF MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med-PC MH -PC	Med - PC MH - PC	Med - C MH - C	Med - C MH - C	Med - C MH - C

Yellow = Collaboration - Medical (Med) and Mental Health (MH)
Purple = Collaboration with Protection from Harm
Orange = Medical Only
Green = Mental Health Only