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

Monitors' Report No. 1

Susan W. McCampbell, Lead Monitor
Harry Grenawitzke, Environmental Health and Sanitation
Amanda Ruiz, MD. Mental Health Monitor
Marc F. Stern, M.D. Medical Monitor
McCampbell and Associates, Inc.
1880 Crestview Way
Naples, Florida 34119-3302
Email: susanmccampbell@mccampbellassociates.com

November 5, 2013

Compliance Report # 1

USA v. Miami-Dade County
Consent Agreement
Settlement Agreement
November 5, 2013

Introduction

This is the first report of compliance regarding the Consent Agreement and Settlement Agreement referenced above. The monitors appreciate the cooperation of Miami-Dade County, particularly the Department of Corrections and Rehabilitation and Corrections Health Services, as we prepared for the initial tour the week of July 15, 2013, during of time onsite, and in response to requests post-tour. We acknowledge how disruptive the monitoring process is to an organization, and the good humor and commitment displayed by all was an asset to the process.

Draft report # 1 was provided to all parties for their review on September 23, 2013. The response from Miami-Dade County was received on October 16, 2013, and from the Dept. of Justice on October 25, 2013. Each monitor has reviewed these comments and made changes to their reports, as they deemed necessary by the content of the two responses.

As part of our agreement for objectivity and transparency each monitor provided measures of compliance for the requirements of the elements of the Consent Agreement and the Settlement Agreement. While all parties have had a chance to review these proposed measure, we anticipate there may be amendments as the monitors learn more about operations, and the defendants work to document compliance. We view this as a healthy process and pledge to continue open communication.

Preparation of this first report became challenging as the leadership at Corrections Health Service (CHS) was replaced following our tour. Jackson Health Systems (JHS) and CHS have been diligent and open in communications and have worked hard to bridge any gaps in collaboration that the organizational changes may have caused. We particularly thank Mr. Migoya, Mr. Steigman and Mr. McKeon for their work, reflecting the clear determination to do all necessary to achieve quality and mental health care.

We extend our thanks not only to the CHS staff, but to Director Tim Ryan, Capt. John Johnson, and all those who worked to produce the requested documents in a very helpful electronic format.

The table of contents/summary of compliance begins for all sections on page 8.

Following this introduction is a discussion of observations, findings and recommendations shared by the monitors – areas of strong consensus. There are then four individual reports provided, each of which each includes an executive summary.

Report A – Protection from Harm, Inmate Grievances, Audits and Continuous Improvement, authored by Susan McCampbell, page 10.
Report B – Fire and Life Safety, authored by Harry Grenawitzke, page 79.
Report C – Medical Care, authored by Marc Stern, MD, page 93.
Report D –Mental Health Care, authored by Amanda Ruiz, MD, 162.

These reports also include a list of the materials reviewed and the interviews conducted. While we did our best to identify all materials reviewed and all individuals interviewed, we most likely missed some. We also have made every effort to protect the confidentiality of inmates whose charts were reviewed as part of the medical/mental health monitoring.

The monitors made their best efforts to collaborate on findings and recommendations that crossed subject/topic lines. This is especially true in assessing and mental health care.

The County has challenges to address in reaching and sustaining compliance. In our work, we strive to provide technical assistance and advice, when asked, and trust this philosophy is also clear in these reports.

Shared Concerns

The topics of shared concerns are:

- Compliance Process
- Crowding and Criminal Justice System Collaboration
- Training and Treatment Center Conditions of Confinement
- Pre-Trial Detention Center, Conditions of Confinement for Inmates with Mental Illness
- Forensic Diversion Facility
- Employee Training Lesson Plans

Each monitors' report may also comment on these topics.

I. Compliance Process

An initial tour to assess compliance following adoption of a consent agreement is typically challenging. Miami-Dade County has a high level of commitment to the tasks, but a level of uncertainty of how these tasks are to be accomplished. The proposed measures of compliance provide the roadmap for what MDCR and CHS need to do and provide to the monitors as documentation. I anticipate that subsequent tours and future report preparation will unfold more smoothly than this initial process.

Because there are two agreements – the Settlement Agreement and the Consent Agreement – a high level of coordination and collaboration is needed from MDCR and CHS for both entities to achieve compliance. There must be companion policies and procedures for elements of documents that have duel responsibilities and require

action from both organizations.

MDCR has designated a person at the rank of Captain to be responsible and accountable for the process. The County needs to assure that this process is adequately resourced and that documentation of the process is maintained. The County may wish to consider establishing a committee of key stakeholders from MDCR and CHS. MDCR and CHS may want to add other agencies as necessary – for example police, fire. The overarching goal to assure that the organizational changes are institutionalized, internal culture adjusted, and that progress is sustainable; not just for the length of time prescribed by the Agreements, but for the long term.[1]

II. Crowding and Criminal Justice System Collaboration

Florida Statute 951.26 requires all counties to establish a Public Safety Coordinating Council (PSCC). Miami-Dade County does not currently have a council that meets this requirement. The council is charged with:

> "(2) . . . assessing the population status of all detention or correctional facilities owned or contracted by the county, or the county consortium, and formulating recommendations to ensure that the capacities of such facilities are not exceeded. Such recommendations shall include an assessment of the availability of pretrial intervention or probation programs, work-release programs, substance abuse programs, gain-time schedules, applicable bail bond schedules, and the confinement status of the inmates housed within each facility owned or contracted by the county, or the county consortium.
> (3)(a) The council may also develop a local public safety plan for future construction needs. The plan must cover at least a 5-year period. The plan may be submitted for consideration to the local planning agency for the county, or the planning agency for each county within the consortium, at least 120 days before the adoption of or amendment to the comprehensive plan for the county by the local planning agency pursuant to part II of chapter 163.
> (b) Each county, or county consortium, that contracts to receive community corrections funds for its community corrections programs under s. 948.51 shall require the public safety coordinating council to develop a comprehensive public safety plan as described therein which includes the future public safety construction needs as described in paragraph (a).
> (4) The council may also develop a comprehensive local reentry plan that is designed to assist offenders released from incarceration to successfully reenter the community. The plan should cover at least a 5-year period. In developing the plan, the council shall coordinate with public safety officials and local community

[1] The County notes that if there is not a specific due date for a provision in the Settlement Agreement, the controlling date is 180 after the effective date of the agreement. This date is October 27, 2013. In instances where the monitors found the County non-compliance, the County is asserting that date; in instances where the monitors found the County in partial compliance, they are not asserting that date. The monitors notified the County that, in their view, this is an incorrect interpretation of the agreement.

organizations who can provide offenders with reentry services, such as assistance with housing, health care, education, substance abuse treatment, and employment."[2]

The Director advises that he has tried unsuccessfully to seek establishment of a council.

Regardless of the reasons for the absence of the PSCC, the County, in our opinion, would benefit from a consolidated, collaborative effort at jail population reduction and jail reform.

III. Training and Treatment Center TTC (Stockade)

Referencing paragraph 8 in the Introduction and Background section of the Settlement Agreement, we have determined that the conditions we observed at the TTC do not meet minimal constitutional conditions of confinement.[3] In making this determination we specifically relied on two sets of nationally recognized standards – those of the Commission on Accreditation for Corrections, Performance-Based Standards for Adult Local Detention Facilities (ALDF), Fourth Edition and the American Correctional Association's Core Jail Standards (CJS), First Edition. We also reviewed the Florida Model Jail Standards. By citing these national standards, we are not suggesting that MDCR and TTC should seek accreditation. The standards are widely used, accepted by the field, and provide an objective measure. [Appendix 3, Report A] provides our overview of relevant standards related to conditions at TTC. [Total bed capacity 1,264][4]

If these basic standards are operationalized at TTC, there will be more than a 35% reduction in the inmate population.

A. Conditions not meeting minimum constitutional standards are:

Succinctly, there are too many inmates housed in the dormitories at TTC with insufficient space, an insufficient number of toilets and showers, insufficient

---

[2] http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0900-0999/0951/Sections/0951.26.html accessed on 8/27/2013

[3] "8. This Agreement neither constitutes an admission by the County of the truth of the findings contained in the Findings Letter, nor constitutes an admission of liability by the County. Any of the deficiencies, risks, or breach intimated by the language of this Agreement, expressed or implied, are disclaimed by the County. The County enters into this Agreement because it is firmly committed to providing constitutionally and legally compliant conditions in the Jail by effectuating its duties under the Constitution and other applicable law. The County demonstrated this commitment not only by entering into this Agreement but also by pursuing accreditation and auditing by professional correctional organizations, with several of its facilities having achieved accreditation by American Correctional Association and Florida Corrections Accreditation Commission, as well as system-wide compliance with the Florida Model Jail Standards."

[4] The County, in their response to the draft report, states that these standards "are neither a requirement nor a determinant as to MDCR meeting constitutional conditions of confinement including overcrowding." We respectfully disagree with that statement. These are the standards that are used in such an evaluation and the totality of conditions prompts our observations and recommendations.

ventilation, as well as insufficient time for recreation and out-of-cell activities. Staff supervision is lacking.

For example, "dorms" have 1,225 square feet (not including toilet/shower areas and the "sally port" entrance to the units). A bunk is 7x3 feet = 21 square feet; 21 square feet/bunk + 35 sq. feet of unencumbered space/inmate = 56 square feet 1,225/56 = 22 inmates. (Or 11 bunks – no more than 22 inmates; not the 34 currently housed now) This computation doesn't include the 100 square feet of space for day rooms. [5]

As inmates (up to 34 in some dormitories) are crowded into these units, and as there is only intermittent supervision of inmates, this results in an insufficient level of supervision and potential and actual harm to inmates. While inmates were not willing to talk with us during our brief tour because, in our view, of the proximity of the MDCR staff, we only heard a few concerns about activities in the unit.[6,7]

- Officers cannot see inmate activity in the back of the dormitory units including the bunks along the wall.
- Officers cannot enter the dormitory without backup.
- Inmates can alter their activities based on knowing officer schedules, and

---

[5] Among the relevant standards are: ALDF (1A-10) and ACA CJS require 35 square feet of unencumbered space for each occupant when confinement exceeds 10 hours per day. This is clearly not the case in TTC housing areas.

- ALDF (1A-12) requires dayroom space no less than 100 square feet, also clearly not the case.
- ALDF (4B-08) requires one toilet for every 12 inmates and one washbasin for every 12 inmates (urinals may be substituted for up to one-half of the toilets); not the case at TTC.
- ALDF (4B-09) requires a minimum ration of one shower for every 12 inmates, not the case.
- ALDF (IA-19) requires that a ventilation system supplies at least 15 cubic feet per minute of circulated air per occupant with a minimum of five cubic feet per minute of outside air. Toilet rooms and cells with toilets have no less than four air changes per hour. A qualified independent source needs to assess.
- ALDF (5C-02) requires that inmates have the opportunity for at least one-hour daily of physical exercise outside the cell, and ALDF 5C-02 requires opportunities for daily leisure-time activities outside the cell.

[6] As noted in the DOJ's finding's letter: "Within the Jail, there is a dangerous lack of adequate supervision within the housing units, particularly the dormitory settings housing maximum security prisoners in PTDC and the Stockade. Because of the antiquated design of these facilities, there are no officers stationed within the majority of the dormitory housing units in PTDC and the Stockade."

[7] The County has been on notice regarding the TTC since 2011. See also Findings Letter of August 24, 2011, "There is a dangerous lack of meaningful supervision in the housing units, particularly the dormitory settings housing maximum security prisoners at PTDD and the Stockade (TTC). The problems with providing adequate supervision to the units in PTDC and the Stockade stem largely from the antiquated design of these facilities. For example, there are not officers stationed inside the majority of the dormitory housing units in PTDC and the Stockade. . . Due to the structure of the units in the Stockade, however, officers patrolling outside the units cannot effectively observe the prisoners without actually entering the units to conduct direct observation. As a result, during the time the officer is inside a particular unit conducting direct observation, the remaining units are unsupervised." The monitors' observation is that the crowded condition of the units prevents visual surveillance of the rear of the housing area without an officer physically entering the unit, going through the sallyport, and walking through the entire unit.

their knowledge that an officer cannot enter the dormitory unit without a back-up.

Additionally we found that:

- Inmates have very little space to do anything but lie on their bunks for the hours between their every-other-day out of dormitory recreation.
- Camera coverage is insufficient. Camera coverage does not substitute for officer supervision.[8]
- The dormitories are dark, lacking sufficient access to natural light.
- There are insufficient showers, toilets and sinks, and the several of those observed were inoperable.
- There is not a basic janitor closet or cleaning supplies, and the cleaning supplies we observed were stored in the dorms posing a danger to inmates (both in terms of mop handles, brooms, buckets, etc.)
- The dormitories were not generally clean, specifically the toilet/shower areas. Shower curtains appeared to be make-shift black plastic trash bags.
- On a positive note, the dormitories are air conditioned; however there is insufficient distribution of air movement that causes very cold (and hot) spots under the vents (which inmates cover with paper to deflect air from blowing on them directly over their bunks); thus further defeating effective the ventilation. More than one discharge and return for air is needed in each dorm.

B. Recommendations

1. MDCR should develop and implement a plan to reduce the number of inmates held in each dormitory at TTC consistent with available square footage, toilets, showers, etc.
2. MDCR needs to assure the consistent cleanliness of the dormitory units with oversight of inmate workers, written housekeeping policies and plans along with daily documented inspections, and corrective action plans/activities where necessary.
3. MDCR needs to assure every day that all existing toilets, urinals, showers and washbasins are in working order, and that any needed repairs are promptly completed.
4. MDCR should authorize a review of the HVAC system to determine effective air movement and distribution needs and institute changes where needed.
5. MDCR should increase out-of-dormitory time for exercise to daily.
6. MDCR should develop a staffing plan to assure that officers walk through the units frequently, not just stand in the doorway.

[8] The County notes that cameras are to be installed in TTC by 5/31/14.

IV. Training Lesson Plans

All lesson plans reviewed were professionally presented. Overall, however, they were lacking in sufficient detail to provide a reviewer with the understanding of what was included in the training and how it relates to written policies and procedures. Many of the lesson plans repeat the exact language from the policy/procedure with no description and discussion of how that information is instructed and how effectiveness of the training is measured and assured. We trust that this area will improve; and are available to provide further direction on the level of detail needed.

V. Forensic Diversion Facility

It would be helpful to the monitoring team to have a much clearer picture of the status of the Forensic Diversion Facility, including the date it will open. The monitors are aware of a recent proposal to repurpose a Dept. of Children and Families' facility is the western part of the County for use as a mental health facility.

VI. 9th Floor Mental Health Units

As the opening date for the forensic diversion facility is unclear, we strongly recommend and urge that the inmates with mental illness now housed on the 9th floor at PTDC be relocated to a more suitable, safe, humane environment. All the monitors were appalled at the conditions on the 9th floor. We do not understand why these conditions have continued.[9] We heard some staff say that fiscal resources had been devoted to re-hanging doors so they swing outward – but that was the only reason we could identify; which, of course, is not a sound or credible reason. Another reason cited was the unit's proximity to CHS' resources; which also not a good reason to retain inmates in this location.

Inmates with mental illness should be moved immediately to a more suitable and safe location.

VII. Investigations, Mortality Reviews

Miami-Dade County and CHS need to immediately improve investigations, as well as refine the processes, related to allegations of inmate/inmate criminal acts, staff misconduct, suicides, and other in-custody inmate deaths. There is a need for better collaboration between the parties charged with investigations (e.g. Miami Dade Police Department, Medical Examiner) and the assurance that there is a review of the final report to insure consistency in findings, as well as

[9] In the County's response to the draft report they requested that the monitors provide "personal observations and facts for which these comments are based are requested." While we appreciate that the County would like details of the observations that were distressing, we believe that the written, historical, and public record clearly speaks for itself and that no other discussion is necessary.

recommendations. Improvements to mortality reviews are also necessary, as identified in the report. Again, collaboration and communication are key to these improvement.

Conclusions

We look forward to continuing our work with the County to achieve compliance. We are available to provide clarification and technical assistance to help the County keep focused on the outcomes and documentation. As the monitors have experience in other jurisdictions, we are in a position to discuss options to reach compliance, and help problem-solve.

Report A: Protection from Harm Summary of Compliance for tour the week of July 15, 2013

Subsection of Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments:
III. A. Protection from Harm					
1. Safety and Supervision					
III.A.1.a. (1)	12		x		
III.A.1.a. (2)	13			x	
III.A.1.a. (3)	14		x		
III.A.1.a. (4)	15		x		
III.A.1.a. (5)	16		x		
III.A.1.a. (6)	17		x		
III.A.1.a. (7)	17		x		
III.A.1.a. (8)	18			x	
III.A.1.a. (9)	19		x		
III.A.1.a. (10)	20		x		
III.A.1.a. (11)	21		x		
2. Security Staffing					
III.A.2. a.	22				Due 11/27/13[10]
III.A.2. b.	23				Due 11/27/13
III.A.2.c.	24				Due 11/27/13
III.A.2.d.	25				Due 3/26/14
3. Sexual Misconduct					
III. A.3.	25		x		
4. Incidents and Referrals					
III. A.4 a.	27		x		
III.A.4. b.	28			x	
III.A.4.c.	28		x		
III.A.4.d.	29			x	
III.A.4.e.	31		x		
III.A.4.f.	32		x		
5. Use of Force by Staff					
III.A. 5 a.(1) (2) (3)	34		x		
III.A.5. b.(1), (2) i., ii, iii, iv, v, vi	34		x		
III.A. 5. c. (1)	37			x	

III.A. 5. c. (2)	37			x	
III.A. 5. c. (3)	39		x		
III.A. 5. c. (4)	40		x		
III.A. 5. c. (5)	41		x		
III.A. 5. c. (6)	42			x	
III.A. 5. c. (7)	44		x		
III.A. 5. c. (8)	45			x	
III.A. 5. c. (9)	45			x	
III.A. 5. c. (10)	46		x		
III.A. 5. c. (11)	47			x	
III.A. 5. c. (12)	48			x	
III.A. 5. c. (13)	49			x	
III.A. 5. c. (14)	50			x	
III.A.5. d. (1) (2) (3) (4)	50		x		
III.A.5. e. (1) (2)	51			x	
III.A.6. a. (1) (2) (3) (4) (5)	53			x	
III.A.6.b.	54				
III.A.6.c.	55			x	
III.C. 1.,2.,3.,4.,5.,6.	55		x		
III.D.1. a. b.	58			x	
III.D. 2.a. b.	61				Due date 10/27/13
IV. A.	63			x	
IV. B.	65			x	
IV. C.	67				Due date 10/27/13
IV. D.	69			x	

Appendix A-1, page 71
Appendix A-2, page 74
Appendix A-3, page 78

Report B: Summary of Fire and Life Safety Compliance
Tour July 15-19, 2013

Subsection of Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments:
III. B. Fire and Life Safety					
III.B.1.	82		x		
III.B.2.	83	x			
III.B.3.	84		x		
III.B.4.	85		x		
III.B. 5.	87			x	
III.B.6	88			x	
D. Audits and Continuous Improvement					
III. D.1.	58				See Report A
III.D. 2.	61				See Report A
IV. Compliance and Quality Improvement					
IV. A.	63				See Report A
IV. B.	65				See Report A
IV. C.	67				See Report A
IV. D.	69				See Report A

Attachment B-1, page 90
Attachment B-2, page 92

Reports C and D: Summary of Consent Agreement (Medical and Mental Health) Compliance/Partial Compliance/Non-Compliance for Tour the week of July 15, 2013

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

Subsection of Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments:
A. MEDICAL AND MENTAL HEALTH CARE					
1. Intake Screening					
III.A.1.a.	96		x-med; x-mh		
III. A. 1. b.	164		x-mh		
III. A. 1. c.	165		x-mh		
III.A.1.d.	98	x-med	x- mh		
III.A.1.e.	100				Medical MH– Not audited
III.A.1.f.	101		x-med x-mh		
III.A.1.g.	102				Medical – Not audited, mh - Not audited
2. Health Assessments					
III.A.2.a.	103				Medical MH – Not audited
III. A. 1. b.	166		x- mh		
III. A. 1. c.	166		x- mh		
III. A. 1. d.	167		x- mh		
III.A.2.e.	104				Medical – Not audited
III.A.2.f. (Covered in (IIIA1a) and C (IIIA2e))	105		x-med; x- mh		
III.A.2.g.	107, 168			x-mh	Medical – Not audited
3. Access to Medical and Mental Health Care					
III.A.3.a.	108			x-med; x- mh	
III.A.3.a.(1)	110	x - med	x-mh		
III.A.3.a.(2)	111		x- mh		Medical – Not audited
III.A.3.a.(3)	112		x-med; x- mh		
III.A.3.a.(4)	113			x- mh	Medical – Not audited
III.A.3.b.	114		x – med; x- mh		

Subsection of Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments:
4. Medication Administration and Management					
III.A.4.a.	116		x – med; x- mh		
III.A.4.b(1)	119, 168		x – med		Not yet due
III.A.4.b(2)	120, 168		x – med		
III. A. 4. c.	169		x-mh		
III. A. 4. d.	170		x-mh		
IIIA.4.e.	121			x-mh	Medical – Not audited
III.A.4.f. (Covered in (III.A.4.a.)	122				Not yet due
5. Record Keeping					
III.A.5.a.	123		x-med	x-mh	
III.A.5 b.	171			x-mh	Medical – Not audited
III.A.5.c.(Covered in III.A.5.a.)	124		x-med; x-mh		
III.A.5.d.	125		x-mh		Medical – Not audited
6. Discharge Planning					
III.A.6.a.(1)	127		x-mh		Medical – Not audited
III.A.6.a.(2)	129		x-mh		Medical – Not audited
III.A.6.a.(3)	131		x-mh		Medical – Not audited
7. Mortality and Morbidity Reviews					
III.A.7.a.	132		x –med	x-mh	
III.A.7.b.	134			x-mh	Medical – Not audited
III.A.7.c.	135			x-mh	Medical – Not audited
B. MEDICAL CARE					
1. Acute Care and Detoxification					
III.B.1.a.	136			x	
III.B.1.b. (Covered in (III.B.1.a.)	139			x	
III.B.1.c.	141				Medical – Not audited
2. Chronic Care					
III.B.2.a.	142				Medical – Not audited
III.B.2.b. (Covered in (III.B.2.a.)	142				Medical – Not audited
3. Use of Force Care					
III.B.3.a.	143				Medical – Not audited
III.B.3.b.	143				Medical – Not audited
III.B.3.c. (1) (2) (3)	145				Medical – Not audited

C. MENTAL HEALTH CARE AND SUICIDE PREVENTION					
1. Referral Process and Access to Care					
III. C. 1. a. (1) (2) (3)	174		x		
III. C. 1. b.	176		x		
2. Mental health treatment					
III. C. 2. a.	177		x		
III. C. 2. b.	178		x		
III. C. 2. c.	179		x		
III. C. 2. d.	180		x		
III. C. 2. e. (1) (2)	182			x	
III. C. 2. f.	183		x		
III. C. 2. g.	185			x	
III. C. 2. g. (1)	185			x	
III. C. 2. g. (2)	186			x	
III. C. 2. g. (3)	186		x		
III. C. 2. g. (4)	187		x		
III. C. 2. h.	188				Not yet due
III. C. 2. i.	189		x	x	
III. C. 2. j.	190			x	
III. C. 2. k.	190				Not yet due
3. Suicide Assessment and Prevention					
III. C. 3. a. (1) (2) (3) (4) (5)	192		x		
III. C. 3. b.	194		x		
III. C. 3. c.	194		x		
III. C. 3. d.	195		x		
III C. 3. e.	196		x		
III. D. 3. f.	197		x		
III.C.3.g.	146, 198			x-mh	
III. C. 3. h.	198				Not yet due
4. Review of Disciplinary Measures					
III. 4. a. (1) (2) and b.	200		x		
5. Mental Health Care Housing					
III. 5. a.	202			x	
III. 5. b.	203			x	
III. 5. c.	204			x	
III. 5. d.	205				Not yet due
III. 5. e.	205		x		

	207		x		
	208		x		
	209		x		
	210		x		
	210		x		
	211		x		
	212			x	
	213		x		
	214			x	
	215	x			
	148, 215		x – mh		Medical: Not completely audited
	216		x		
	218			x	
	218				Not yet due
	219			x	
	219				Not yet due
	219		x		
	220			x	
	221			x	
	222		x		
	224			x	
	226			x	
	226			x	
	227		x		
	228				Not yet due
	228				Not yet due
	229				Not yet due
	230				Not yet due
	58				To be Determined
	150				Medical – Not audited
	151				Medical/MH – Not audited

					To be Determined
	152				Not yet due
					To be Determined
					To be Determined
					To be Determined
	153				Not yet due
	154				Medical/MH not audited
	155				Not yet due
	157		x – med x- mh		
	159				Not yet due
					To be Determined
	12				See Report A
	23				See Report A
	25				See Report A
	25				See Report A
	32				See Report A
	34				See Report A
	51				See Report A
	37				See Report A
	41				See Report A
	42				See Report A
	46				See Report A
	47				See Report A
	48				See Report A
	55		x – med		
	55				See Report A
	63				Not yet due
	65		x- med		
	67				Not yet due

Report A
Compliance Report # 1
Protection from Harm
Inmate Grievances
Audits and Continuous Improvement
Report of Tour Week of July 15 – 19, 2013

Executive Summary

The requirements reviewed in this report relate to the Settlement Agreement sections for protection from harm (III. A.), inmate grievances (III. C.) and audits and continuous improvements (III. D.) For purposes of this report, these requirements were divided into 50 separate paragraphs. My assessment is that as of the initial tour, 6 paragraphs are in compliance; 16 are in partial compliance, and 28 are in non-compliance.

The areas that require attention for the parties to this process are:

Findings/Overview:

I. Prison Rape Elimination Act

Compliance with PREA is a challenge for jails throughout the United States. MDCR has been involved with PREA standards for some time. MDCR needs to develop an action plan for all elements of the standards, and, importantly, collaborate with CHS. CHS will need to develop protocols to be responsive to PREA.

II. Investigations

MDCR is a large jail operation. As such it is essential that MDCR possess, or has access to an investigative function that is immediately responsive, skilled and trained for handling investigations in a jail setting, and accountable for results.

Allegations identified through grievances, inmate disciplinary procedures, third party reporting, staff reports, audits – may initially appear to be facility rule violations, but can, after initial review, be criminal violations. These need to be investigated as such, by individuals with the authority to give, for example, Miranda warnings, and coordinate with the prosecutor. Investigations into inmate suicides or cases of serious inmate self-harm must be thorough, with a goal of informing the department and CHS of changes that can be made to ensure inmate safety. This is especially true in meeting the mandates of the Prison Rape Elimination Act.

At a minimum, MDCR needs to develop a memorandum of understanding with the Miami Dade Police Department with details about how allegations are responded to, handled, coordinated, and completed. This may seem unnecessary because both

agencies are under the organizational umbrella of the Deputy County Mayor. Regardless of this organizational relationship, there are substantial issues that need to be addressed to ensure that investigations are appropriately initiated and managed.

An alternative is to appropriately cross train, cross designate MDCR employees as law enforcement officers with the same powers and responsibilities as MDPC officers.

List of Documents Reviewed (Appendix A-1)
List of Standards for TTC (Appendix A-2)
List of Individuals Interviewed (Appendix A-3)

A. Findings and Recommendations

III. A. PROTECTION FROM HARM

Consistent with constitutional standards, the MDCR Jail facilities shall provide inmates with a reasonably safe and secure environment to ensure that they are protected from harm. MDCR shall ensure that inmates are not subjected to unnecessary or excessive force by the MDCR Jail facilities' staff and are protected from violence by other inmates. 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.

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 this tour:	Compliance:	Partial Compliance: 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)			
Monitor's Recommendations:			

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: (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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
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 produced a report entitled "Inmate Bed Classification Analysis and Risk Analysis of Maximum Security Inmates" dated June 27, 2013. The County provided a 2008 report from a consultant from the National Institute of Corrections as evidence of a validation study of the system's classification instruments/processes. This report is not a validation study, and in fact identified 20 recommendations to improve the process.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Although not required by this agreement, a County jail system of this size needs to conduct a validation study every few years (2 years) to assure that the manner in which classification is done produces a safe environment for inmates and staff. Such a analysis, using data generated from MDCR examines if the instruments (forms) and process used to classification arriving inmates accurately assess their risk, and ultimately their housing. The reclassification process is also reviewed. The validation process looks at the processes associated with intake, classification and housing. Staffing is also examined to assure that resources at intake and for reclassification are appropriate and meet the system's needs. Among the data examined to complete a validation study are for example: inmate disciplinary write-ups, inmate/inmate violence, grievances, numbers of "keep separate from" inmates, and other indicators or disorder in the facilities. Looking at this data, the system can ask the questions are we appropriately classifying inmates – over or under classifying, and are inmates safe. Additionally, recent research about instruments to classify female inmates points toward the need for separate metrics so as not to over-classify females using male based data. The validation process also relies on interviews with employees regarding their observations about inmate behaviors. This description is meant to be a very brief summary of what constitutes a validation study.		

	For the purposes of this paragraph, no validation study is required. In reviewing the report provided by MDCR, which is primarily made up of charts and graphs, there is no indication that any type of critical review of the system's classification data was conducted. While reporting about the number of beds in various classification categories (e.g., minimum, medium, maximum, other) is helpful, the question really is: does the system have sufficient beds if inmates are classified correctly? And there is no analysis of whether inmates are classified correctly. No basis for such a claim exists. The report includes data regarding completed disciplinary hearings, but there is no analysis of what that means to this requirements of this paragraph. The report does conclude, however, that MDCR does not have adequate beds for disciplinary segregation. The questions regarding why that is remain to be answered. The report states that "The Risk Analysis of maximum security inmates, determined that inmates were initially classified appropriately; however, inmates identified that warranted a custody level change or housing assignment change was [sic] reclassified accordingly. Additionally, the objective risk analysis of maximum security inmates will continue to ensure inmates are assigned to the appropriate housing areas." No other information or data are provided to support this assertion. I met with the classification staff, and while dedicated to their work, they didn't have an understanding of what was needed to be able to meet the requirements of this paragraph through data collection and analysis.
Monitor's Recommendations:	1. MDCR has many talented staff who can review the research in light of this requirements of this paragraph and begin the work. I urge the County to request short-term (no cost) technical assistance from the National Institute of Corrections for the sole purpose of helping outline the <u>steps</u> needed to complete this work, including the data to be collected. NIC doesn't have the funding capability to conduct a validation study, but rather to advise on how best to accomplish the work.

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: (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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures requiring conduct of rounds.		

Steps taken by the County to Implement this paragraph:	MDCR directive DSOP: 11-020, effective date 5/21/12, Physical Sight Check Procedures, establishes the procedures for conducting rounds, including at irregular intervals.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Departmental policy is in compliance with this paragraph. I did not have sufficient time on site to examine housing unit logs, or interview inmates and employees regarding procedural compliance. I will do that during the next tour, as well as request samples of housing unit logs prior to the next tour.
Monitor's Recommendations:	None at this time.

Compliance Status this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
Steps taken by the County to Implement this paragraph:	MDCR directive DSOP: 11-020, effective date 5/21/12, Physical Sight Check Procedures states that staff will document physical sight checks on the Physical Sight Check Sheet.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The directive does not give sufficient direction about the data to be maintained, and although it implies that the Area Supervisor is to review the documentation, it is not specific enough. There is insufficient direction to supervisors about what they are to review. The directive does not prohibit the use of pre-printed rounding times. There is no mention of use of video surveillance in this order.		

Monitor's Recommendations:	Based on the review schedule for directives, amend this order to provide more specific direction and meet the elements of this paragraph.

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: (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 areas 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.		
Compliance Status this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<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.		
Steps taken by the County to Implement this paragraph:	The County indicates that the cameras in the Pre-Trial Detention Center were installed on 7/1/13.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The County provided the following schedule for installation of cameras in a letter to McCampbell dated 9/28/13: PTDC – 10B Disciplinary wing – December 31, 2013 PTDC - Kitchen – January 31, 2014 WDC Kitchen – September 30, 2014 (although this facility is now closed and holds no inmates) TTC – all inmate housing units – May 31, 2014 TGK – kitchen, intake center – May 31, 2014 Metro West Detention Center – August 31, 2014		
Monitor's Recommendations:	Provide the monitors with any updates on installation. Assure there are policies and procedures in place regarding how cameras are monitored, the response to incidents, how long digital recordings are retained, and the repair of cameras and recorders.		

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: (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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
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:	MDCR has installed a "watchman" system		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	A written directive regarding the operation, use, supervisory and management oversight of the system was not provided.		
Monitor's Recommendations:	Develop a written directive governing the use of this hardware/software. Provide the monitor with examples of reports generated by the system as well as proof of supervisory oversight.		

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: (7) Security supervisors shall conduct daily rounds on each shift in the inmate housing units, and document the results of their rounds.		
Compliance Status this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		

Measures of Compliance:	Protection from Harm: 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 III.A.1. a. (4)
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III.A.1. a. (4)
Monitor's Recommendations:	See III.A.1. a. (4)

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: (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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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:	No documentation was provided regarding compliance.		
Monitor's analysis of conditions to	See above, no documentation provided regarding compliance.		

assess compliance, verification of the County's representations, and the factual basis for finding(s)	
Monitor's Recommendations:	Develop written policies/procedures and training lesson plans to comply with the paragraph.

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: (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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
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 provided the Lesson Plans for a 4-hour training program presumably for employees who are transferring to work in the facility. The lesson plans are sparse, with topics areas listed. There is no pre-or-post testing to indicate the participant's knowledge gained, or if they gained knowledge. There is an orientation form and checklist referenced, but not attached to the lesson plan.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	• A policy and procedure requiring correctional officer training was not provided. • The lesson plans are basic, and need more detail in terms of exactly what is taught, rather than just an outline. • Some measure of knowledge gained needs to be included, a "passing" score established, and a plan for remediation if a participate fails.		
Monitor's Recommendations:	1. Develop the guiding directive requiring the training 2. Address the other measures of compliance.		

Paragraph Coordinate with Dr. Ruiz	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: (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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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. Mental Health: 1. Policies and procedures regarding training of staff assigned to special management units. 2. Lesson plans for the 8 hours of training. 3. Copies of hand-outs, slides, and videos utilized in the training 4. Copy of results of hands-on demonstration and/or pertinent drills related to management of mental health patients 5. Evidence training was held annually; evidence those working in the units attended. 6. Documentation of knowledge gained (e.g., pre and post tests) 7. Remedial training, if any.		
Steps taken by the County to Implement this paragraph:	Protection from Harm: A lesson plan has been developed for training. Mental Health: A lesson plan has been developed for training. CHS has stated it intends to provide Qualified Mental Health Professionals (QMHP) to provide adequate training for correctional staff in the identification of mental illness and its management.		
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: The lesson plan is not sufficiently detailed. Mental Health: The CIT lesson plan does not adequately outline the content of the course. This lesson plan did not include the suicide		

	prevention training curriculum topics as outlined in the Consent Agreement. No records were provided to assess the number of staff who have attended and the quality of the learning he or she achieved as a result.
Monitors' Recommendations:	Protection from Harm: Develop a more detailed lesson plan. Assure participants knowledge gained in included. Mental Health: Please implement adequate pre-service and biennial training for mental health and suicide prevention or all correctional officers. In reviewing the documentation provided, the training program is a general outline of procedures to be followed. However, the training syllabus needs to be based on the MDCR and CHS policies, or law or regulations. For officers, medical and mental health staff to be competent to administer the written policies, the training plan and specific course syllabuses needs to be consistent with those policies and include enough detail to assure management that all provisions of the policies are addressed in the required training. Mock suicide response drills and practicums are recommended. Testing post-training should be completed. This should be the format for review of the mental health and suicide prevention training. The lesson plan should include the topics covered and the assigned professional who is teaching and coordinating the course. For future reviews, please provide copies of the lesson plan content, including any hand-outs, power point, and video training that are used.

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: (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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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 produced for review "Inmate Violence Report FY 2012-2013 Second Quarter) which reports and compares data for the last two fiscal years regarding: inmate-on-inmate assaults, inmate-on-staff assaults; department-wide response to resistance (use of force); reasons for uses of force; and data for each facility. The report concludes:		

	• Inmate-on-inmate assaults increased 16% in the comparison period; • Inmate-on-staff assaults increased 37% in the comparison period; and • The number of responses to resistance (uses of force) increased 75% in the comparison period.
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 keeping the data. The trends are difficult to establish over such a short period of time. But the conclusions that the defendants reach is that all indicators are up. No other information has been provided indicating efforts to reduce these numbers.
Monitor's Recommendations:	Further examine and refine the data to determine what plan of action is needed to address the reported increases.

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:

Paragraph	III. A. 2. Security Staffing: a. Within 150 days of the Effective Date, MDCR shall conduct a comprehensive staffing analysis and plan to determine the correctional staffing and supervision levels necessary to ensure reasonable safety. Upon completion of the staffing plan and analysis, MDCR will provide its findings to the Monitor for review. The Monitor will have 30 days to raise any objections and recommend revisions to the staffing plan.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due (11/27/13)
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Completion of a comprehensive staffing analysis. 2. Review by the monitor. 3. Documentation of discussions, recommendations by the monitor regarding the comprehensive staffing analysis.		
Steps taken by the County to Implement this paragraph:	MDCR has a draft of a staffing plan.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The due date for this work was 9/27/13. The County requested, and I concurred with a 60 day extension. Due date 11/27/13.		
Monitor's Recommendations:	Complete the internal review of the draft and provide to the monitor for review.		

Paragraph Coordinate with Drs. Ruiz and Stern	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.		
Protection from Harm: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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. Ruiz and Stern; interview with medical and mental health personnel 5. Review of patient scheduling deficiencies (e.g. cancelled, rescheduled appointments). Medical Care: • Audit Step a: (Inspection) This compliance measure will be assessed by exception, i.e. any reports of failure to escort inmates to and from the medical health care unit due to custody staffing shortage. Mental Health: 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. Ruiz and Stern; interview with medical and mental health personnel 5. Review of patient scheduling deficiencies (e.g. cancelled, rescheduled appointments).		
Steps taken by the County to Implement this paragraph	Protection from Harm: See III. A. 2. a. The due date for this work was 9/27/13. The County requested, and I concurred with a 60 day extension. Due date 11/27/13. Medical Care: Not audited by the Medical Monitor during this tour. Mental Health: Although this provision was not specifically audited in terms of review of the MDCR staffing plan, interviews with staff indicated that issues with staffing and transportation of inmates to the PTDC from other facilities contributed in delays in access to care. Issues with staffing and the ability to provide adequate supervision also contribute to a policy at the		

	PTDC related to mentally ill and suicidal inmates being prohibited from recreation and showers until the treatment team meeting occurs. This will be discussed further in the mental health section of this report.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: See III. A. 2. a. Medical Care: The Medical Monitor found some examples of problems with access to care, especially among the medical grievances. However, he did not assess whether these problems stemmed from custody staffing shortages or other causes. Mental Health: Adequate staffing of correctional officers is required for escort to medical and mental health clinics and for adequate supervision of patients with SMI. This should be assessed in coordination with mental health staffing. Delays in access to care secondary to inadequate correctional staffing and delays in access to care secondary to inadequate mental health care staffing should be differentiated and analyzed accordingly. In addition, adequate correctional staffing will be reviewed and is required for the provision of showers, recreation, and access to private treatment by mental health for patients in the PTDC.
Monitors' Recommendations:	Protection from Harm: See III. A. 2. a. Medical Care: Mental Health: See III. A. 2. a and III C. 7

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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due 11/27/13
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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:	See III. A. 2. a.		
Monitor's analysis of conditions to assess compliance, verification of	See III. A. 2. a. The due date for this work was 9/27/13. The County requested, and I concurred with a 60 day extension. Due date		

the County's representations, and the factual basis for finding(s)	11/27/13.
Monitor's Recommendations:	See III. A. 2. a.

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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due (3/26/14)
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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:	See III. A. 2. a.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III. A. 2. a. Not yet due; due 3/26/14		
Monitor's Recommendations:	See III. A. 2. a.		

Paragraph Coordinate with Drs. Ruiz and Stern	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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status	Compliance:	Partial Compliance:	Non-Compliance: Not audited

this tour:			
Unresolved/partially resolved issues from previous tour:	NA		
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 based on self-audit. Medical Care: • Audit Step a: (Inspection) Medical staff receive appropriate PREA training. • Audit Step b: (Chart Review) Medical care delivered pursuant to a possible sexual assault is clinically appropriate and consistent with PREA. Mental Health: 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 based on self-audit.		
Steps taken by the County to Implement this paragraph:	Protection from Harm: MDCR has developed policy 15-008, Inmate Sexual Abuse/Abuse Prevention, effective 8/6/12. This is the first step toward system-wide changes needed to address the DOJ PREA standards. The MDCR is also using a newly updated inmate orientation video, using peer-educators, to inform inmates of their rights and how to report allegations of abuse. Medical Care: Not audited by the Medical Monitor during this visit. Mental Health: This provision was not specifically evaluated by the Mental Health Monitor during this visit.		
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Considerable work remains, as it does for most jails in the country, to achieve PREA compliance. Medical Care: None Mental Health: Patients with a history of severe mental illness, developmental delay and inmates with a history of sexual charges with children will be at increased risk for sexual assault within the Jail. Vulnerable individuals should be placed in separate and therapeutic housing to ensure safety.		
Monitors' Recommendations:	Protection from Harm:		

	If MDCR has not already do so, I recommend completion of the PREA Jail Toolkit (see measures of compliance) that allows the agency to assess current compliance, and from that generates a work plan to achieve compliance. Medical Care: None Mental Health: None at this time.

Paragraph	4. Incidents and Referrals a. MDCR shall ensure that appropriate managers have knowledge of critical incidents in the Jail to take action 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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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. Mental Health: 1. Review of suicide attempts 2. Review of deaths in all inmates with severe mental illness (SMI)		
Steps taken by the County to Implement this paragraph:	MDCR DSOPO 10-003, "Major Incident Reporting Procedures", effective 6/11/12 provide direction regarding reporting and recording major incidents within MDCR.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	DSOP 10-003 does not have sufficient detail and direction to meet the mandates of this paragraph. The policy is too broad, lacking in specificity. There are no time lines provided for notifications. The procedures provide that the employee union is notified before the MCDR chain-of-command. One example of the need for more specificity in the procedure: under section E. Documentation. "2. All MDCR staff		

	involved, other than the originator of the Incident Report will submit a completed Supplementary Incident Report detailing their involvement in the incident;" but there is no direction as to who are the "staff involved." Does that mean those working in the area of the incident; those who responded to an incident? Accountability will be increased if there is more detail in terms of the roles and responsibilities of those involved.
Monitor's Recommendations:	Review the requirements of the paragraph and conform the order. Provide more specific direction.

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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
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)	MDCR DSOP 10-003, "Major Incident Reporting Procedures", effective 6/11/12, does not include the mandates of this paragraph. Due 10/27/13		
Monitor's Recommendations:	Review the requirements of the paragraph and conform the order.		

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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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:	MDCR policy 10-003, Major Incident Reporting Procedures, effective date 6/11/12 provides reporting procedures.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The policy, section III. E. Documentation, does not include specific reference to the items note above. Due 10/27/13		
Monitor's Recommendations:	Revise the policy to address the requirements of the paragraph. It is not sufficient to have the form, for example, include these elements with policy direction contained in an order.		

	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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not completely audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not completely audited
Unresolved/partially resolved issues from previous tour:	NA		

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. Medical Care: • Audit Step a: (Inspection) Medical policies and procedures address the screening of medical grievances for allegations of staff misconduct and their referral for investigation when appropriate. • Audit Step b: (Inspection) When interviewed, CHS leaders report screening medical incident reports and grievances for allegations of staff misconduct and referring for investigation when indicated by policy. • Audit Step c: (Inspection) Medical grievances and incident reports which contain allegation so of staff misconduct are referred for investigation. 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:	Protection from Harm: No information was provided regarding compliance Medical Care: Not completely audited by the Medical Monitor during this tour. Mental Health: CHS policy J-A-11 addresses grievances.
Monitors' analysis of conditions to assess compliance, verification of	Protection from harm: No documentation was provided for review regarding compliance Due 10/27/13

the County's representations, and the factual basis for finding(s)	Medical Care: CHS policy (J-A-11) regarding the grievance process does not yet address this issue. Mental Health: The policy addressing grievances does not address triage for incident reports.
Monitors' Recommendations:	Protection from Harm: Develop written policy and procedure to meet the requirements of this paragraph. Medical Care: CHS should incorporate into its grievance policy a process for screening and addressing medical grievances related to possible staff misconduct as described in this paragraph. Mental Health: The Risk Management and Quality Improvement Committee for CHS should systematically review and analyze serious incident reports, use of force reports, and inmate grievances for allegations of staff misconduct, particularly as they relate to inmates with mental illness, developmental delay and cognitive disorder secondary to profound substance misuse. This should include an assessment of the number of grievances related to mental health given the population and make-up of the institution.

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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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:	MDCR provided for review: • CRIPA Related Training outline for 7/1/13 – 6/30/17 indicating that incident report writing will be conducted in the first year (7/1/13 – 6/30/14) in a 16 hour block that includes suicide prevention, legal aspects of use of force and response to resistance;		

	• Training Bureau's Plan of Action (July 2013) to address DOJ requirements; • MDCR's 2013 Training Plan; • An overview schedule for new correctional officer program; • MDCR Lateral Officer Curriculum • Lesson plans: - Major Incident Reporting Procedures
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The lesson plan, Major Incident Reporting Procedures adequately covers the elements of the policy. What is missing is the actual instructions and practical exercises on *writing a report.*
Monitor's Recommendations:	Amend the lesson plans to assure that the employee not only knows the policy, but is given practical exercises in writing report.

Paragraph Coordinate with Drs. Ruiz and Stern	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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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. Medical Care: • Audit Step a: (Inspection) Initial and on-going officer training curricula include instructions to immediately inform a member of the Qualified Medical Staff when a serious medical need of an inmate arises. Mental Health: See Protection from Harm		
Steps taken by the County to	Protection from Harm:		

Implement this paragraph:	DSOP 14-001 "Inmate Injury/Illness-Request for Health Care", effective 6/1/07 provides that employees "immediately report to CHS personnel and the shift Supervisor/Shift Commander" any emergency or serious inmate injury/illness. Medical Care: Not audited. Mental Health: Specific training as to this provision was not audited. The policy was reviewed.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Lesson plans were not provided Medical Care: Not audited by the Medical Monitor during this tour. Mental Health: MDCR DSOP 12-005 states: It is imperative that good judgment be exercised when dealing with mentally ill inmates. All staff assigned to supervise mentally ill inmates, (suicidal and non-suicidal as determined by IMP/mental health staff), must have previously received in-service training or specialized training in the management and supervision of inmates with conditions of mental illness; e.g., crisis intervention, human behavior, etc. The hours of training and the training content shall be in accordance with current requirements, standards and guidelines. Training plans that were submitted related to the identification of severe mental illness, suicide prevention, and its management were outlines of training topics. The actual training materials, content, sign-in sheets and testing material were not provided.
Monitor's Recommendations:	Protection from Harm: Provide lesson plans for review and/or develop update lesson plans. Medical Care: None Mental Health: For future reviews, please provide actual training materials, content, sign-in sheets and testing material. In addition, I will examine incident reports for evidence of prompt identification and referral of patients with SMI to QMHPs.

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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
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 policy 11-041 "Response to Resistance", effective 11/30/12 outlines procedures for use of force.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The directive includes all required elements of this paragraph, as the primary proofs of compliance. No use of force incident reports were provided for review.		
Monitor's Recommendations:	Prior to the next tour, provide incident reports to fully assess compliance with this paragraph.		

Paragraph <u>Coordinate with Dr. Ruiz</u>	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

<table>
<tr><td></td><td colspan="3">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 this tour:</td><td>Compliance:</td><td>Partial Compliance: July 2013</td><td>Non-Compliance:</td></tr>
<tr><td>Mental Health: Compliance Status this tour:</td><td>Compliance:</td><td>Partial Compliance: July 2013</td><td>Non-Compliance:</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="3">NA</td></tr>
<tr><td>Measures of Compliance:</td><td colspan="3"><u>Protection from Harm:</u>
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.

<u>Mental Health:</u>
1. Policy regarding recognizing and supervising inmates with mental illness; use of restraints; monitoring those in restraints
2. Corresponding medical and mental health policies/procedures.</td></tr>
</table>

	3. Lesson plans and training provided. 4. Review of uses of restraints; required logs. 5. Review of use of seclusion. 6. Maintenance of data regarding uses of force involving inmates on the mental health caseload, by facility.
Steps taken by the County to Implement this paragraph:	Protection from Harm: MDCR policy 12-005, Recognizing and Supervising Mentally Ill Inmates, includes references to uses of restraints. Mental Health: DSOP 12-005 states: The condition of the inmate's limbs shall be routinely and frequently monitored at intervals not to exceed 15 minutes by sworn staff and 30 minutes by IMP/mental health staff to assure proper blood circulation. The IMP/mental health staff will ensure each restraint is loosened (one at a time) every 2 hours and "range-of-motion" exercises are provided to each limb for at least 10 minutes. This process is a continuation of a planned event and should also be captured on video. This may be achieved via use of a tripod placed safely in the cell to capture the event in a less staff intensive manner.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Regarding, i, above – the policy states "Restraints shall only be used following written approval by IMP/mental health staff when required for purposes other than transportation purposes." There is no reference to injectable drugs. Regarding, ii, above – the policy does not include response to an emergency to protect others from serious harm, and the statement regarding "only after the Jail attempts or rules out less-intrusive and non-physical interventions." Regarding 2., above, the policy needs to track the language regarding checks by trained custodial staff. The directive need to clearly state if custodial staff are permitted, or not, to order an inmate into restraints absent a medical directive. Mental Health: MDCR policy states that the IMP/mental health staff will check the inmate in restraint every 30 minutes; this is not in keeping with the Agreement, which requires that inmates are checked by medical staff every 15 minutes. MDCR policy requires that "Placement of an inmate in four-point restraints should always be used as a last resort to deter an inmate from imminent serious harm. Placement into four-point restraints will be determined by IMP mental health staff, who shall provide a Health Services Incident Addendum and a Mental Health/Medical Relocation form for the procedure. The initial order by the mental health professional may be verbal, but must be followed by a written order within an hour of the initial verbal order." It does not specifically state that the medical record should be reviewed for contra-indications to restraint. CHS policy J-I-01 outlines the use of seclusion and restraint. It states that inmates will be monitored every 15 minutes by qualified medical staff and outlines the requisite documentation for placing patients in restraint.
Monitors' Recommendations:	Protection from harm: Revise the order to include the missing language. Assure that the CHS directives as consistent with the requirements.

	Mental Health: MDCR should revise its policy to remove inconsistencies with the Agreement and the CHS policy. Adequate training regarding proper use of seclusion and restraint is recommended for all medical, mental health and custody staff. A useful document in terms of the differentiation between custody restraints and medical restraint is the APA Position Statement on Segregating Patients with Mental Illness, December 2012.

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:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding reporting of uses of force; definitions; reporting formats; time requirements. 2. Review of incident reports. 3. Review of investigations into uses of force. 4. Review of remedial/corrective actions, if any.		
Steps taken by the County to Implement this paragraph:	MDCR policy 11-041 "Response to Resistance", effective 11/30/12 outlines procedures for use of force.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Written Directive 11-003, Incident Report Procedures provides in section III. I. "Incident reports should be prepared immediately after an incident in order to be as accurate as possible; however, it shall be completed and approved by a Shift Supervisor/Commander prior to being relieved from duty." Written directive 11-041 Response to Resistance provides in section XI. A. "2. Staff who initiate and are involved in a RTR (Response to Resistance) event shall be responsible for the following: . . . b. Completing a RTR MDCR Incident Report detailing the event/incident, prior to the end of his/her shift."		
Monitor's Recommendations:	Amend the order to include the specific language of 24 hours. Suggest changing "should" to "shall" in 11-003, section III. Assure lesson plans match requirements.		

Paragraph Coordinate with Drs. Ruiz and Stern	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.		
Protection from Harm: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force reports; specifications for reporting. 1. Review of incident reports. 2. Review of investigations. 3. Review of inmate disciplinary reports. 4. Review of lesson plans. 5. Review of Medical Care/mental health records regarding injuries, including any required off-site hospitalizations. 6. Review of sample of staff workers' compensation claim relating to uses of force, inmate/inmate altercations. 7. Remedial, corrective action if necessary. 8. Review of digitally recorded incidents. 9. Review of MDCR Inmate Violence Report <u>Medical Care:</u> • Audit Step a: (Chart Review) For each MDCR use of force report, the date and time of reported medical attention correlates with a similarly dated/timed entry in the inmates medical record. <u>Mental Health:</u> See Protection from Harm		
Steps taken by the County to Implement this paragraph:	Protection from harm: MDCR policy 11-041 "Response to Resistance", effective 11/30/12 outlines procedures for use of force. MDCR policy 10-003 "Major Incident Reporting Procedures, effective 6/11/12, provide direction for reporting major events/incidents. <u>Medical Care:</u> Not audited by Medical Monitor this tour.		

	Mental Health: The County provided a copy of the MDCR Inmate Violence Report for Quarter 2, 2012-2013. I did not review specific use of force reports for patients with mental illness that required restraint or other modalities of control.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Neither directive includes the language in this paragraph. Additionally, neither lesson plan associated with these directives includes on the elements of this paragraph. Medical Care: Not audited Mental Health: The MDCR Inmate Violence Report for Quarter 2, 2012-2013 stated The number of responses to resistance during the first two quarters of this year increased by 75% (76) when compared to the same period last year. The number of inmate-on-staff assaults during the first two quarters of this year increased by 371% (26) when compared to the same period last year. Twenty-one percent (21%) of the time, custody response included 4-point restraint and / or the restraint chair. The report did not identify what percentage of the use of force cases involved patients with a history of mental illness or may have been delirious secondary to detoxification / seizure.
Monitors' Recommendations:	Protection from Harm: Amend one or both orders to include the language from this paragraph. Amend/update relevant lesson plans. Assure any training for investigators covers this material. Medical Care: None Mental Health: Please see Protection from Harm.

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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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:	MDCR policy 11-041 "Response to Resistance", effective 11/30/12 outlines procedures for use of force.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The directive conforms to the language in the paragraph. I wasn't provided any use of force packets to review to assess compliance. Will do that on the next tour.
Monitor's Recommendations:	None at this time. I will review reports on 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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
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:	MDCR policy 11-041 "Response to Resistance", effective 11/30/12 outlines procedures for use of force.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The directive conforms to the language in the paragraph. I wasn't provided any use of force packets to review to assess compliance. Will do that on the next tour.		
Monitor's Recommendations:	None at this time. I will review reports on next tour.		

Paragraph Coordinate with Dr. Stern and Dr. Ruiz	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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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. Medical Care: • [No medical audit step unless questions/issues are referred by the Security Monitor.] Mental Health: See Protection from Harm I will review use of force reports as they relate to patients with SMI.		
Steps taken by the County to Implement this paragraph:	Protection from Harm: MDCR policy 11-041 "Response to Resistance", effective 11/30/12 outlines procedures for use of force. Medical Care: Not audited by the Medical Monitor during this visit		
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: The directive conforms to the language in the paragraph. I wasn't provided any use of force packets to review to assess compliance. Will do that on the next tour. Medical Care:		

	No issues were referred to the Medical Monitor by the Security Monitor during this visit. Mental Health: As indicated above, the MDCR Violence Report identified that twenty-one percent (21%) of the time, custody response included 4-point restraint and / or the restraint chair. The report did not identify what percentage of the use of force cases involved patients with a history of mental illness or may have been delirious secondary to detoxification / seizure. Six cases were reported to have involved a use of force in order to 'prevent suicide.' It did not identify whether medication may have been offered to the patient on a voluntary basis or if adequate mental health assessment and treatment was provided before the incident.
Monitors' Recommendations:	Protection from Harm: None at this time. I will review reports on next tour Medical Care: None Mental Health: None at this time.

Paragraph Coordinate with Dr. Stern and Dr. Ruiz	III. A. 5. c. (6) MDCR shall maintain its criteria to identify use of force incidents that warrant a referral to IA for investigation. This 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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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. Medical Care: • (duplicate) CONSENT044 (IIIB3c) Audit Step b: (Inspection) When interviewed, nurses and practitioners on staff report that when they evaluate patients with any injury, they always consider whether the injury might be the result of staff-on-inmate abuse, and if so, (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. • Audit Step a: (Chart Review) Medical records of inmates subject to use of force where the force may be excessive, show evidence of referral (with patient permission) to jail authorities. Mental Health: See Protection from Harm Use of force reports as they relate to inmate with SMI and evidence of their adequate treatment both before and after the incident will be reviewed.
Steps taken by the County to Implement this paragraph:	Protection from Harm: MDCR policy 11-041 "Response to Resistance", effective 11/30/12 outlines procedures for use of force. Medical Care: Mental Health: See Protection from Harm
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: The language of this paragraph is not included in the directive. Medical Care: Not audited by the Medical Monitor during this visit Mental Health: One of the death cases (which the monitors acknowledge predates the effective date of the consent agreement) was significant for the fact that the patient had a history of depression with treatment (both an anti-depressant and an anti-psychotic). The patient was subsequently involved in an 'altercation with his peer' and died as a result of a subarachnoid hemorrhage. This death was labeled a Cat 3, which indicated it required more focused review to identify opportunities for improvement in systems and processes; that review and/or its documentation did not occur.
Monitor's Recommendations:	Protection from Harm: Amend the order to specify the duties required in this paragraph.

	Medical Care: None Mental Health: It is recommended that all inmate deaths, particularly those with evidence of improvement in systems and processes be reviewed and documented in a timely manner. These reviews should include a corrective action plan and identify accountable systems and persons for implementation.

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 this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding reporting, recording, photographing use of force incidents. 1. Review of job descriptions/post orders. 2. Review of training for those who may/will be photographers. 3. Review of incident reports; use of force packets. 4. Review of investigations; critique of utility of photographs. 5. Review of remedial or corrective action plans, if any. 6. Interview with IAB staff.		
Steps taken by the County to Implement this paragraph:	MDCR policy 11-041 "Response to Resistance", effective 11/30/12 outlines procedures for use of force.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The directive conforms to the language in the paragraph. I wasn't provided any use of force packets to review to assess compliance. Will do that on the next tour.		
Monitor's Recommendations:	None at this time. I will review reports on next tour		

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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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:	MDCR policy 11-041 "Response to Resistance", effective 11/30/12 outlines procedures for use of force.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The language of this paragraph is not included in the directive. Due 10/27/13		
Monitor's Recommendations:	Amend the order to specify the duties required in this paragraph. Assure that post orders are updated. Assure training is updated.		

Paragraph See also PREA policies/procedures.	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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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 policy 11-041 "Response to Resistance", effective 11/30/12 outlines procedures for use of force.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Neither the Response to Resistance directive, nor the Standard Operating Procedures 13-001 for SIAB include this language. Due 10/27/13
Monitor's Recommendations:	Determine the most appropriate directive in which to insert this language. Amend training lesson plans as required.

Paragraph Coordination with Dr. Stern	III.A.5.c. (10) The Jail will ensure that inmates receive any required medical care following a use of force.		
Compliance Status this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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. Medical Care: • (duplicate) CONSENT043 (IIIB3b) Audit Step a: (Chart Review) Detainees subjected to Use of Force are evaluated immediately afterwards: a) documentation reflects the nature of the force and any patient symptoms, b) evaluation is conducted by, or under the direct supervision of, an RN or practitioner, c) the content of the evaluation is clinically appropriate, including evaluation of reasonably possible injuries based on the nature of the force, symptoms, or findings.		
Steps taken by the County to Implement this paragraph:	Protection from Harm: MDCR policy 11-041 "Response to Resistance", effective 11/30/12 outlines procedures for use of force. Medical Care: Not audited by Medical Monitor during this tour.		

Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: The directive conforms to the language in the paragraph. I wasn't provided any use of force packets to review to assess compliance. Will do that on the next tour. A joint review of CHS files alongside Dr. Stern is also needed to assure compliance. Medical Care: Not audited by the Medical Monitor during this visit
Monitors' Recommendations:	Protection from Harm: Review of compliance via reports and medical files will be undertaken during the next tour. Medical Care: None

Paragraph Coordination with Dr. Stern	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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Unresolved/partially resolved issues from previous tour:	NA		
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. Medical Care: • [No medical audit step unless questions/issues are referred by the Security Monitor.]		
Steps taken by the County to Implement this paragraph:	Protection from Harm: No documentation of compliance provided. Medical Care: Not audited by the Medical Monitor this tour.		
Monitor's analysis of conditions to assess compliance, verification of	Protection from Harm: No information provided.		

the County's representations, and the factual basis for finding(s)	Medical Care: No issues were referred to the Medical Monitor by the Security Monitor during this visit.
Monitor's Recommendations:	Protection from Harm: Develop policy and procedure regarding the requirements of this paragraph. Medical Care: None.

Paragraph Coordinate with Drs. Ruiz and Stern	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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
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. Medical Care: [No medical audit step unless questions/issues are referred by the Security Monitor.] Mental Health: See Protection from Harm. Trends as they relate to use of force involving patients with SMI and/or in the process of detoxification will be reviewed.		
Steps taken by the County to Implement this paragraph:	Protection from Harm: *See* III.A.5.c. (11) Medical Care: Not applicable. Mental Health:		

	See Protection from Harm
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: See III.A.5.c. (11) Medical Care: No issues were referred to the Medical Monitor by the Security Monitor during this visit. Mental Health: As indicated above, the MDCR Violence Report identified that twenty-one percent (21%) of the time, custody response included 4-point restraint and / or the restraint chair. The report did not identify what percentage of the use of force cases involved patients with a history of mental illness or may have been delirious secondary to detoxification / seizure. Six cases were reported to have involved a use of force in order to 'prevent suicide.' It did not identify whether medication may have been offered to the patient on a voluntary basis or if adequate mental health assessment and treatment was provided prior to the incident.
Monitor's Recommendations:	Protection from Harm: See III.A.5.c (11) Medical Care: None Mental Health: Analysis of trends and issues with use of force during Mental Health Review Committee should identify and implement opportunities for improvement related to the treatment of patients with SMI. This should include but is not limited to timely identification of suicide risk, delirium related to detoxification, and adequate treatment to address /prevent acting out related to mood and psychotic disorders.

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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour	NA		
Measures of Compliance:	Protection from Harm: 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:	No documentation was provided to address this paragraph
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Due 10/27/13
Monitor's Recommendations:	Develop policies and procedures for compliance. Develop/update lesson plans

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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
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:	See III.A.5.c. (11)		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III.A.5.c. (11) Due 10/27/13		
Monitor's Recommendations:	*See* III.A.5.c. (11)		

Paragraph	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.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/19/2103	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding training. 2. 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. 3. Training schedules. 4. Documentation of provision of updates to supervisors; sign-offs, etc. 5. Reports of random interviews. 6. Observation and interviews. 7. Report noted in III.A.5.c.(12)		
Steps taken by the County to Implement this paragraph:	Lesson plans have been developed.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The lesson plans are not in sufficient enough detail for such an important topic. It should be clearer about what was taught, less on an outline format.		
Monitor's Recommendations:	Develop performance based lesson plans. Insure more detail in the lesson plans.		

Paragraph Coordinate with Drs. Ruiz and Stern	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.		
Protection from harm: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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. <u>Medical Care:</u> Not audited by the Medical Monitor during this visit.		

	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:	No documentation provided.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Due 10/27/13
Monitor's Recommendations:	Develop written policy/procedure to track this language and assure compliance.

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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
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 has developed a draft policy, DSOP 4-017, "Early Warning System".
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The draft is a good start; In developing the policy, MDCR should assure that the specific language of the paragraph is incorporated.
Monitor's Recommendations:	Proceed with finalizing the draft policy and implement. Train supervisors, collective bargaining units, staff regarding the early warning system.

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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
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:	See III.A.6.a.1-5		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III.A.6.a.1-5		
Monitor's Recommendations:	See III.A.6.a.1-5		

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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
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:	See III.A.6.a.1-5		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III.A.6.a.1-5 Due 10/27/13		
Monitor's Recommendations:	See III.A.6.a.1-5		

Paragraph Coordinate with Drs. Ruiz and Stern	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	Compliance:	Partial Compliance: July 2013	Non-Compliance:

Status this tour:			
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not completely audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Unresolved/partially resolved issues from previous tour:	NA		
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: • Audit Step a: (Inspection) The content of medical grievance replies is responsive and meaningful. As provided for in CHS Policy J-A-11, when appropriate, CHS staff meet with patients to discuss their grievances. • Audit Step b: (Inspection) Medical and mental health grievances are responded to in writing within 20 days. • Audit Step c: (Inspection) Remedies to medical grievances are implemented. • Audit Step d: (Inspection) There is a system in place for inmates to file medical grievances without the intervention of an officer. • Audit Step e: (Inspection) When interviewed, with occasional exception, inmates report that they can file a medical grievance without the intervention of an officer. • Audit Step f: (Inspection) Review of medical and mental health grievances alleging excessive use of force shows that they are handled immediately and appropriately • Audit Step g: (Inspection) CHS staff review medical grievances on a quarterly basis to identify trends and systemic areas of concern and provide these to the Medical Monitor. • (duplicate) CONSENT018/IIIA3a(4) Audit Step b: (Inspection) Review of emergency medical grievances shows that they are handled immediately and appropriately. Mental Health: See Protection from Harm and Medical Care		

Steps taken by the County to Implement this paragraph:	Protection from Harm: MDCR DSOP 15-001 "Inmate Complaint/Grievance Process", effective 11/30/12 guides the inmate grievance process. MDCR has an undated Inmate Handbook that includes basic information about the grievance process. Medical Care: Not completely audited by the Medical Monitor during this tour. Mental Health: Specific to mental health, an average of two grievances were filed per site. CHS Policy regarding grievances is outlined in J-A-11.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: I placed this requirement in partial compliance only because the MDCR has a policy. But, essentially all of the elements of this order need to be addressed in the MDCR policy/procedures. Taking each one of the 6 requirements and including and clarifying the policy is needed. Here are specifics, not meant to be inclusive but illustrative.. 1. Allow inmates to get a grievance form without asking an employee. 2. Provide grievance boxes (or some other process) in housing units and other locations (recreation, clinic, etc.) that allow an inmate to file a confidential grievance. 3. The grievance process must be amended to conform with the DOJ PREA standards (no time limits to file a grievance regarding sexual abuse) 4. Assure the language contained in the Inmate Handbook matches the policy. 5. Define "offense" and "frivolous" in the policy. 6. Revise how investigations into grievance alleging employee misconduct are handled, requiring a management level review prior to determining how the grievance will be handled. 7. Assure that CHS' policies and procedures regarding grievance align with the MDCR policy. 8. Provide assistance for LEP, mentally ill and developmentally disabled inmates to file a grievance. 9. Provide for management oversight and data collection. Medical Care: As described in the Medical Monitor's introduction to this report, over 60 recent medical grievances were reviewed. Several grievance replies were illegible, unclear, unresponsive to the complaint, misclassified as unsubstantiated when the content of the reply suggested otherwise, generated without the benefit of face-to-face discussion with the patient when such discussion would have been helpful, or led to further health care but with longer than appropriate delays. No emergency medical grievances or medical grievances alleging excessive use of force were found. Mental Health: The number of grievances specific to mental health and issues regarding its delivery is unusually low given the size of MDCR. There is no evidence of an effective system to triage mental health requests within 24 hours of submission and

	no priority review for inmate grievances identified as emergency medical or mental health care was identified. CHS policy does not address emergency grievances or prioritize grievances that are submitted following use of force.
Monitors' Recommendations:	<u>Protection from Harm:</u> Revise procedures to comply with all elements of the requirements. <u>Medical Care:</u> 1. When appropriate (e.g. to clearly understand the grievance or more clearly explain a resolution) during adjudication of medical grievances, grievants should be seen in person by CHS staff. 2. Grievance responses should be written in clear, legible English, devoid of jargon. 3. Grievance responses should address the issue at hand, recognize if something did not go as planned. Grievances should be substantiated when the complaint is legitimate. 4. When a grievance leads to the need for further health care, that health care should be provided in a timely manner. 5.Grievances which suggest possible system problems should be subjected to management review (e.g. quality improvement process) for further analysis and possible remediation. <u>Mental Health:</u> The number of grievances specific to mental health and issues regarding its delivery is unusually low given the size of MDCR. Policy should be revised to reflect the necessity of proper access to a grievance system – including for patients with developmental delay or SMI- and a triage system for the grievances should be implemented. The Mental Health Review Committee and Quality Improvement Committee should explore issues why inmates with SMI may not be filing grievances or getting their needs met. These patients are frequently at risk and are unable to express their needs.

Paragraph <u>Coordinate with Drs. Ruiz and Stern, and Grenawitzke</u>	III. D. Self Audits 1. Self Audits MDCR shall undertake measures on its own initiative to address inmates' constitutional rights or the risk of constitutional violations. The Agreement is designed to encourage MDCR Jail facilities 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. a. On at least a quarterly basis, command staff shall review data concerning inmate safety and security to identify and address potential patterns or trends resulting in harm to inmates in the areas of supervision, staffing, incident reporting, referrals, investigations, classification, and grievances. The review shall include the following information: (1) documented or known injuries requiring more than basic first aid; (2) injuries involving fractures or head trauma; (3) injuries of suspicious nature (including black eyes, injuries to the mouth, injuries to the genitals, etc.); (4) injuries that require treatment at outside hospitals; (5) self-injurious behavior, including suicide and suicide attempts;

	(6) inmate assaults; an (7) allegations of employee negligence or misconduct. b. MDCR shall develop and implement corrective action plans within 60 days of each quarterly review, including changes to policy and changes to and additional training.		
Protection from Harm: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Fire and Life Safety: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding self-audits. 2. Self-monitoring reports. 3. Corrective action plans, if any. 4. Evidence of implementation of corrective action plans, if any. <u>Fire and Life Safety:</u> 1. Development and implementation of effective and consistent policies for regular audits of all facilities housing inmates. It should include audits by designated staff trained in auditing techniques and the polices within each facility and from MDCR for all fire and life safety provisions as well as cleanliness, functioning of electrical and plumbing fixtures etc. 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. Medical Care: Not audited by medical Monitor during this visit. <u>Mental Health:</u> See Protection from Harm Review of minutes from Mental Health Review Committee and Quality Assurance Committee, including adequate and timely analysis of the quarterly MDCR Violence Report.		
Steps taken by the County to Implement this paragraph:	<u>Protection from Harm:</u> No information was provided indicating the County's current compliance status.		

	Fire and Life Safety: I saw no evidence of a consistent internal audit program or evidence of training for officers charged with conducting internal audits. Medical Care: Not audited by the medical Monitor during this visit. Mental Health: CHS has hired a Director of Quality Assurance and an Associate Director. Reviews regarding mental health care for not begun to date.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: No documentation regarding compliance was provided. Fire and Life Safety: No evidence of compliance during this tour Medical Care: Not audited by the Medical Monitor during this tour. Mental Health: CHS has hired a Director of Quality Assurance and an Associate Director. Reviews regarding mental health care for not begun to date.
Monitors' Recommendations:	Protection from Harm: MDCR needs to develop written policy and procedure addressing how they are going to comply with this requirement. Fire and Life Safety: MDCR need to develop and implement a formal documented procedure and schedule for internal audits, corrective actions for non-conformances and necessary follow-up enforcement. Develop a training plan for officers charged with conducting internal audits. Medical Care: None. Mental Health: I strongly recommend that both CHS and MDCR comprehensively review each of the inmate deaths and each adverse / serious event in a systematic and organized fashion. A qualitative review should include an examination of the cause of death, contributing factors, and an analysis of what may have been preventable or what may be improved. Trends should be analyzed and systemic issues identified for improvement.

Paragraph Coordinate with Drs. Ruiz and Stern, and Grenawitzke	III. 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.		
Protection from Harm: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not Yet Due (10/27/13)
Fire and Life Safety: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not Yet Due(10/27/13)
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not Yet Due(10/27/13)
Mental Health: Compliance Status	Compliance:	Partial Compliance:	Non-Compliance: Not Yet Due(10/27/13)

this tour:			
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 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. Fire and Life Safety: Same as the measures of compliance as Protection from Harm Medical Care: • (duplicate) CONSENT117 (IIID2a(6)) Audit Step a: (Inspection) The Medical Monitor receives bi-annual reports of inmate injuries, medical emergencies and in-custody deaths. [NB: For the purpose of this report, MDCR should include deaths which occur outside the MDCR facility (e.g. hospital) and regardless of whether or not the inmate was in custody, if the death resulted from a health status/condition that existed while the inmate was at MDCR. Mental Health: See Protection from Harm		
Steps taken by the County to Implement this paragraph:	Protection from Harm: No information was provided indicating the County's current compliance status. Fire and Life Safety: No information provided indicating compliance status. Medical Care: Not yet due. Mental Health: Bi-annual reports related to medical, mental health and suicide prevention have not started. A medical and mental health-staffing plan is pending.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: No documentation regarding compliance was provided. Fire and Life Safety: No information provided indicating compliance. Medical Care:		

	Not audited by the Medical Monitor this tour. Mental Health: Inmate deaths that were reviewed for the period July 2012 through April 2013 are concerning. Five of the eleven inmate mortality reviews indicated that patient had either mental illness and/or substance misuse issues. Another four out of fifteen persons were transferred to the hospital for seizure. No corrective action plan or analysis of these events was included. Reportable incidents should include severe adverse medical events involving patients with mental health issues and substance use issues.
Monitor's Recommendations:	Protection from Harm: MDCR needs to develop written policy and procedure addressing how they are going to comply with this requirement. Fire and Life Safety: See recommendation as Protection from Harm Medical Care: Medical Care: None. Mental Health: Reportable incidents should include severe adverse medical events involving patients with mental health issues and substance use issues. It is imperative that the County tracks these issues, analyze systemic problems and implement plans to correct them.

Paragraph Coordinate with Drs. Ruiz and Stern, and Grenawitzke	**IV. COMPLIANCE AND QUALITY** IMPROVEMENT 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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due (10/27/13)
Fire and Life Safety: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due (10/27/13)
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due (10/27/13)
Mental Health: Compliance Status	Compliance:	Partial Compliance:	Non-Compliance: Not yet due (10/27/13)

this tour:			
Unresolved/partially resolved issues from previous tour:	NA		
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. Medical Care: • (duplicate) CONSENT119 (IV.A) Audit Step a0: (Other) This compliance measure will be assessed by exception, i.e. failure to meet any of the 3 requirements below as they pertain to any other provision of the Consent Agreement. a) Develop/revise operational documents to implement the Consent Agreement, b) Provide initial and in-service training to relevant jail staff with respect to new/revised policies and procedures, c) Send new policies and procedures to Medical Monitor for approval. Mental Health: See Protection from Harm		
Steps taken by the County to Implement this paragraph:	Protection from Harm: See all above descriptions of MDCR's activities in support of compliance. Fire and Life Safety: Same as above. Medical Care: Not audited by the Medical Monitor during this tour.		

	Mental Health: CHS has hired Rachel Rodriguez, RN, MSN, LHRM as Associate Director of Quality Assurance. Together with Kevin Andrews, Vice President of Quality and Patient Safety and Bill McKeon, new interim Director of Health Services, CHS has reported plans to revise policy, implement training, and track continuous quality improvement.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: See above all analysis of MDCR's activities in support of compliance. Fire and Life Safety: Same as above Medical Care: Not audited by the Medical Monitor during this tour. Mental Health: Same as above
Monitor's Recommendations:	See all recommendations regarding MDCR's activities in support of compliance.

Paragraph Coordinate with Drs. Ruiz and Stern, and Grenawitzke	**IV.** COMPLIANCE AND **QUALITY** IMPROVEMENT 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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Fire and Life Safety: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:	NA		
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 Medical Care: • (duplicate) CONSENT120 (IV.B) Audit Step a: (Inspection) CDCR has policies and procedures governing its quality improvement process (described in CONSENT110/IIID1b (Audit Step a) and CONSENT110/IIID1c (Audit Step a). • (duplicate) CONSENT110 (IIID1b) Audit Step a: (Inspection) Review of appropriate documents (e.g. meeting minutes) reveal that at least quarterly CHS staff review data regarding medical care to identify potentially harmful patterns or trends. Such review will include not only the active cause of the patterns or trends, but also the underlying (or root) cause(s). • (duplicate) CONSENT111 (IIID1c) Audit Step a: (Inspection) Review of appropriate documents reveals that within 30 days of quarterly reviews, MDCR staff have developed and implemented corrective action plans addressing potentially harmful patterns or trends in medical care. The corrective action plans address the active and underlying (or root) cause(s) in a sustainable manner (e.g. changes to policy, procedures, job descriptions, training curricula.) Mental Health: See Protection from Harm
Steps taken by the County to Implement this paragraph:	Protection from Harm: The County's response to the draft report presents their view that under IV. Compliance and Quality Improvement, they have 180 days to be in compliance with A-D. I don't read the Settlement Agreement as such; with the 180 days only referenced in A., not B-D. Fire and Life Safety: No information provided to document evidence of compliance. Medical Care: See Consent 120 (IV.B) Consent 110 (IIID1b), Consent 110 (IIID1c), Consent 110 (111D1d), and Consent 111 (IIID1c.) Mental Health: CHS has hired persons in quality assurance as identified above. In addition, policies have been written regarding medical, mental health and correctional review of medical compliance. However, meeting minutes, reviews and corrective action plans were not provided for review.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: No information has been provided. Fire and Life Safety: No information provided to document evidence of compliance.

	Medical Care: See Consent 120 (IV.B) Consent 110 (IIID1b), Consent 110 (IIID1c), Consent 110 (111D1d), and Consent 111 (IIID1c.) Mental Health: The Agreement requires the implementation of a Mental Health Review Committee and a Risk Management & Quality Improvement Committee. These committees have not been implemented to date. CHS Policy J-A-04- addendum states: (Mental Health Review) Committee members will include CHS Director, CHS Medical Director, CHS Lead Psychiatrist, Mental Health Program Director, Quality Risk Management Representative, and MDCR Medical Liaison. MDCR has no companion policies for Mental Health Review Committee or Quality Improvement / Risk Management. DSOP 14-007 speaks to medical compliance, but it does not outline or prescribe the need to maintain open collaboration and communication with CHS to improve mental health care delivery and suicide prevention.
Monitor's Recommendations:	Protection from Harm: Develop written policy and procedures to comply with this paragraph. Fire and Life Safety: 1. Development and implementation of policies as identified in the Measures of Compliance for this provision. Medical Care: See Consent 120 (IV.B) Mental Health: MDCR and CHS should revise policy and implement a plan to ensure adequate communication between custody, medical and mental health. CHS plans to implement the Quatros Incident Reporting System. This information will be useful to custody. The County should implement plans for the mental health review committee that include adequate representation from custody on a mandatory basis. This should review, on at least a monthly basis, data triggers at the individual and system levels. It should also analyze and aggregate mental health data to identify trends that present a risk of harm.

Paragraph Coordinate with Drs. Ruiz and Stern, and Grenawitzke	IV. COMPLIANCE AND **QUALITY** IMPROVEMENT 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 this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due
Fire and Life Safety: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due

Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due
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. Medical Care: • (duplicate) CONSENT121 (IV.C) Audit Step a: (Inspection) There is evidence of annual review of policies and procedures for any needed changes. • (duplicate) CONSENT119 (IV.A) Audit Step a: (Other) This compliance measure will be assessed by exception, i.e. failure to meet any of the 3 requirements below as they pertain to any other provision of the Consent Agreement. c) Send new policies and procedures to Medical Monitor for approval. Mental Health: See Protection from Harm		
Steps taken by the County to Implement this paragraph:	Protection from Harm: No information has been provided concerning compliance with this paragraph. The County's response to the draft report presents their view that under IV. Compliance and Quality Improvement, they have 180 days to be in compliance with A-D. I don't read the Settlement Agreement as such; with the 180 days only referenced in A., not B-D. Fire and Life Safety: No information provided to document compliance Medical Care: See Consent 120 (IV.B) Consent 110 (IIID1b), Consent 110 (IIID1c), Consent 110 (111D1d), and Consent 111 (IIID1c.) Mental Health: No information provided to document compliance		

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: No information has been provided. Due date based on anniversary date of effective date of Settlement Agreement; or governed by written policy/procedures Fire and Life Safety: No information provided to document compliance Medical Care: Not evaluated by the Medical Monitor during this tour. Mental Health: Review of all policies and procedures for any changes needed to fully implement the terms of the Agreement may occur at Mental Health Review Committee and/or Risk Management / Quality Improvement Committee. MDCR has no companion policies for Mental Health Review Committee or Quality Improvement / Risk Management. DSOP 14-007 speaks to medical compliance, but it does not outline or prescribe the need to maintain open collaboration and communication with CHS to improve mental health care delivery and suicide prevention.
Monitor's Recommendations:	Protection from Harm: Develop written policy and procedures to comply with this paragraph. Fire and Life Safety: Development and implementation of policies meeting the provision. Medical Care: None Mental Health: MDCR and CHS should revise policy and implement a plan to ensure adequate communication between custody, medical and mental health. The County should implement plans for the mental health review committee or quality improvement committee that revise and implement policy yearly based on information collected throughout the year and corrective action plans based on adverse events. Policy review should include adequate representation from custody, medical, mental health and nursing

Paragraph Coordinate with Grenawitzke	IV. 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	Compliance:	Partial Compliance: July 2013	Non-Compliance:

Status this tour:			
Fire and Life Safety: Compliance Status this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
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:	No policies have been provided for review, to date.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The County's response to the draft report presents their view that under IV. Compliance and Quality Improvement, they have 180 days to be in compliance with A-D. I don't read the Settlement Agreement as such; with the 180 days only referenced in A., not B-D.		
Monitor's Recommendations:	Protection from Harm: Develop a schedule (spreadsheet) that includes all policies and procedures, and when they are scheduled for annual review. Include new policies/procedures that need to be written to comply with this order. Provide that to the monitor as a schedule of work. Fire and Life Safety: Development of policies and review process, along with a training component to assure training to changed policies is completed before making the policies effective.		

Appendix A-1

Materials Reviewed Prior to Miami Dade Tour By # of Document Request
July 11, 2013

1. 35 - Boot Camp SOP Table of Contents
2. 35 - Metro West Detention Center SOP Table of Contents
3. 35 - MDCR Departmental Standard Operating Procedures Table of Contents
4. 35 - TGK Post Orders T of C
5. 35 - TGK SOP T of C
6. 36 - MCDR Response to Resistance Incident Worksheet
7. 36 - Response to Resistance Lesson Plan 4/18/13
8. 36 - 11-041 MCDR Response to Resistance
9. 38 - MDCR PREA Summary of Employee Investigations 2013 YTD (N=9)
10. 38 - MDCR Employee Summary of Investigations 2013 YTD (N=9)
11. 38 - MDCR PREA Tracking Report 2013 (N=18)
12. 38 - MDCR SIAB Response to Resistance Tracking Log First Quarter 2013 (N=76)
13. 39 - MDCR SIAB Response to Resistance Tracking Log Second Quarter 2013 (N=82)
14. 40 - SSV 2007 – 2012
15. 2013 Response to Resistance Trends First Quarter
16. 41 - Inmate Profile System Incident Report Summary Response to Resistance, Use of OC, inmate/inmate fight requiring medical care
17. 41 - Inmate/inmate fights requiring medical treatment summary and narratives
18. 42 - MDCR Inmate Violence Report FY 2012-2013 (Q2) Full report w/graphics
19. 43 – Inmate Bed Classification Analysis and Risk Analysis of Maximum Security Inmates
20. 44 – Metro West Classification Housing Criteria
21. 44 – PTDC Classification Housing Criteria
22. 44 – TGK Classification Housing Criteria
23. 44 – TTC Classification Housing Criteria
24. 45 – 11-001 – Intake and Release Bureau
25. 45 – 19-005 Objective Jail Classification
26. 45 – Procedural Directive: Inmate Sexual Assault/Battery Prevention
27. 46 – Boot Camp Daily Roster
28. 46 – Metro West Daily Roster
29. 46 – PTDC Daily Roster
30. 46 – TGK Daily Roster
31. 46 – TTC Daily Roster
32. 46 – Realignment of staff from WDC (2)
33. 47/48– 15-008 PREA Policy; Procedural Directive
34. 49 – 10-003 Major Incident Reporting Procedures
35. 50 – Worker's Compensation Claims
36. 51/52 – 4-105 Complaints, Investigations and Dispositions
37. 51 – MDCR SIAM Employee Investigations YTD 2013 (N-212)
38. 51/52 – Sample of investigative report
39. 53 – 4-107 Early Warning/Intervention System
40. 54 – Grievance Forms English, Creole, Spanish
41. 54 – 15-001 Inmate Complaint/Grievance Process
42. 54 – MW Grievances 2011- 2013
43. 54 – PTDC Grievances 2011- 2013
44. 54 – TGK Grievances 2011 – 2013
45. 54 – TTC Grievances 2011 – 2013
46. 54 – Boot Camp Grievances 2011 – 2013 (N=0)
47. 55 – 11-042 Departmental and Facility Inspections
48. 55 – Monthly Facility Safety Inspection PTDC 1/12/13

49. 55 – Weekly Facility Safety Inspection PTCD 4/5/13
50. 56 – Contracts for services to MDCR (N=25)
51. 57 – MW Security/Sanitation Checklist 6/12/13
52. 57 – MW Security Supervisors SOP
53. 57 – 11-021 Overview of Supervisory Duties and Responsibilities
54. 57 – 11-020 Physical Sight Check Procedures
55. 57 – TTC Daily Security/Sanitation Checklist 9/9/12
56. 57 – TGK Security Supervisor's Checklist 5/13/13
57. 57 – PTDC Transitional Housing Division Security Inspection Form 6/21/13
58. 58 – 16-001 Inmate Disciplinary Procedures
59. 58 – Disciplinary Sanctions for Cadets since Jan 2013
60. 58 – MW Inmate Disciplinary Log Jan – May 2013
61. 58 – PTDC Inmate Disciplinary Log Jan – May 2013
62. 58 – TGK Inmate Disciplinary Log Jan – May 2013
63. 59 – 11-019 Contraband Detection Procedure
64. 59 – MW Contraband Report 1/1/13 – 6/11/2013
65. 59 – PTDC Contraband Report 1/8/13 – 6/6/13
66. 59 – TGK Contraband Report 5/28/13 - 6/8/13
67. 59 – TTC Contraband Report 1/8/13 - 4/20/13
68. 60 – MW Safety and Security Procedures Lesson Plan 5/21/13
69. 60 – PTDC Safety and Security Procedures Lesson Plan 5/21/13
70. 60 – TGK Safety and Security Procedures Lesson Plan 5/21/13
71. 60 – TTC Safety and Security Procedures Lesson Plan 5/21/13
72. 2.2.036 Entrance into Opposite Gender Inmate Housing Areas
73. 2.2.038 Integrity of Facility and Housing Areas
74. 2.7.001 Span of Control
75. 2.7.003 New Employee Orientation
76. 3-036 Policy and Planning Bureau Commander
77. 4-006 Forms Control and Duplicating Services
78. 4-010 Short and Long-Range Planning
79. 6-013 Employee Counseling and Discipline Procedures
80. 9-010 Inmate Housing and Environmental Conditions
81. 11-030 Logs and Other Record Keeping Systems
82. 11-044 Emergency Restraint Chair Procedures
83. 17-005 Limited English Proficiency
84. 18-017 Transgender Inmates
85. Department's Document System 7/11/12
86. MDCR Inmate Grievance Report FY 2011-2012 4th Quarter
87. DSOP 3.0.000 Organization
88. Rules 2.2.000 General Conduct and Responsibilities
89. 2.7.000 Rules – Personnel
90. Miami Dade County Office of the Mayor, Mental Health Task Force: Care Comes First, Final Report,
91. Housing Reports for PTDC, Jan. 10-15, Feb 7 – 12, March 14 -19, April 11 – 16, May 8 – 13, June 6 –
92. MDCR Security and Internal Affairs Bureau, Standard Operating Procedure NO. SIAB 13-001
93. Monthly Facility Safety Inspections, December 18, 2102
94. Mental Health Detention Facility: Design Criteria Package 04-08-11 GSA Project No. Z000105
95. Florida Model Jail Standards 7/1/13
96. Lessons Plans
    - DSOP 4/015 Complaints, Investigations and Dispositions
    - Emergency Procedures Fire and Evaluation
    - Key Control Concepts/Procedures
    - Inmate Sexual Assault Abuse Prevention
    - Safety and Security Procedures TGK

- Crisis Intervention Training
- Discrimination, Harassment, and Retaliation
- Emergency Restraint Chair for CHS Staff
- Inmate Complaint/Grievance Process
- Limited English Proficiency
- Major Incident Reporting Procedures
- Safety and Security Procedures (MWDC)
- Preservation of a Crime Scene
- Safety and Security Procedures (PTDC)
- REACT Band-it
- Special Management Unit
- Review of Staffing Requirements
- Overview of Supervisory Duties and Responsibilities
- Safety and Security Procedures (TTC)

97. Training Sign-in Sheets
    - Emergency Restraint Chair Training
    - CPR
98. CRIPA Related Training (Schedules for Years 1 – 4)
99. Miami-Dade Public Safety Training Institute Correctional Officer Training Class – Overview
100. Miami-Dade Corrections and Rehabilitation, Training Bureau, Lateral Officer Curriculum - Overview
101. Training Plan 2013
102. Sample Employee Training History Records
103. Training Bureau – Table of Contents
104. Final Report of the Miami-Dade Grand Jury – Jackson Memorial Hospital

Attachment A-2
Compliance/Comparison of National Standards

Standard #	Language
4-ALDF-1A-10	Multi-occupancy rooms/cells house between two and 64 occupants and provide 25 square feet of unencumbered space per occupant. When confinement exceeds 10 hours per day, at least 35 square feet of unencumbered pace is provided for each occupant.
4-ALDF-1A-12	Dayrooms with space for varied inmate activities are situated immediately adjacent to inmate sleeping areas. Dayrooms provide a minimum of 35 square feet of space per inmate (exclusive of lavatories, showers, and toilets) for maximum number of inmates who use the dayroom at one time. No dayroom encompasses less than 100 square feet of space, exclusive of lavatories, showers, and toilets.
4-ALDF-1A-13	Dayrooms provide sufficient seating and writing surfaces. Dayroom furnishings are consistent with the custody level of the inmates who are assigned.
4-ALDF-1A-14	Light levels in inmate cells/rooms are at least 20 foot-candles in personal grooming areas and at the writing surface. Lighting throughout the facility is sufficient for the tasks performed.
4-ALDF-1A-15	All inmate rooms/cells provide the occupants with access to natural light.
4-ALDF-1A-16	Inmates in the general population who are confined in their rooms/cells for 10 or more hours daily have access to natural light by means of an opening or window of at least three square feet. Inmates in the general population who are confined in their rooms/cells for less than 10 hours daily have access to natural light through an opening or window as described above or through an opening or window of at least three square feet betw3een their room/cell and an adjacent space.
4-ALDF-1A-17	Each dayroom provides a minimum of 12 square feet of transparent glazing per inmate whose room/cell does not contain an opening or window with a view to the outside.
4-ALDF-1A-22	Adequate space is provided for janitorial closets accessible to the living and activity areas. The closets are equipped with a sink and cleaning implements.
4-ALDF-4B-08	Inmates have access to toilets, and washbasins with temperature-controlled hot and cold running water 24 hours per day and are able to use toilet facilities without staff assistance when they are confined in their cells/sleeping areas. Toilets are provided at a minimum ratio of one for every 12 inmates in male facilities and one for every eight inmates in female facilities and one washbasin for every 12 inmates unless national or state building or health codes specify a different ratio. Urinals may be substituted for up to one-half of the toilets in male facilities. All housing units with three or more inmates have a minimum of three toilets.
4-ALDF-4B-09	Inmates have access to operable showers with temperature-controlled hot and cold running water, at a minimum ratio of one shower for every 12 inmates, unless national or state building or health codes specify a different ratio. Water for showers is thermostatically controlled to temperatures ranging from 100 degrees to 120 degrees Fahrenheit to ensure the safety of inmates and to promote hygienic practices.
4-ALDF-5A-01	Inmate programs and services are available and include, but are not limited to, social services, religious services, recreation, and leisure time activities.
4-ALDF-5C-	Inmate have access to exercise opportunities and equipment, including at least one-hour daily of physical exercise outside the cell

1-CORE-1A-06	Single cells provide at least 35 square feet of unencumbered space. At least 70 square feet of total floor space is provided when the occupant is confined for more than ten hours per day.
1-CORE-1A-07	Multiple-occupancy rooms/cells house between two and sixty-four occupants and provide 25 square feet of unencumbered space per occupant. When confinement exceeds ten hours per day, at least 35 square feet of unencumbered space is provided for each occupant.
1-CORE-1A-08	Dayrooms with space for varied inmate activities are situated immediately adjacent to inmate sleeping areas. Dayrooms provide a minimum of 35 square feet of space per inmate (exclusive of lavatories, showers, and toilets) for the maximum number of inmates who use the dayroom at one time. No dayroom encompasses less than 100 square feet of space, exclusive of lavatories, showers, and toilets.
1-CORE-1A-09	All inmate rooms/cells provide the occupants with access to natural light. Lighting throughout the facility is sufficient for the tasks performed.
1-CORE-1C-04	The facility conforms to applicable federal, state, and/or local fire safety codes.
1-CORE-2A-12	Physical plant design facilitates continuous personal contact and interaction between staff and inmates in housing units. All living areas are constructed to facilitate continuous staff observation, excluding electronic surveillance, of cell or detention room fronts and areas such as dayrooms and recreation spaces.
1-CORE-4B-04	Inmates, including those in medical housing units or infirmaries, have access to showers, toilets, and washbasins with temperature controlled hot and cold running water twenty-four hours per day. Inmates are able to use toilet facilities without staff assistance when they are confined in their cells/sleeping areas. Water for showers is thermostatically controlled to temperatures ranging from 100 degrees to 120 degrees Fahrenheit.
1-CORE-5C-01	Inmates have access to exercise and recreation opportunities. When available, at least one hour daily is outside the cell or outdoors.
5.08	The following housing standards apply to all facilities: (SEE APPENDIX "C" CONCERNING YOUTH DETENTION FACILITIES) (a) Specified Unit of Floor Space: (1) Single cells shall contain a minimum of 63 square feet of floor space. (2) Multiple occupancy cells shall contain a minimum of 40 square feet of floor space per inmate in the sleeping area. (3) Dormitory housing units shall contain a minimum of 75 square feet of floor space per inmate, including both sleeping and day room areas. However, inmates who are allowed out of their unit for a minimum of 8 hours per day (e.g., work programs, treatment programs, educational programs, etc.) may be housed in areas designated with a minimum of 70 square feet of floor space per inmate (sleeping and day room areas included). (4) Day rooms shall contain a minimum of 35 square feet per inmate for all cell areas, except disciplinary and administrative confinement. (5) Any facilities constructed prior to October 1, 1996, may also use the applicable factoring procedures as set forth in Appendix A or B. (b) Each single cell will contain at least: (1) A sink with cold and either hot or tempered running water; (2) Flushable toilets;

	(3) Bunk; (4) Artificial lighting which is of at least 20 foot-candles at 30 inches above the floor for reading purposes; (5) Ventilation, which circulates, at least 10 cubic feet of fresh air or purified air per minute per person; (6) Acoustics that ensure noise levels that do not interfere with normal human activities; (7) Temperatures shall be maintained within a normal comfort range. (c) All other housing areas shall provide a minimum of: (1) Artificial lighting which is of at least 20 foot-candles at 30 inches above the floor; (2) Ventilation, which circulates, at least 10 cubic feet of fresh or purified air per minute per person; (3) Toilets and sinks in the ratio of a minimum of 1 to 12 inmates. Urinals may be substituted for up to one-half of the toilets in male housing units; (4) Shower facilities in the ratio of a minimum of 1 to 16 inmates; (5) Cold and either hot or tempered running water in the sinks; (6) Showers shall have tempered running water; (7) Ready access during non-sleeping hours to tables and chairs or areas designed for reading or writing; (8) Temperatures shall be maintained within a normal comfort range. Upon admission and thereafter if indigent, inmates shall be provided reasonable access to toothpaste, toothbrush, shaving equipment, a comb, soap, and a clean towel. Dangerous shaving implements shall be restricted or issued for use only under observation when it is determined that issuance of such equipment would pose a threat to the safety of the inmate, staff or other inmates. (e) Female inmates shall be provided necessary hygiene items. (f) Hair grooming will be made available. (g) Inmates shall be required to bathe at least twice weekly. (h) Drinking cups shall be provided unless the living area is provided with drinking bubblers or fountains. (i) Each inmate in general population will be allowed to shower daily. (j) Sinks, toilets, water fountains, and floor drains will be kept in good repair. (k) Utility closets, pipe chases, and corridors will be kept clean and free of clutter at all times. (l) The Officer-in-Charge or designee shall determine what personal items may be kept in the cell or stored with the inmate; however, an inmate shall be allowed to retain a reasonable amount of personal property including but not limited to his or her legal material, personal hygiene items, writing paper and writing instrument, and authorized reading material, in reasonable quantities, as approved by the Officer-in- Charge or designee. Personal items will be kept in an orderly manner. Fire potential is reduced by limiting the amount of personal property in the cells. (m) The Officer-in-Charge or designee shall inspect all areas daily or cause them to be inspected.

	Appropriate disciplinary action should be taken against inmate s who fail to have their area, the common areas, and their persons clean and orderly.
9.06	Exercise (SEE APPENDIX "C" CONCERNING YOUTH DETENTION FACILITIES) (a) Inmates shall have the opportunity to have a minimum of 3 hours of outdoor exercise per week, weather permitting. Uncontrollable or violent inmates are not subject to the provisions of this paragraph. (b) Sufficient space, and staffing to permit both individual activities and group activities shall be provided. (c) Inmates shall be allowed to remain in their housing areas or cells if they so desire.

Attachment A-3

List of Interviews

There was both an exit and entrance interview. Attendees were asked to sign in. Those records are av
While it is difficult to identify every person with whom I spoke in five days, this list is intended to iden
many individuals relevant to this process.

Deputy Mayor Chip Iglesias
Valda Christian, County Attorney's Office

JHS/CHS

- Carlos Migoya
- Don Steigman
- Rick Morris
- Dr. Calderone
- Dr. Mikes

MDCR

Director Tim Ryan
Chief Daniel Junior
Capt. John Johnson
Lt. Wynnie Testamark-Samuels
Lt. Jan Smith
Capt. Edwin Cambridge, SIAB
Capt. Angela Lawrence, Training
Chief Walter Shuh
Captain Cassandra Jones, Metro West
Captain Cynthia Young, TTC
Captain Yvonne Richardson, TGK
Assistant Director Marydell Guevara
Assistant Director Daniel Mera
Assistant Director Jackie Berry
Tyronne Williams
Dr. Carolina Montoya
Captain Wendy Mayes
Commander Simon Waterman
Commander Frank Brophy
Chief Linda Evans
Lt. Richard Marquez

Miami-Dade County's Criminal Justice System

- The Honorable Nushin Sayfie
- The Honorable Carlos Martinez, Public Defender
- The Honorable Katherine Fernadez-Rundle, State's Attorney
- The Honorable Steven Leifman

Report B
Compliance Report # 1
Fire and Life Safety
Report of Tour Week of July 15 – 19, 2013

Executive Summary

The attached report is submitted in accordance with the consent agreement in the case of United States of America, Plaintiff vs. Miami-Dade County, Miami-Dade County Board of Commissioners; and Miami-Dade County Public Health Trust, Defendants case 1:13-CV-21570-CIV-ZLOCH. From July 16-20, I conducted a tour of the Miami-Dade County Corrections and Rehabilitation Department (MDCR) facilities including Boot Camp, Pretrial Detention Center (PTDC), Training & Treatment Center (TTC; also referred to as Stockade), and Metro West Detention Center (MWDC).

The purpose of the tour was to assess compliance with the Miami Dade Settlement Agreement Part B Fire and Life Safety Provisions. This initial report outlines the actions taken by Miami-Dade Correction and Rehabilitation Department (MDCR) to address constitutional rights of inmates detained at facilities identified in the previous paragraph.

The focus of this report is on the issues of Fire and Life Safety provisions.
That stated I believe it is also my responsibility to address additional extenuating issues observed during the tour that may negatively impact the civil rights of inmates housed within one or more of the housing facilities utilized by MDCR. One example of extenuating issues is the overcrowding of inmates and environmental conditions at the Training and Treatment Center (TTC).

TTC consists of four cell blocks with six dormitory housing units within each cell block. While there I observed two dormitories, A-1 and A-8. It is a housing unit that measure approximately 27 feet by 43 feet or 1161 square feet(based upon a estimation of the number of 12 inch tiles for length and width of the dorms. This will be formally measured during the next tour). There were 16 two-person bunks with 32 inmates housed there. American Correctional Association Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, requires in Provision 4-ASDF-1A10, "Multiple-occupancy rooms/cells house between two and 64 occupants and provide 25 square feet of unencumbered space per occupant. When confinement exceeds 10 hours per day, at least 35 square feet of unencumbered space is provided for each occupant. ("Unencumbered space" is usable space that is not encumbered by furnishings or fixtures. At least one dimension of the unencumbered space is no less than seven feet. In determining the unencumbered space, the total square footage is obtained and the square footage of the fixtures is subtracted. All fixtures must be in operational position for these calculations.) When you subtract 336 square feet for the bunk space (7feet by 3 feet times 16 bunks) the total square footage is approximately 825 square feet or 25.8 square feet of unencumbered space. This calculation does not include desk space or the four feet of space between each bunk which would further reduce the amount of unencumbered space.

Florida Model Jail Standards state in Chapter 5, Section 5.08 (3) "Dormitory housing units shall contain a minimum of 75 square feet of floor space per inmate, including both sleeping and day room areas. However, inmates who are allowed out of their unit for a minimum of 8 hours per day (e.g., work program, treatment programs, educational programs, etc.) may be housed in areas designed with a minimum of 70 square feet of floor space per inmate (sleeping and day room areas included)." If you divide the 1161 square feet available by 32 inmates. This represents only 36.3 square feet per inmate or a little over ½ the space required for housing inmates. The number of inmates that should be housed there in accordance with the ASDF standards would be approximately 22 . Further there were only two toilets, 4 lavatories, and three showers. As stated in the introduction of this report, ACA standards require one toilet for every 12 inmates Ventilation in the dormitory rooms here consisted on one discharge vent and one return vent with no diffusion of air throughout the housing areas creating cold blowing air in one area of the dormitory and very warm conditions at the other end of the room. I strongly urge that MDCR consider taking steps to reduce the number of inmates housed there to meet at least the Florida Jail Standards, if not the ACA Standards.

At the PTDC, there were numerous complaints from both inmates and staff regarding rodents. Miami-Dade does have a contract for pest control that includes all facilities within MDCR. I have suggested that there be a specific meeting with the leadership of the pest control contractor once management staff has reviewed both the RFP and the contract provisions for services to be provided by the pest control company. I am willing to review those documents and prepare an agenda of topics for discussion for that meeting, and if necessary attend the meeting to assure that the appropriate steps are taken to eliminate the facility of pests who can carry and transmit diseases. [11]

Prior to the tour I reviewed several MDCR policies related to fire safety, evacuation, chemical control, key control. I also reviewed the companion policies for each of the facilities for these same policies. Most policies were less than one year old, and while quite thorough and well written in some cases need further review to eliminate inconsistencies, duplication, identifying specific responsible persons with accountability for implementing specific steps in the procedures and reporting outcomes and corrective actions needed. In some cases even the need for specific facility policies should be reviewed especially when the MDCR policy is quite clear and there is no need for a facility specific policy such as chemical control and key control. I would like to review the revised policies prior to them being finalized. Further, I would like to see the training process developed addressing the method to provide documented training to any revised policy prior to its implementation.

[11] In the County's response to the draft report, they note: "MDCR has contracted with a pest control company for routine pest control services of its facilities since 2001. Despite this, concerns regarding rodent infection continue. Toro Pest Control, the on-call 24-hour pest control vendor, is contracted for handling rodent extermination. Additionally, Pre-Trial Detention Center's medical clinic and kitchen are routinely inspected by the Miami-Dade County Department of Health, and issues identified by these inspections are corrected as quickly as possible."

In future visits, once the policies are fully implemented, I will be monitoring documented evidence of their implementation keying specifically on whether corrective actions taken when non-conformities are identified have been effectively addressed.

I want to express my appreciation for the hard work that went into preparing for this first visit. The MDCR leadership is clearly committed to improving the conditions within all facilities to assure the safety and health of the inmates housed within the MDCR system. I am confident that given the commitment and work to date the provisions for fire and life safety will be met.

Findings and Recommendations

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** Necessary fire and life safety equipment shall be properly maintained and inspected at least monthly. MDCR shall document these inspections.		
Compliance Status this tour (date):	Compliance:	Partial Compliance: 7/20/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour(s):	*N/A First Tour*		
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 has developed and implemented a new policy, DSOP 10-022, entitled Fire Response and Prevention Plan effective 7/2/12. This is the first issue of this policy. It establishes several areas pertaining to this provision and other provisions of the consent agreement. The policy establishes a Department Safety Officer with the responsibility to coordinate and ensure compliance with all life safety and fire safety codes and regulations. It provides for training of officers, documentation of fire safety certifications and inspections by the Accreditation and Inspections Bureau (AIB) of MDCR. Including quarterly fire drills on each shift in each area of the facility, inspection every six months of the kitchen cooking hood extinguishing systems, and filters and cleaning, monthly inspection s of all fire and emergency equipment for all facilities, quarterly inspections of all SCBA equipment, housing unit inspections by designated and trained staff. As has been the custom each facility also has developed their facility specific plan for fire response. Most significantly those policies mirror what is in the MDCR policy and other than for evacuation routes and plans, the fire prevention and firefighting provisions should be eliminated from the facility specific plans. MDCR should have one		

assess compliance, verification of the County's representations, and the factual basis for finding(s)	improvements and understanding. I believe that with a rewrite of DSOP 10-006 could most likely eliminate the need for the facility specific companion SOPs. The existing ones mostly copy the language out of DSOP10-006. During the visit, I reviewed the 2nd quarter inspections for TGK dated May 13-14, 2013.This inspection was conducted by a Fire Inspector from the Compliance, Inspection and Accreditation Bureau. The report included photos of violations and documented evidence of corrective actions taken by the facility commander. Because of time constraints, I did not have the opportunity to review any reports for the other facilities. I will review those in future visits. According to the policy, fire extinguishers are to be checked for pressure once per month. All were tagged and up to date that I looked at. I looked at extinguishers in all facilities. Also they are checked every three years under a contract. They do maintain a current inventory of the location of all fire extinguishers.
Monitor's Recommendations:	1. Eliminate the redundancy of facility specific provisions for fire prevention and safety. There should be one policy for all of MDCR. There does however, need to be a facility specific fire and emergency evacuation plan. The plans should be simple, easy to understand and easy to follow. 2. Once the policies are redrafted, please provide a copy for review before implementing. 3. Have available an inventory of the location of all fire and life safety equipment for each facility and located in a designated area of each facility. This should include but not be limited to fire alarms, fire extinguishers, SCBA equipment, defibrillators, smoke detectors, and etc. 4. Provide copies of fire safety inspections completed by CIAB for the 3rd and 4th quarter of 2013 for my review prior to my next visit. It should include documented evidence of corrective actions. 5. Provide documented evidence of the fire extinguisher three year inspection checks for all facilities prior to my next visit .

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 this tour (date):	Compliance: 7/20/13	Partial Compliance:	Non-Compliance:
Unresolved/partially resolved issues from previous tour(s):	*N/A First Tour*		
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:	Miami-Dade County has a contract with Fred McGilvray Inc. of Miami, FL to inspect all fire suppression systems and provide maintenance for all facilities.. The contract period is 12/1/11-5/31/14. Further, they have a contract to		

	inspect the fire alarm systems testing with Florida Fire Alarm, Inc. of Miami, Florida to inspect, test and certify for all facilities. This contract period is from 4/1/11 through 9/30/13. Miami-Dade Fire Rescue Department annually completes their annual fire safety inspection of each facility.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	I reviewed the 2013 fire sprinkler inspection that was completed for each facility in accordance with the contract: TTC completed on 5/16/13 Boot Camp completed on 5/22/13 PTDC completed on5/6-7/13 TGK completed on 5/13-14/13 MWDC completed on 5/20-21/13 I reviewed the fire alarm testing that was completed for each facility for 2013 in accordance with the contract: TTC completed 3/21/13 with letter documenting all corrective actions taken as necessary on 6/11/13 Boot Camp completed 3/19/13 with letter documenting all corrective actions taken as necessary on 6/11/13 PTDC completed 3/29/13 with letter documenting all corrective actions taken as necessary on 6/11/13 TGK completed 3/22/13 with letter documenting all corrective actins taken as necessary on 6/11/13 MWDC completed 3/25/13 with letter documenting all corrective actions taken as necessary on 6/11/13 I reviewed the Miami-Dade Fire Prevention Division inspection reports for the following TTC inspected and approved 2/27/13 PTDC inspected 3/5/13 Re-inspection Compliance 4/5/13 TGK inspected and approved 3/5/13 Boot Camp inspected11/14/12; Re-inspection Compliance 12/12/13 MWDC inspected 2/8/13 Re-inspection Compliance 4/5/13 Also during this visit I met with Kathy Dagling of the City of Miami Fire Department and a representative of the Miami-Dade Fire Prevention Division. They both indicated that their inspections are completed annually with a follow-up inspection, if necessary is completed within30-45 days to assure corrective actions taken or a "notice of violation" is issued. Further both departments participate at least annually in a fire drill.
Monitor's Recommendations:	None at this time.

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 this tour (date):	Compliance:	Partial Compliance: 7/20/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour(s):	*N/A First Tour*		
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 has developed Policy DSOP11-023 entitled "Key Control.". This policy has an effective date of 7/11/12. I t addresses all aspects of key control throughout the MDCR facilities. Additionally each facility has developed their respective Key Control Policy as follows: MWDC: SOP No. M13-016 TGK: SOP No. 036 TTC: SOP T13-030 PTDC SOP P13-026 Boot Camp SOP B12-004 Each policy outlines the requirement for emergency keys to be marked and identifiable by sight and touch and outlines the easily accessible location. Staff has been trained on their notching scheme and responsibility.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	I have reviewed each of the policies and provided written comments. I believe that there only needs to be one policy for the entire complex. DSOP 11-023 should the very few facility specific differences that would make training and understanding of the system simpler for officers moving from one facility to another. I have also suggested that MDCR consider the use of glow sticks as an easy way to be able to identify keys. That said, the policy for marking emergency keys and establishing responsibility and accountability have been implemented throughout the MDCR facilities. This policy is included in the training requirements for all officers. On future tours, I will observe officer understanding of the policy through questions.
Monitor's Recommendations:	1. Assess the feasibility of the use of glow sticks on all emergency keys. 2. Condense all facility specific policies into one MDCR Policy and eliminate the facility policy for key control. 3. Evaluate my policy specific comments and make changes where appropriate. If making changes, please provide a draft copy for final review. 4. Provide a list of staff that needs to be trained on the use of emergency keys for each facility and evidence of training for them on the emergency key use, inspection, and maintenance.

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 this tour (date):	Compliance:	Partial Compliance: 7/20/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour(s):	*N/A*		
Measures of Compliance:	<u>Fire and Life Safety:</u> 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.
Steps taken by the County to Implement this paragraph:	DSOP 10-022 entitled "Fire Response and Prevention Plan" requires that the AIB commander or Departmental Safety Officer (DSO) conduct fire drills. It further states that there be a quarterly fire drill on each shift, in each area of the facility" as outlined in the "MDCR Fire Drill Procedures." There are currently 4 levels of drills: Level I: Simulations (Walk/Talk Through Level II: Alarm Activation, Deployment of SCBA, and Inmate Evacuation Within the Facility Level III: Deployment of Artificial Smoke and SCBA Level IV: Evacuation Outside of Facility with Interagency Response. The only requirement on how many of each type are acceptable is that there must be a Level IV fire drill twice per year. A copy of the MDCR Accreditation and Inspections Bureau Fire Drill Report must be completed and forwarded to the Shift Supervisor/Commander and the Facility/Bureau Supervisor for review.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	In reviewing DSOP 10-022, there were a number of questions that are not clear or need responses. They include what is meant by "in each area of the facility." I did not have a copy of the" MDCR Fire Drill Procedures" nor a copy of the "MDCR Accreditation and Inspections Bureau Fire Drill Reports" to review. It is also not clear who maintains the inspection reports or how corrective actions of any non-conformities resulting from the drills are documented to assure that the corrective action was completed and that it was effective. The policy states that there needs to be Level IV fire drills twice a year. Is that requirement for each facility or for MDCR as a whole? How many of the drill can be level I, II or III? This needs to be clarified. (Keep in mind that I reviewed the policy prior to ever being in any of the facilities. Therefore, some comments may be self-explanatory). Prior to the next visit, I would like to review the fire drill reports for each facility for all of 2013. While the provision only requires quarterly drill on each shift, I believe the objective should be that all officers understand the fire response and evacuation plan and should be able to demonstrate that understanding. Depending on how MDCR defines "in each area", they should consider increasing the frequency of drills to assure that every officer on every shift has gone through a drill at least once in the past three years. That should be the goal rather than an arbitrary quarterly drill requirement.
Monitor's Recommendations:	1. Review the comments provided to DSOP 10-022 and provide me a copy of the draft revision prior to establishing an effective date. You will want to assure that all training to the revised document is completed prior to the effective date. I would like to see your response to each of the questions raised in my initial review. 2. Provide copies of the fire drills reports for all drills conducted for all facilities on each shift for 2013 by the end of January, 2014 for my review. The reports need to include both the non-conformities identified, the documented corrective actions taken, and how you measured that the corrective actions were effective to address the issue.

	3. Clarify the minimum and/or maximum number of drill types for each facility as appropriate. This is to assure that each facility does not only conduct Level I drills all year. 4. Develop an annual drill schedule for each facility that assures the appropriate coverage of all "areas". 5. A list of safety officers documenting at least one safety officer on each shift for each facility including weekends and holidays.

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 this tour (date):	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour(s):	*N/A First Tour*		
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 has developed DSOP 10-010 entitled "Chemical Control". Each facility has also developed its own SOP for Chemical control as follows: TGKCC: SOP No. 040 Control and Use of Flammable/Combustible, Toxic Caustic Materials; effective 10/1/12 TTC: Control of Flammable/Combustible, Toxic and Caustic Materials SOP 13-027; effective 6/30/13 Boot Camp: Control and Use of Flammable/Combustible, Toxic and Caustic Materials; effective 2/6/13 MWDC: Chemical Inventory, Storage and Use; effective 7/1/11 PTDC: Chemical Control; effective 6/14/13		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	In reviewing each of the policies, I find that the MDCR policy is very good. However, the facility specific policies are incomplete and do not reference the MDCR Policy DSP10-010, lack of responsibility, no mention of training, incomplete chemical inventory accountability and/or lack of consistent procedures. In reviewing chemical dilution practices during my tour, I found that all chemicals are diluted using different formulas; none of which followed the chemical manufacturer's recommendations. For example one facility was using household bleach without dilution when the manufacturer specified one teaspoon to one gallon of water. Another facility was using ZEPO Pine Cleaner at one gallon of concentrate to four gallons of water; while the manufacturer specified 33/4 oz. of Pine Cleaner to one gallon of water. Not only is this a waste of expensive chemicals, it provides inmates accessibility to chemicals well in excess of safe use. Moreover, their current practice provides no more cleaning and disinfection		

	benefit than that specified by the chemical manufacturer. Here, again is a perfect example of cost savings and safety to have all chemicals mixed at one location to the manufacturer's specifications. This does not allow officers or inmates' access to any chemical at a toxic level. It provides consistent training and consistent use throughout MDCR. I suspect the facility will see a significant cost savings without compromising safety of the inmates or officers.		
Monitor's Recommendations:	1. Consolidate all chemical control policies into one MDCR document and eliminate all facility specific policies for chemical control. 2. Dilute all concentrated chemicals following the chemical manufacturer's specifications 3. Train both sanitation officers and inmate workers on both the safe and effective use of all chemicals used within MDCR 4. Mix all chemicals at one central location to assure consistency of product and safety. 5. Provide evidence of training of all sanitation officers and inmate workers who have responsibility to use chemicals either in housing areas, kitchen, classrooms, 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 this tour (date):	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour(s):	*N/A First Tour*		
Measures of Compliance:	Fire and Life Safety: 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 has provided me with a copy of the "Orientation Video Manual" dated May 28, 2012. This is a training outline on a variety of topics related to working for MDCR. They also provided me with a training program outline titled, "Fire Fighting Principles/Procedures. Revised 1/1/03. As discussed in previous provisions. MDCR has drafted several policies regarding fire safety. Specifically Policy DSOP10-006 and DSOP 10-022.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	In reviewing the documentation provided, the training program is a general outline of procedures to be followed. However, the training syllabus needs to be based on the MDCR policies, or law or regulations. If management expects officers and other staff to competent to administer the written policies, then the training plan and specific course syllabuses need to be consistent with those policies and include enough detail to assure management that all provisions of the policies are addressed in the required training. It further prevents staff from making the excuse "No one ever told me that before!" This needs to be the format for review of the Orientation Video Manual as well as the Fire Fighting Principles /Procedures outline.		

	There is also a need for developing a training DSOP which establishes the basis for a training plan, assigns responsibility for training, identify how training manuals, syllabuses, method of validation of the training, and verification of training will be documented, accordingly a process and time frame to review training process, and training programs, review and change process for testing, a process to assure through supervision and management review to identify areas of re-training where drills, inspections, or interviews demonstrate that need. Here is a link of an example of a training plan format. There are several others, but they are very similar to the one specified. www.hhs.gov/ocio/...Training%20Plan/eplc_training_plan_template.doc A training plan should include at a minimum the following: 1. The competency to be achieved; 2. The time frame for achieving the competency; 3. Training to be taken; 4. Delivery method; 5. Who is responsible for the delivery and/or assessment of the competency; 6. Assessment details and arrangements; 7. And a record of acceptable prior learning for qualification; and 8. Name of the qualification or Certificate to be issued. Competency based training and completion is an approach that places emphasis on what a person can do in MDCR as a result of completing a training program. It is comprised of competency standards that each participant is assessed against to ensure all outcomes required have been achieved. As a result, progression through a competency based program is determined by the participant demonstrating that they have met the competency standard through the training program and related work, not by time spent in training. Typically participants may be able to complete a program much more efficiently. I suggest that in the overall training SOP, there be a matrix created within MDCR that identifies all of the training that is required for each position, including contracted services. With that documentation in place, MDCR can have the confidence it needs to assure the specifically needed training for each position. The training matrix needs to include at a minimum, title of training course, the date of the training, training time, the trainer or training organization, verification of attendance, test results or other documentation that demonstrates that the training was effective,
	1. Establish a MDCR training DSOP as described above. 2. Create a training plan for the organization. 3. Develop a training matrix for each position. 4. Establish a process for retraining 5. Establish a method to document that all training for a position is completed or how management will know what training is required. 6. Establish and follow a process to review training and the training SOPs and plan.

APPENDIX B-1

Materials Reviewed Prior To and Following Miami Dade Tour

1. Miami-Dade County Jail Settlement Agreement
2. MDCR Departmental Standard Operating Procedures (DS)P) Table of Contents
3. MDCR DSOP, "Document System," "Department's Document System;" Effective 7/11/2012
4. MDCR Standard Operating Procedure Matrix
5. TTC Housing Criteria
6. PTDC classification Housing Criteria
7. Aramark Inmate One Touch Kiosk Commissary Ordering presentation
8. MDCR Daily Jail Population Statistics 9/9/13
9. Florida Model Jail Standards 7/01/2013
10. DSOP 10-006, "Emergency Procedures Re: Evacuation;" Effective 6/6/2012
11. PTDC SOP P12-009, "Emergency Procedures Re: Facility Evacuation;" Effective 2/2/2012
12. TTC SOP T11-002, "Emergency Response Plan;" Effective 3/1/2011
13. MWDC SOP M12-015, "Emergency Procedures Re: Facility Evacuation;" Effective d6/25/2012
14. PTDC SOP P12-003, "Emergency Procedures Ref: Fire Response;" Effective 2/10/2012
15. Boot Camp Program SOP B13-002. "Emergency Procedures Re: Evacuation;" Effective 2/14/20
16. TGKCC SOP 055, "Fire Evacuation;" Effective 3/4/2012
17. MDCR DSOP 10-010, "Chemical Control Effective;" 6/11/2012
18. TGKCC SOP 040, "Control and Use of Flammable/Combustible, Toxic Caustic Materials Effective 10/1/2012
19. TTC SOP 13-027, "Control of Flammable/Combustible Toxic and Caustic Materials;" Effective 6/
20. Boot Camp Program SOP B13-007, "Control and Use of Flammable/Combustible, Toxic and Cau Materials;" Effective 2/6/2013
21. MWDC SOP M12-024, "Chemical Inventory, Storage & Use;" Effective 6/26/2012
22. PTDC SOP P13-030, "Chemical Control;" Effective 6/14/2013
23. MDCR DSOP 11-023, "Key Control;" Effective 6/11/2012
24. MWDC SOP M13-016; "Key Control;" Effective 7/1/2013
25. TGKCC SOP 036, "Key "Control;" Effective 7/1/2013
26. TTC SOP T13-030, "Key Control Procedures;" Effective 6/20/2013
27. PTDC SOP P13-026, "Key Control;" Effective 6/14/2013
28. Boot Camp Program SOP B12-004, "Key Control;" Effective 9/30/2012
29. Contract Award Sheet Dept. of Procurement Management, "Service to Fire Alarm Systems Prequ 6694-4/11-4
30. Miami Dade County6 Appendix Affidavits Formal Bids"
31. Miami Dade County "Award Sheet Bid Number 6694-4/11-3, "Service to Fire Alarm Systems"
32. Tally Sheet 6694-4/11-3, "Service to Fire Alarm System (Inspection, reporting, testing, certifica tagging, repairs, and parts)"
33. Miami-Dade County Invitation to Bid, "Maintenance of Fire Suppression Systems for Various Mi County Departments, Bid No: 0751-4/12-OTR.
34. Miami-Dade County Contract Award Sheet, "Fire Suppression Systems Maintenance" Bid No. 07 4
35. Attachment to Award Sheet Bid Number 0751-4/12-2 "Service to Fire Suppression Systems"
36. Correspondence dated 6/11/13 from Florida Fire Alarm, Inc. Re: Fire Alarm Systems at Boot Ca
37. Miami-Dade Fire Rescue Department – Inspection Report Metro West Detention Dated: 2/8/2(
38. Miami –Dade Fire Rescue Department – Inspection Report Boot Camp Dated: 11/14/2012
39. Miami –Dade Fire Rescue Department – Inspection Report TTC Dated: 2/27/2013
40. Miami –Dade Fire Rescue Department – Inspection Report TGKCC Dated: 3/5/2013
41. MDCR Fire Inspection Report for TGKCC Dated: 4/9-10/2013
42. MDCR Fire Inspection Report for TGKCC Dated: 5/13-14/2013
43. MDCR Fire Inspection Report for TGKCC Dated 6/25-26/2013
44. MDCR Major Life Safety Violation Summary Report by Facility 3rd Quarter (April-June) FY – 201
45. PTDC Sprinkler Inspection Report Dated: 3/5/2013

46. TTC Sprinkler Inspection Report Dated: 3/12/2013
47. TGKCC Sprinkler Inspection Report Dated: 3/19/2013
48. MDCR DSOP 10-022, "Fire Response and Prevention Plan;" Effective 7/2/2012
49. MDCR Training Bureau Table of Contents
50. MDCR Orientation Video Manual Dated: 5/28/2012
51. MDCR E-Learning Spread Sheet Dated 8/23/2013
52. Florida CMS Correctional Basic Recruit Training Program Ch. 8 Responding to Incidents and Emergencies
53. 2012 Florida Dept. of Law Enforcement "Responding to Incidents and Emergencies CJK _0335
54. Emergency Procedures Fire and Evacuation Lesson Plan dated 7/24/2012
55. Chapter 8 Responding to Incidents and Emergencies Unit 1 Identifying Emergency Situations
56. "Firefighting Principles/Procedures Effective 1/1/03 Training outline
57. Facility and Equipment CJK_0315 Hazardous Materials and Sensitive Supplies 2012 Florida Dept. of Law Enforcement
58. PTDC Pest Control Reports from Toro Pest Control for January- July, 2013

APPENDIX B-2

List of Persons Interviewed During the Tour

Deputy Mayor Genaro "Chip" Iglesias
Valda Christian, County Attorney's Office

MDCR
- Tim Ryan, Director
- Capt. John Johnson
- Lt. Wynnie Testamark-Samuels
- Capt. Angela Lawrence, Training
- Chief Walter Shuh
- Captain Cassandra Jones, Metro West
- Captain Cynthia Young, TTC
- Captain Yvonne Richardson, TGK
- Captain Denson, PTDC
- Michael Goilan, Maintenance
- Captain Floyd, Key Control and Sanitation

JHS/CHS
- Carlos Migoya
- Don Steigman
- Rick Morris
- Dr. Calderon
- Dr. Mikes

Miami-Dade County's Criminal Justice System
- Judge Nushin Sayfie
- Carlos Martinez, Public Defender
- Katherine Fernandez-Rundle, State's Attorney
- Judge Steven Leifman

Report C

Compliance Report # 1
Medical Care
Report of Tour Week of July 15 – 19, 2013

Executive Summary

During this first tour, the majority of the Medical Monitor's time was spent familiarizing himself with the physical plant, personnel and operations of the MDCR. Thus many of the relevant compliance measures of the two Orders were not formally evaluated. Relevant findings are contained within the body of the report. In this introductory section, however, the Medical Monitor captures two topics: grievances and training.

The most significant findings regarding grievances are presented here because grievances are the subject of several separate paragraphs of the Orders, and it was more logical to present the underlying data in one place. The recommendations related to grievances, however, can be found in their respective paragraphs. The medical monitor reviewed the recent grievance logs from all facilities and a sampling of recent grievances, as provided by MDCR, as shown in the following table:

Facility	# of Grievances reviewed
TGK	23
TTC	4
PTDC	28
MWDC	8

Certain patterns emerged. Medical staff at TGK meet directly with most patients to discuss their grievances. There is clearly an effort to understand the patient's concern. This is highly commendable. Staff at MWDC do this, but to a lesser extent. Unfortunately, staff at the other facilities do this rarely, if ever. Many responses are illegible or written in technical jargon unlikely to be understood by the patient. Some are addressed late (greater than 20 days). Of greatest concern, there are grievance responses that either a) do not address the issue at hand, b) indicate the grievance is "unsubstantiated" when it appears CHS staff subsequently plans to do what the patient asked for, or c) fail to recognize or perpetuate an access to care problem identified in the grievance. Some examples follow:

- Patient 16 at PDTC submitted a grievance on 6/27/13. He stated that he broke his hand on 6/20/13, received an x-ray on 6/24/13, but had not received any further attention, such as a cast. On 7/4/13 the respondent wrote that he was seen in the Orthopedic Hand Clinic on 7/1/13. Despite what seemed to have been a gap in medical care, the gap was not addressed in the grievance response and the grievance was found to be unsubstantiated.
- Patient 17 at PDTC submitted a grievance on 6/24/13. He stated that he suffered an injury in the community and despite submitting a Health Care Request slip, had not

yet been examined. The grievance was forwarded to CHS staff on 6/27/13. On 7/8/13 the respondent wrote that the patient was seen by a provider for this the same day (7/8/13). The grievance was substantiated. Despite having been notified of this issue on 6/27/13 it took over a week for the patient to access healthcare as of the date of notification, and over two weeks to access health care from the date of his first request. This was not addressed in the grievance response.

- In a similar set of circumstances, Patient 18 patient at PDTC submitted a grievance on 6/25/13, CHS staff was notified on 6/27/13, and the patient was finally seen, according to the response, on 7/11/13, two weeks later.
- Patient 19 at MWDC submitted a grievance on 5/6/13. He stated that he had not received any response to requests for an HIV test and for evaluation of pain in his arm. The grievance respondent wrote that the patient was seen by the eye specialist [sic] and the grievance was found to be unsubstantiated.
- Finally, Patient 20 at PDTC submitted a grievance on 6/12/13. She stated that she was 51 years old and had lumps in breasts. Two months prior to incarceration she was told they needed to be addressed. She was arrested on the day of her appointment, informed CHS staff of the need for follow-up, and has been waiting for 7 1/2 months. The grievance was forwarded to CHS staff on 6/13/13. The respondent wrote that the patient had an appointment scheduled in the Breast Center (for a mammogram) "in July." Though substantiated, there was no explanation for the failure to address this problem sooner, nor the reason for yet another 2 week (at a minimum) delay to have another mammogram.

With regard to training, the Medical Monitor has not yet reviewed training programs and curricula. He will do so during subsequent tours. In the interest of MDCR being as successful in its efforts to meet the requirements of the Agreements as quickly as possible, the Medical Monitor shares these criteria against which he will evaluate training programs and curricula. Training curricula should be formalized. There should be a curriculum for each training required by the agency. They should be kept in a prescribed place (much the same way that all policies are kept in a prescribed place). Their development and modifications should be subject to some control (to ensure that they can't be changed on the whim of one employee and that they continue to match policy/procedure/job descriptions). Their updating should be prescribed (to ensure they're up to date). Training should be competency-based, meaning that the goal of the learning should be that an employee will be able to DO something, not just KNOW something. Thus it should be clear when reviewing a curriculum, what skill is being taught, and how competency in that skill is being assessed in order to "graduate" the trainee. The qualifications of the instructor should be specified. Please see the guidance provided by the Sanitary Monitor, Mr. Grenawitzke, elsewhere in this report, for more detail.

Compliance Measures

1. A number of the Medical paragraphs could not be rated as Complaint/Partially Compliant/Non-Compliant, either because the provision is not yet due, because the Medical Monitor did not assess it during the visit, or because the Medical Monitor assessed only

part of the paragraph and that part was non-compliant (but there is insufficient information about other parts of the paragraph). For lack of a "Not Applicable" choice, the Medical Monitor made a parenthetical comment in the "Non-Complaint" box of the paragraph. The reader should therefore not consider these paragraphs non-complaint.

2. The Medical Monitor reviewed the chart of a patient who recently died. Some examples in this report are drawn from that case. However, the Monitor did not provide any more formal feedback on that case as it is still under investigation by the County.

List of Documents Reviewed by Medical Monitor (Appendix C-1)
List of Staff Interviews by Medical Monitor (Appendix C-2)
List of Patients Reviewed by Medical Monitor (Appendix C -3) (not available in the public version of this document)

Abbreviations:
MAR Medication Administration Record
PA Physician Assistant
NP Nurse Practitioner (APRN)
ML Midlevel practitioner (PA or NP)
PRN Medications prescribed "as needed"

A. MEDICAL AND MENTAL HEALTH CARE

1. Intake Screening

Paragraph Stern and Ruiz	CONSENT001(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's 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:	Partial Compliance: July 2013	Non-Compliance:
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Intakes conducted in a setting confidential • Audit Step b: (Chart Review) Intakes conducted as soon as possible upon admission, no later than 24 hours • Audit Step c: (Inspection) Jail and CHS Intake Procedures followed • Audit Step d: (Inspection) Intake form calls for recording of observable and non-observable medical needs • Audit Step e: (Chart Review) Intake form has documentation of observable and non-observable medical needs • Audit Step f: (Inspection) Intake done by LPN or RN • Audit Step g: (Chart Review) Intake done by LPN or RN • Audit Step h: (Inspection) Policy specifies an appropriate training strategy (e.g. who is trained, how often) for nurses who perform intake medical screening. • Audit Step i: (Inspection) An effective curriculum is used during training that addresses qualifications of trainers, curriculum, assessment of competency. [NB: Training for LPNs will include tools to make a determination of "clinically significant findings" without the need to make an assessment.] • Audit Step j: (Inspection) Training records show that nurses who perform intake medical screening receive training as specified in policy. Mental Health: 1. Record review that qualified nursing staff are conducting mental health screening and evaluation		

Steps taken by the County to Implement this paragraph:	Medical Care: The County recently modified its intake process. Intake was moved from PTDC to TGK. An RN is assigned to the LEO Lobby to do a pre-screening to assure the inmate is healthy enough to process. A team of LPNs conduct screening in an area of the booking area. Inmates identified with greater needs are moved immediately to a third area where they are assessed by a mid-level practitioner. Mental Health: 1. CHS has written policy, J-E-02, Receiving Screening. It states: "Receiving screening is performed on all inmates upon arrival at the intake facility to ensure that emergent and urgent health needs are met. Intake Screening consists of four components: a. Pre-booking screening prior to acceptance b. Medical intake screening c. Mental health screening and evaluation d. Health Insurance Questionnaire" 2. Booking and screening was moved to Ted Guildford Knight Correctional Center (TGK) in the LEO Lobby on June 18, 2013. 3. MDCR policy (DSOP 14) regarding access to mental health care states, "It is the policy of the Miami-Dade Corrections and Rehabilitation Department (MDCR) to provide inmates with medical, dental and mental health services while housed in a MDCR detention facility. All inmates in need of health services shall be identified and given access to care in a timely manner as well as afforded continuity of care. Healthcare encounters, including medical and mental health interviews, examinations and procedures shall be conducted in a private setting and in a manner that encourages the inmate's subsequent use of health services."
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 Medical Monitor toured the old and new intake areas. The new area constitutes a marked improvement. Confidentiality can be a problem at the pre-screening, screening, and assessment areas. In the pre-screening area, if the room is crowded, other inmates may be within hearing distance of the inmate being interviewed by the nurse. In the screening area, sound isolation is a little better, but there is room for improvement. If the language line is used for interpretation, it is used on speaker phone, which can be heard by other inmates in the area. In the assessment area, there is little visual privacy from people in the waiting area or from the camera mounted overhead. Also, an open door reduces auditory privacy. One nurse did not question patients about tuberculosis symptoms if they reported a history of a negative skin test in the past. The last tuberculosis question is "N/A". Some nurses interpret that to mean that the other questions are not applicable, while some interpret that to mean that the answer to the other questions were negative. This can lead to incorrect documentation. Nurse's record patient weight as reported by the patient. This is recorded in vital signs (which implies that it was measured by a nurse). More importantly, self-reporting may not be accurate. Mental Health: Pre-booking mental health screening and evaluation is conducted by a social worker in an area of TGK that has partitions. These partitions offer a measure of confidentiality in terms of sight and sound. They are not sound-proof.

	The CHS policy as written does not state that inmates must be screened within 24 hours of arrival. We were informed that screening is occurring within 24 hours. Concurrent weekly reviews and audits have been proposed by the Director of Quality Improvement, including 200 randomly selected records per month until achievement of 95% compliance for two consecutive quarters.
Monitors' Recommendations:	Medical Care: 1. Better auditory privacy should be provided during health pre-screening in the LEO Lobby of TGK. 2. Better auditory privacy should be provided during health screening in the Booking area for face-to-face conversation with the nurse. 3. Better auditory privacy should be provided during health screening in the Booking area when using the language line for interpretation. One possible solution is use of an extra hand piece rather than the speaker phone. 4. Better auditory privacy should be provided during health assessments in the Booking area. 5. Better visual privacy from people in the waiting area should be provided during health assessments in the Booking area. 6. Better visual privacy from security cameras during health assessments in the Booking area. 7. Necessary steps in the training or supervision of nurses who conduct intake screenings should be taken to assure that nurses correctly screen for tuberculosis. 8. The tuberculosis questions asked in screening should be clear and unambiguous. One solution is to eliminate the choice of "N/A." Questions about tuberculosis symptoms are rarely not applicable. 9. Weights should be measured during screening using a scale. Mental Health: Intake screening policy should be updated to reflect the time-line of screening within 24 hours. For example, J-E-02 could be updated to state, "Receiving screening is performed on all inmates upon arrival at the intake facility *within 24 hours. This screening shall* ensure that emergent and urgent health needs are met. *Emergent referrals shall be seen within 2 hours by a qualified mental health professional and a psychiatrist within 24 hours. Urgent referrals must be seen by qualified mental health staff within 24 hours."* Training should be tailored to the policy, as discussed in Section III C 7 of this report. Mental Health Monitor concurs with the proposed audits and review of records to assess adherence to the intake screening policy.

Paragraph Stern and Ruiz	CONSENT004 (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: July 2013	Partial Compliance:	Non-Compliance:
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Interview with Intake nurses reveals that after identification of "emergency referral" in Intake, patient stays under constant observation. • Audit Step b: (Chart Review) A patient identified as having an emergency medical need is seen by a practitioner immediately. Mental Health:		

	1. Record review of adherence to screening, assessment, and trigger events as described in Appendix A 2. Review of housing logs; 3. Review of observation logs for patients placed on suicide precaution. 4. Interview of staff and inmates
Steps taken by the County to Implement this paragraph:	Mental Health: 1. CHS has written policy, J-G-05, Suicide Prevention Program states, "The facility identifies suicidal inmates and intervenes appropriately." It also states, "Patients who are identified as being at risk for suicide at any time by medical or correctional personnel should be placed on a suicide watch and referred for mental health services." Policy does not provide a triage level or timeline for emergent mental health referrals. 2. MDCR 12-003 states that inmates confined to a single cell under direct observation (administrative confinement) for psychiatric purposes shall be examined by an IMP/IMP mental health staff within 48 hours following their confinement.
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 Medical Monitor did not observe or identify the charts of any patients to whom this paragraph would apply. However, based on the Medical Monitor's inspection and discussion with staff, it appears to me that medical patients identified as "emergency referral" would remain under constant observation until seen by a medical professional. Mental Health: CHS states, "All inmates identified as an emergency referral for medical or mental health evaluation will be expedited within 30 minutes of emergency referral and two hours for mental health evaluation by a qualified mental health professional." This timeline is not specified in mental health policy or policy for response to emergent / urgent mental health assessments. MDCR policy is inconsistent with the requirements of the consent agreement.
Monitors' Recommendations:	Medical Care: None Mental Health: 1. Update MDCR and CHS Mental Health policy to reflect intended definitions and timelines for access to care, including designating the difference between urgent and emergent mental health referrals. 2. Consider separating 'emergent referrals' from 'urgent referrals' on the mental health screening and initial intake form, as well as any other medical triage referral forms. 3. Run continuous quality improvement / audits on a regular basis for validation of system and to assess timely access to care.

Paragraph Stern and Ruiz	CONSENT005 (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:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Measures of Compliance:	Medical Care: • Audit Step a: (Chart 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). • Audit Step b: (Chart Review) Previous medical records in the chart are reviewed timely by a practitioner. Mental Health: 1. Policy regarding obtaining collateral information and previous psychiatric and medical records 2. Review of records 3. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	Mental Health: CHS Policy J-E-12 states, "Information is acquired from community providers in accordance with consent requirements to provide a continuum of care for patients with existing health needs."		
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: Not evaluated by the Medical Monitor during this visit. Mental Health: Insufficient information was reviewed to provide an opinion on compliance with this provision.		
Monitors' Recommendations:	Medical Care: None Mental Health: CHS reports plans to process Release of Information requests, which shall be embedded into intake forms. It also plans to develop a log to maintain ROI requests and follow through. During future site visits, I will ask to see the log for processing of ROI and will review medical records for evidence that outside records have been requested, received, reviewed and the collateral information has been utilized as clinically appropriate.		

Paragraph Stern and Ruiz	CONSENT006 (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.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Intake screening form calls for assessment of drug or alcohol use and withdrawal • Audit Step b: (Chart Review) Intake screening forms include documentation of assessment of drug or alcohol use and withdrawal • Audit Step c: (Chart Review) Patients screening positive for withdrawal or withdrawal risk referred to practitioner • Audit Step d: (Chart Review) Patients referred to practitioner for withdrawal or withdrawal risk receive further evaluation and, if necessary, placement in Detox. • Audit Step e: (Inspection) Policy specifies an appropriate training strategy (e.g. who is trained, how often) for nurses who perform intake screening for drug and alcohol use and withdrawal. • Audit Step f: (Inspection) An effective curriculum is used during training that addresses qualifications of trainers, curriculum, assessment of competency. • Audit Step g: (Inspection) Training records show that nurses who perform intake assessments of drug or alcohol use and withdrawal receive training as specified in policy. Mental Health: See Medical Care		
Steps taken by the County to Implement this paragraph:	Medical Care: CHS includes some questions about drug and alcohol use and withdrawal in its intake screening. Mental Health: See Medical 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 Care: The Medical Monitor reviewed CHS's Medical Intake Screening form. While it includes some questions about drug and alcohol use and withdrawal potential, some of the questions called for in CHS's policy J-E-02 Receiving Screening are missing. The policy states that patients will be questioned about "Legal and illegal drug use (including type, time of last use and quantities)." Quantities of drugs and time of last use of drugs and alcohol are missing. The Medical Monitor did not evaluate the rest of this measure during this visit. Mental Health: Similar to the Medical Intake Screening Form, the Mental Health Screening and Evaluation form asks regarding prior alcohol and drug use. However, the form does not specify question regarding amount of alcohol or drug use and date or time of last use.		
Monitors' Recommendations:	Medical Care:		

	1. CHS should add questions to the Medical Intake Screening form that address quantities of drugs taken, and time of last use of drugs and alcohol. 2. CHS should consider adding other questions from the "Simple Screening Instrument for Substance Abuse [SSI-SA]," a validated questionnaire developed by the Substance Abuse and Mental Health Services Administration (SAMSHA) of the US DHHS. It can be found within SAMSHA TIP 42 at http://www.ncbi.nlm.nih.gov/books/NBK64197/pdf/TOC.pdf. Mental Health: The amount and date/time of last alcohol and drug use is necessary in order to properly assess risk for detoxification, delirium, and signs of withdrawal. It is recommended that these questions be added to either the medical or mental health intake form, or both. If they are added only to one, medical and mental health should review the medical record and document this information was reviewed in their evaluation assessment.

Paragraph Stern and Ruiz	CONSENT007 (III.A.1.g.) (Covered in CONSENT001/IIIA1a) 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:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Measures of Compliance:	Medical Care: • (duplicate) CONSENT001 (IIIA1a) Audit Step h: (Inspection) Policy specifies an appropriate training strategy (e.g. who is trained, how often) for nurses who perform intake medical screening. • (duplicate) CONSENT001 (IIIA1a) Audit Step i: (Inspection) An effective curriculum is used during training that addresses qualifications of trainers, curriculum, assessment of competency. [NB: Training for LPNs will include tools to make a determination of "clinically significant findings" without the need to make an assessment.] • (duplicate) CONSENT001 (IIIA1a) Audit Step j: (Inspection) Training records show that nurses who perform intake medical screening receive training as specified in policy. Mental Health: See Medical Care		
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):	Medical Care: Not evaluated by the Medical Monitor during this visit. Mental Health: Not audited.		
Monitor's Recommendations:	Medical Care: None Mental Health: None		

2. Health Assessments

Paragraph	CONSENT008 (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:	Non-Compliance: Not audited
Measures of Compliance:	*The measures of compliance from the Settlement Agreement and/or Consent Agreement and/or what you will use to measure compliance* • Audit Step a: (Chart Review) All detainees receive an initial health assessment within 14 days of arrival. • Audit Step b: (Chart Review) The initial health assessment is clinically adequate. This includes: a) it was conducted by an appropriate clinician, b) it is legible, c) all clinically appropriate history and physical examination was collected (either by the initial assessor or someone to whom the assessor referred the patient), d) the plan is clinically appropriate, e) the plan is executed as planned.		
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):	The Medical Monitor reviewed CHS policy J-E-04 (Initial Health Assessment). The policy states "A registered nurse completes the hands-on portion of the health assessment. The responsible physician documents the review of registered nurse health assessments when significant findings are present." In the Medical Monitor's opinion, in the absence of intensive training in physical diagnosis, RNs will not typically have the skills necessary to complete the history and physical examination after the discovery of significant positive findings. Thus, when significant findings are present, it is not typically sufficient for the responsible physician to simply review the assessment, but rather should generally evaluate the patient, conducting any additional questioning, physical examination, and testing as indicated. When the Medical Monitor evaluates Audit Step b above in the future, such referral to a practitioner (physician, PA, or NP), will be one element of a "clinically appropriate history and physical examination." The Medical Monitor did not evaluate the rest of this measure during this visit.		
Monitor's Recommendations:	1. When an RN discovers a significant positive finding (history or physical) during an initial health assessment, the finding should be addressed in person by a practitioner (physician, PA, NP). 2. CHS policy J-E-04 (Initial Health Assessment) should be modified to reflect that when a physician reviews an Initial Health Assessment performed by an RN that indicates a positive finding, the physician should visit with the patient and address that finding, unless in his/her opinion, no further evaluation is indicated (which he/she should document). 3. Technical assistance: CHS might consider replacing allowing any practitioner (not just physicians) to perform the review of RNs' Initial Health Assessments and re-evaluation as indicated.		

Paragraph	CONSENT012 (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:	Partial Compliance:	Non-Compliance: Not audited
Measures of Compliance:	Inmate Medical: • Audit Step a: (Chart Review) *(For simplicity, this audit step addresses 3 overlapping compliance measures simultaneously: (1) the need for patients to receive an Initial Health Assessment by a practitioner within 24 hours if a chronic disease is identified during intake screening (CONSENT012 (IIIA2e)); (2) the need for patients to receive an Initial Health Assessment by a practitioner within 24 hours if clinically indicated during intake screening (CONSENT013 (IIIA2f)); and (3) the need for patients to receive an evaluation by a physician within 48 hours if a serious medical problem is identified during intake screening (CONSENT022 (IIIA4b(2)))*. Patients identified during Intake Screening as having a significant medical problem (including a serious medical need or a chronic disease) are seen by a practitioner (physician, PA, NP, as appropriate) within 24 hours of arrival. The evaluation will include follow-up (such as enrollment in a chronic care program for those with a chronic disease) as clinically indicated.		
Steps taken by the County to Implement this paragraph:	The County recently modified its intake process. Intake was moved from PTDC to TGK. An RN is assigned to the LEO Lobby to do a pre-screening to assure the inmate is healthy enough to process. A team of LPNs conduct screening in an area of the booking area. Inmates identified with greater needs are moved immediately to a third area where they are assessed by a mid-level practitioner.		
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):	While the Medical Monitor did not audit the charts of patients to whom this paragraph would apply to verify that the system is working, the County clearly has an appropriate mechanism in place to accomplish the task.		
Monitor's Recommendations:	None		

Paragraph Stern and Ruiz	CONSENT013 III A. 2. f. (Covered in CONSENT001 (IIIA1a) and CONSENT012 (IIIA2e)) 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: July 2013	Non-Compliance:
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • (duplicate) CONSENT001 (IIIA1a) Audit Step b: (Chart Review) Intakes conducted as soon as possible upon admission, no later than 24 hours • (duplicate) CONSENT012 (IIIA2e) Audit Step a: (Chart Review) *(For simplicity, this audit step addresses 3 overlapping compliance measures simultaneously: (1) the need for patients to receive an Initial Health Assessment by a practitioner within 24 hours if a chronic disease is identified during intake screening (CONSENT012 (IIIA2e)); (2) the need for patients to receive an Initial Health Assessment by a practitioner within 24 hours if clinically indicated during intake screening (CONSENT013 (IIIA2f)); and (3) the need for patients to receive an evaluation by a physician within 48 hours if a serious medical problem is identified during intake screening (CONSENT022 (IIIA4b(2)))*. Patients identified during Intake Screening as having a significant medical problem (including a serious medical need or a chronic disease) are seen by a practitioner (physician, PA, NP, as appropriate) within 24 hours of arrival. The evaluation will include follow-up (such as enrollment in a chronic care program for those with a chronic disease) as clinically indicated. Mental Health: 1. Record review that qualified nursing staff are conducting mental health screening and evaluation 2. Results of internal audits 3. Schedule of review for policies, procedures, practices. 4. Schedule for in-service training. 5. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	Mental Health Care: 1. CHS has written policy, J-E-02, Receiving Screening. It states: "Receiving screening is performed on all inmates upon arrival at the intake facility to ensure that emergent and urgent health needs are met. Intake Screening consists of four components: 1. Pre-booking screening prior to acceptance 2. Medical intake screening 3. Mental health screening and evaluation 4. Health Insurance Questionnaire" 2. Booking and screening was moved to Ted Guildford Knight Correctional Center (TGK) in the LEO Lobby on June 18, 2013. MDCR policy (DSOP 14) regarding access to mental health care states, "It is the policy of the Miami-Dade Corrections and Rehabilitation Department (MDCR) to provide inmates with medical, dental and mental health services while housed in a MDCR detention facility. All inmates in need of health services shall be identified and given access to care in a timely manner as well as afforded continuity of care. Healthcare encounters, including medical and mental health interviews, examinations and procedures shall be conducted in a private setting and in a manner that encourages the		

	inmate's subsequent use of health services."
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: As noted in Consent 001 ((IIIA1a) Audit Step b, the County appears to conduct Intake Screenings as soon as possible. As noted in CONSENT012 (IIIA2e) Audit Step a, the County clearly has the mechanism in place to refer patients with significant medical problems to a practitioner. Mental Health: Pre-booking mental health screening and evaluation is conducted by a social worker in an area of TGK that has partitions. These partitions offer a measure of confidentiality in terms of sight and sound. They are not sound-proof. The CHS policy as written does not state that inmates must be screened within 24 hours of arrival. We were informed that screening is occurring within 24 hours. Concurrent weekly reviews and audits have been proposed by the Director of Quality Improvement, including 200 randomly selected records per month until achievement of 95% compliance for two consecutive quarters.
Monitor's Recommendations:	Medical Care: None Mental Health: Intake screening policy should be updated to reflect the time-line of screening within 24 hours. For example, J-E-02 could be updated to state, "Receiving screening is performed on all inmates upon arrival at the intake facility *within 24 hours. This screening shall* ensure that emergent and urgent health needs are met. *Emergent referrals shall be seen within 2 hours by a qualified mental health professional and a psychiatrist within 24 hours. Urgent referrals must be seen by qualified mental health staff within 24 hours."* Training should be tailored to the policy, as discussed in Section III C 7 of this report. The Mental Health Monitor concurs with the proposed audits and review of records to assess adherence to the intake screening policy.

Paragraph Stern and Ruiz	CONSENT014 (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:	Partial Compliance:	Non-Compliance: not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Training curricula (i.e. initial training and periodic in-service) for practitioners performing intake screenings is adequate, including factual content and teaching methodology (which includes presentation of material and assessment of learning). • Audit Step b: (Inspection) Training records show that practitioners performing initial health assessments receive initial and in-service training, including evidence of performance on assessments of learning. Mental Health: 1. Review of policy regarding mental health and mental health staff training 2. Review of records, including sign-in sheets, for any training performed 3. Review of training materials, including power point slides and the training of the presenters		
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):	Medical Care: Not audited during this visit Mental Health: The Response to Consent Agreement reflects plans to train medical, mental health and custodial staff on relevant mental health policies and procedures. This training has not occurred to date. No lesson plans were submitted. An outline of the CIT lesson plan was reviewed. This lesson plan did not include the suicide prevention training curriculum topics as outlined in the Consent Agreement.		
Monitor's Recommendations:	Medical Care: None Mental Health: Please implement adequate annual training protocols for all mental health staff. In reviewing the documentation provided on CIT, the training program is a general outline of procedures to be followed. The training syllabus needs to be based on the CHS and /or MDCR policies, or law or regulations. If management expects officers, medical and mental health staff to be competent to administer the written policies, then the training plan and specific course syllabuses needs to be consistent with those policies and include enough detail to assure management that all provisions of the policies are addressed in the required training. This should be the format for review of the mental health and suicide prevention training.		

3. Access to Medical and Mental Health Care

Paragraph Stern and Ruiz	CONSENT014.5 (III.A.3.a.) Defendants shall ensure inmates have adequate access to health care with a medical and mental health care request system, ("sick call" process), for inmates.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Staff maintain adequate confidentiality of patient health care information (auditory, visual, documents). Mental Health: 1. Availability of mental health care slips in English, Spanish and Creole 2. Availability of writing implements to fill out mental health care slips 3. Evidence of culturally-sensitive policies and procedures for ADA inmates with cognitive disabilities 4. Presence and implementation of confidential collection method for mental health slips daily 5. Review of logs of sick call slips, appointments, for appropriate triage 6. Review of Mental Health grievances		
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):	Medical Care: Maintaining confidentiality of medical information is important for at least two reasons. First, it is required by HIPAA and good medical practice. Second, in its absence, patients may avoid seeking care or providing full and accurate information during encounters, both of which impair full access to care. Confidentiality in the Intake area is discussed in CONSENT001(IIIA1a). The Medical Monitor observed or learned of breaches of confidentiality in other settings: -lack of visual and auditory privacy from custody staff and other inmates during sick call at MWDC; -lack of visual and auditory privacy from custody staff during practitioner visits on the PTDC 9th floor (CCTV camera overhead, open door); -lack of auditory privacy from other inmates during sick call by use of inmate interpreters; -lack of auditory privacy from custody staff when patients have urgent requests for health care and information is ferried back and forth over the phone between nurse and patient, with officer as intermediary. Mental Health: A sick call system is in place in which inmates may place sick call requests during pill pass. However, there was no evidence of a system in place in order to request sick call for patients in administrative segregation that are not receiving medication.		
Monitors' Recommendations:	Medical Care: 1. Other inmates or non-health care staff should never be used as interpreters for delivery of medical care except in emergencies. 2. Telephones with access to the language line should be available wherever clinical care is routinely delivered.		

	3. All clinical encounters should be conducted outside earshot and observation by other inmates. Generally, clinically encounters should also be conducted outside earshot and observation by custody staff. Where there is concern for staff safety, limited visual access (e.g. a small observation window not easily accessed by the casual passer-by) may be used. 4. Because there are rare instances where concern for staff safety demands the presence of officers during a clinical encounter, instruction about patient confidentiality should be included in initial and ongoing training for officers, and they should sign statements acknowledging that they received this information. 5. Officers should not be used as intermediaries to conduct clinical encounters over the phone when a patient presents to the officer with an urgent medical problem, beyond the officer relaying the nurse what the patient originally volunteered to the officer upon presentation. Additional information should be obtained directly by the nurse, either over the phone, or in person. <u>Mental Health:</u> Please ensure an adequate sick call system for patients in administrative segregation, patients with mental health vulnerabilities, and patients with developmental or cognitive delay. This should include adequate access to a counselor or provider to assist with writing or expressing requests, if clinically necessary.

Paragraph Stern and Ruiz	CONSENT015 (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: July 2013	Partial Compliance:	Non-Compliance:
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Health care slips on the living units are available in English, Spanish, and Creole. Mental Health: 1. Availability of mental health care slips in English, Spanish and Creole 2. Availability of writing implements to fill out mental health care slips 3. Evidence of culturally-sensitive policies and procedures for ADA inmates with cognitive disabilities 4. Presence and implementation of confidential collection method for mental health slips daily 5. Review of logs of sick call slips, appointments, for appropriate triage 6. 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):	Medical Care: Multilingual slips are available. Mental Health: Multilingual slips are available. This provision is also covered in III C regarding access to mental health care.		
Monitor's Recommendations:	Medical Care: None Mental Health: As indicated in other areas of this report, please ensure an adequate sick call system for patients in administrative segregation, patients with mental health vulnerabilities, and patients with developmental or cognitive delay. This should include adequate access to a counselor or provider to assist with writing or expressing requests, if clinically necessary.		

Paragraph Stern and Ruiz	CONSENT016 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:	Partial Compliance:	Non-Compliance: not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Interviewed COs report a confidential way for detainees with impaired communication skills to access care. Mental Health: 1. Interview with inmates with cognitive or physical disabilities 2. Interview with staff 3. Review of medical record to assess access to care		
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):	Medical Care: Not audited during this visit Mental Health: No mental health records were reviewed of patients with cognitive disabilities during this tour. However, a death case was reviewed in which the patient was physically disabled secondary to an assault, reportedly of a sexual nature. This case demonstrated that the patient did not receive adequate or timely medical care despite interaction with mental health; the patient was referred for medical care but did not receive it in a timely manner. CHS reported that a counselor is to be provided by MDCR for patients with cognitive disabilities.		
Monitors' Recommendations:	Medical Care: None Mental Health: Staff interviews and inmate records indicate that inmates are interviewed at cell-side in the PTDC. This procedure does not offer adequate confidentiality or access to care. In addition, it is recommended that any counselor assigned to assist patients with physical and cognitive disabilities receive adequate training in the identification and management of mental illness.		

Paragraph Stern and Ruiz	CONSENT017 (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:	Partial Compliance: July 2013	Non-Compliance:
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Interviewed nurses report a confidential method of collecting health care request slips. • Audit Step b: (Inspection) Interviewed detainees report a confidential method of collecting health care request slips. Mental Health: 1. Review of policy and procedure for sick call 2. Review of log tracking sick call requests and referral for care 3. Review of medical records to assess access and implementation of adequate care 4. Interview of staff 5. 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):	Medical Care: Based on the Medical Monitor's interviews with nurses, the system of slip collection is confidential. The Medical Monitor did not interview detainees regarding this during the visit. Mental Health: Inmates in administrative segregation interviewed during this tour indicated that they have difficulty submitting sick call slips and accessing them if they are not already receiving treatment. This may occur because sick call slips are collected during pill pass. As a result, inmates that are not receiving already receiving medications may not have an adequate opportunity to get and turn in sick call requests.		
Monitor's Recommendations:	Medical Care: None Mental Health: As indicated in other areas of this report, please ensure an adequate sick call system for patients in administrative segregation, patients with mental health vulnerabilities, and patients with developmental or cognitive delay. This should include adequate access to a counselor or provider to assist with writing or expressing requests, if clinically necessary.		

Paragraph Stern and Ruiz	CONSENT018 (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:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Measures of Compliance:	Medical Care: • Audit Step a: (Chart Review) Health care request slips are reviewed appropriately, including: a) within 24 hours or submission b) by, or under the direct supervision of RNs or practitioners c) clinically appropriately. • Audit Step b: (Inspection) Review of emergency medical grievances shows that they are handled immediately and appropriately. Mental Health: 1. Review of policy and procedure 2. Review of submitted sick call slips for evidence of triage 3. Review of emergency grievances and mental health grievances		
Steps taken by the County to Implement this paragraph:	CHS Policy regarding grievances is outlined in J-A-11.		
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: Not audited during this visit Mental Health: The current policy does not specify a procedure for triage of sick call slips or grievances, nor does it define the make-up or content of emergent vs. urgent referrals for care.		
Monitors' Recommendations:	Medical Care: None Mental Health: Please update policy to provide adequate procedures and definitions for urgent vs. emergent referrals and criteria for emergent grievances.		

Paragraph Stern and Ruiz	CONSENT019 (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: July 2013	Non-Compliance:
Mental Health : Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection and Chart Review) This is an overarching requirement. It is measured primarily by MDCR's success with all other medically-related requirements in the Consent Agreement. it is also the "catch-all" for any failure a) to train staff to identify and treat serious medical needs, and b) of staff to identify or treat a serious medical need. Mental Health: 1. Review of policies and procedures for mental health training. 2. Review of documentation and lesson plans related to mental health care staff training. 3. Review of mental health records for assessment of treatment of inmates with SMI.		
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):	Medical Care: 1. Use of physician vs. PA/NP irrespective of case complexity. While many clinical problems can be managed equally well by practitioners of either training level, more complex cases should only be handled by physicians. In some venues (e.g. PTDC clinic) physicians and PA/NPs are used interchangeably. Patients are scheduled for the next available practitioner, which some days may be a physician, and other days may be a PA/NP. 2. Inadequate PA/NP oversight. While some PA/NPs may be licensed to practice independently, in a complex medical environment, they should receive physician supervision (especially when required by law). Based on the Medical Monitor's interviews with physicians and PA/NPs, there is inadequate supervision of midlevel practitioners by physicians. Mental Health: While mental health intake screening is being performed by social workers, currently there is no review to assess whether this screening is missing patients with SMI and whether they are being referred to treatment on a timely basis. Training for all staff related to mental health has yet to be implemented.		
Monitors' Recommendations:	Medical Care: 1. Patients should be assigned to physician or PA/NP clinic based on clinical need, not random assignment. 2. The ratio of physicians to PA/NPs should be based on that clinical need (as well as any statutory limitations). 3. CHS should assure that there is a collaborative practice (including filing and adherence to any required collaborative agreements) between all PA/NPs and their collaborating physician(s). This should include consultation and or transfer of patients between the two when clinically indicated, ready access to physician consultation, and periodic random oversight of practice (in-person and by Chart Review). Mental Health: Please ensure adequate training of medical and mental health staff relative to the identification and management of SMI. This should include identification of patients at risk for detoxification and withdrawal.		

	Quality assurance and risk management staff as well as mental health leadership should review a sample of medical records and incident reports on a regular basis to evaluate access to mental health care.

4. Medication Administration and Management

Paragraph Stern and Ruiz	CONSENT020 (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: July 2013	Non-Compliance:
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) The policies and procedures governing medication management and administration are adequate. This would include, among others, most of the provisions of NCCHC J-D-01 and J-D-02. • Audit Step b: (Inspection) Pill line is conducted in a calm, confidential setting. • Audit Step c: (Inspection) Patients are correctly identified prior to medication administration. • Audit Step d: (Inspection) Ordered medications are administered unless there is a legitimate reason. • Audit Step e: (Inspection) Patients receive the right the right medication, by the right route, at the right dose, at the right time. • Audit Step f: (Inspection) Medication administration is properly documented. • Audit Step g: (Chart and MARs) Medication administration is properly documented, including stop dates. • Audit Step h: (Inspection) The number of medication-related grievances (for medical and MH medications) will fall each 6 months, with a goal of <5 grievances/1000 detainees ADP/12 months. • Audit Step i: (Inspection) Policy specifies an appropriate training strategy (e.g. who is trained, how often) for health care staff involved in the medication management. • Audit Step j: (Inspection) An effective curriculum is used during training that addresses qualifications of trainers, curriculum, assessment of competency. • Audit Step k: (Inspection) Training records show that health care staff involved in the medication management receive training as specified in policy. Mental Health: 1. Policy regarding medication administration and documentation 2. Review of medication error reports. 3. Interview of inmates and staff. 4. Review of medication administration records (MARs).		
Steps taken by the County to Implement this paragraph:	Mental Health: CHS policy J-D-01 outlines medication administration and the maintenance of medication records.		
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. Documentation of medication administration on MARs has deficiencies. For example, review of MARs at PTDC revealed ordered dosages of medication for which no documentation existed, i.e. cells on the MAR were blank. MARs at PTDC also had obsolete documentation. The Medical Monitor found numerous MAR cells filled in with the letter "A," a code used on MAR forms that were discontinued 3 months earlier. 2. Administration of medications has deficiencies. At PTDC the Medical Monitor found documentation that patients		

	did not get important medication because they were not in their cell. As inmates do not roam freely at PTDC, it is the responsibility of the County to make sure patients receive scheduled medications, even when they are out of their cells. At MWDC medication pass takes a long time. According to nurses the Medical Monitor interviewed, it sometimes takes so long that patients at the later end of the pass receive their medications beyond the acceptable time frame for that medication dosage. This constitutes a medication error. The Medical Monitor did not assess the underlying reason for this at MWDC. Reasons can typically include: inadequate staffing; inadequate use of "keep on person" medications; over prescribing. 3. Policies do not address which staff are to receive training on medication management and how often. The Medical Monitor did not evaluate all elements of this measure during this visit. <u>Mental Health:</u> Current policy states: CHS uses Diamond Pharmacy as their pharmacy vendor. In very limited situations, it may be allowed to have medication from Department of Health Pharmacy and /or Community Pharmacy, and has to meet the following requirements: a- Medication must be in the original manufactures sealed container. b- The container must be free of any evidence of tampering. This is in order to prevent the introduction of contraband into any of the jails. Sapphire, the Electronic Medication Administration and CPOE system will go live August 19, 2013. Medications are provided in unit doses as available. Examination of current pharmacy procedures for inmates with mental health illnesses demonstrated inadequate record keeping. CHS was unable to provide me documentation or tracking of numbers of inmates with mental health diagnoses, their medications, and evidence of adequate continuity of care.
Monitors' Recommendations:	<u>Medical Care:</u> 1. On MARs – and except for PRN medications - every cell for an ordered dosage should be filled in, either with documentation that the medication dose was administered, or, if not, why. 2. When a patient is scheduled to receive a medication, medical staff must provide the medication, even if the patient is not in his/her cell. This can be accomplished by either making arrangements for the medication to be administered at the distant location, or by providing a dose for self-administration. This should also be incorporated into policy. 3. Medications must be administered within the right time frame. For medications administered more than once a day, this is usually within 60 minutes, plus or minus, of the scheduled time (some experts recommend a narrower time frame of 30 minutes, but 60 minutes is reasonable for most medications). The time frame is usually not as critical for medications ordered once a day or less often. 4. Policy should reflect which staff are to receive training on medication management and how often. <u>Mental Health:</u> CHS anticipates that Sapphire will permit for reporting and auditing of timely medication administration, missed

	medications and compliance with medication reconciliation process. This will reportedly be audited by the Quality Department. Provided that the Sapphire system is implemented, this may be adequate. Should implementation of Sapphire be delayed or aborted, another pharmacy tracking system should be implemented. This may require assigning one specific individual at each facility to track inmates with mental health disorders, their medications and accuracy of medication dispensation. Possible tools to assist with tracking include developing an Excel or Access database and intermittent review of medication administration records.

Paragraph Stern and Ruiz	CONSENT021 (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:	Partial Compliance: July 2013	Non-Compliance:
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: Not due yet
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Nurses conducting Intake screening, will effectively question patients about current medications (this includes medications they ARE taking, and medications they SHOULD BE taking). • Audit Step b: (Chart Review) For each current medication listed on a patient's Intake Screening form, the medication is either: a) ordered continued by a practitioner; b) ordered discontinued or changed by a practitioner, in which case the clinical justification is appropriate and is either documented or is obvious (e.g. therapeutic substitution of a non-formulary with a formulary medication). • Audit Step c: (Chart Review) The first does of medications ordered by a practitioner for a newly admitted patient, will be administered within 24 hours unless otherwise ordered by the practitioner. Mental Health: 1. Review policy 2. Review intake screening 3. Review medication continuity 4. Review sample of medical records		
Steps taken by the County to Implement this paragraph:	Medical Care: Not evaluated by the Medical Monitor during this visit. Mental Health: Not evaluated		
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: Based on the Medical Monitor's observation of the Intake area and interviews with staff, the Medical Monitor believes MDCR has the system in place to have a Qualified Medical Professional evaluate the need for continuation of medications patients were taking prior to admission. Except for one patient, the Medical Monitor did not have the opportunity to audit whether the system actually works. This patient was on a medication for high blood pressure in the community. Its need was evaluated and the first dose administered on the day of admission. Mental Health: Not evaluated.		
Monitor's Recommendations:	Medical Care: None Mental Health: None		

Paragraph] Stern and Ruiz	CONSENT022 (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: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • (duplicate) CONSENT012 (IIIA2e) Audit Step a: (Chart Review) *(For simplicity, this audit step addresses 3 overlapping compliance measures simultaneously: (1) the need for patients to receive an Initial Health Assessment by a practitioner within 24 hours if a chronic disease is identified during intake screening (CONSENT012 (IIIA2e)); (2) the need for patients to receive an Initial Health Assessment by a practitioner within 24 hours if clinically indicated during intake screening (CONSENT013 (IIIA2f)); and (3) the need for patients to receive an evaluation by a physician within 48 hours if a serious medical problem is identified during intake screening (CONSENT022 (IIIA4b(2)))*. Patients identified during Intake Screening as having a significant medical problem (including a serious medical need or a chronic disease) are seen by a practitioner (physician, PA, NP, as appropriate) within 24 hours of arrival. The evaluation will include follow-up (such as enrollment in a chronic care program for those with a chronic disease) as clinically indicated. Mental Health: See III A2e		
Steps taken by the County to Implement this paragraph:	Medical Care: See CONSENT012 (IIIA2e) Mental Health: See IIIA2e		
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 CONSENT012 (IIIA2e) Mental Health: See IIIA2e		
Monitor's Recommendations:	Medical Care: None Mental Health: See IIIA2e		

Paragraph Stern and Ruiz	CONSENT025 (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:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Measures of Compliance:	Medical Care: • Audit Step a: (Chart Review) Patients will receive their first dose of non-emergent medications within 3 days of the order. • Audit Step b: (Chart Review) Patients will receive their first dose of emergent mediations immediately. • Audit Step c: (Chart Review) Laboratory tests not marked as urgent will be drawn within 3 days. • Audit Step d: (Chart Review) Laboratory tests marked as urgent will be drawn immediately. Mental Health: 1. Policy regarding physician orders, laboratories and reporting 2. Review of medical and mental health records 3. Review of reports to psychiatrist regarding emergent or abnormal results		
Steps taken by the County to Implement this paragraph:	Mental Health: No CHS policy was identified which addressed the availability of laboratory tests and timeline for review of results.		
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: Not audited during this visit. Mental Health: No CHS policy was identified which addressed the availability of laboratory tests and timeline for review of results.		
Monitor's Recommendations:	Medical Care: None Mental Health: CHS should develop and implement policy that governs availability of laboratory testing and review of the results in a timely manner. Specific to psychotropic medications, laboratory tests may be necessary to review medication-specific levels, effects of medications (such as liver function elevations or hyperglycemia related to anti-psychotics and mood stabilizers, etc.) Urine pregnancy tests should be available for all women of childbearing age. If phlebotomy and laboratory testing are not available on-site, adequate arrangements should be made for timely testing.		

Paragraph Stern and Ruiz	CONSENT026 (III.A.4.f.) (Covered in CONSENT020 (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:	Partial Compliance:	Non-Compliance: Not yet due
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: Not due yet
Measures of Compliance:	Medical Care: • (duplicate) CONSENT020 (IIIA4a) Audit Step i: (Inspection) Policy specifies an appropriate training strategy (e.g. who is trained, how often) for health care staff involved in the medication management. • (duplicate) CONSENT020 (IIIA4a) Audit Step j: (Inspection) An effective curriculum is used during training that addresses qualifications of trainers, curriculum, assessment of competency. • (duplicate) CONSENT020 (IIIA4a) Audit Step k: (Inspection) Training records show that health care staff involved in the medication management receive training as specified in policy. Mental Health: 1. Review of policy and procedure related to medication administration 2. Review of training related to medication administration		
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):	Medical Care: See CONSENT020 (IIIA4a) regarding medication management policy. Other parts of the measure were Not audited during this visit Mental Health: See section III A4a		
Monitor's Recommendations:	Medical Care: See Recommendation 4 in CONSENT020 (IIIA4a) regarding medication management policy. Mental Health: See section IIIA4a		

5. Record Keeping

Paragraph Stern and Ruiz	CONSENT027 (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:	Partial Compliance: July 2013	Non-Compliance:
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Measures of Compliance:	Medical Care: • Audit Step a: (Chart Review) Paper medical records are adequate. This would include, among others, the provisions of NCCHC J-H-01 and J-H-04. (This audit will sunset when an EHR is implemented.) • Audit Step b: (Chart Review) Electronic medical records (contained in one or more electronic programs) are adequate. This would include, among others, the provisions of NCCHC J-H-01 and J-H-04. Mental Health: 1. Policy regarding medical records and documentation 2. Review of medical and mental health records for organization and legibility 3. Review of medical record indicates it is adequate, including necessary components such as intake screening, mental health evaluation, progress notes, orders, updated problem list, and collateral information, as needed.		
Steps taken by the County to Implement this paragraph:	Medical Care: CHS is actively working on implementation of an EHR Mental Health: CHS has plans to implement an electronic medical record and computerized physician order entry		
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: MDCR's medical records were generally available, well organized, and legible. Mental Health: CHS continues to use a hard-copy written medical record. Medical records were notably difficult to navigate. In one case, I requested a medical record of an inmate transferred from PTDC to Metro West; I was informed the record did not exist and/or could not be located.		
Monitors' Recommendations:	Medical Care: None Mental Health: 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.		

Paragraph Stern and Ruiz	CONSENT029 (III.A.5.c.) (Covered in CONSENT027/IIIA5a) CHS shall document all clinical encounters in the inmates' health records, including intake health screening, intake health assessments, and reviews of inmates.		
Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • (duplicate) CONSENT027 (IIIA5a) Audit Step a: (Chart Review) Paper medical records are adequate. This would include, among others, the provisions of NCCHC J-H-01 and J-H-04. (This audit will sunset when an EHR is implemented.) • (duplicate) CONSENT027 (IIIA5a) Audit Step b: (Chart Review) Electronic medical record are adequate. This would include, among others, the provisions of NCCHC J-H-01 and J-H-04. Mental Health: 1. Review of policy and procedure related to documentation 2. Review of medical record 3. Review of HER, once implemented		
Steps taken by the County to Implement this paragraph:	Medical Care: See CONSENT027 (IIIA5a) Mental Health: CHS Policy J-H-04 states: The health record is available and used for all nursing, medical, dental and mental health encounters.		
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 CONSENT027 (IIIA5a) Mental Health: The medical record should document all mental health encounters with inmates. For example, if the psychiatrist is present while an inmate requires restraint, the decision to use restraints for medical purposes should be reflected in the record. This should include an order to both start and stop the restraint.		
Monitors' Recommendations:	Medical Care: None Mental Health: The medical record should document **all** mental health encounters with inmates. If the psychiatrist is not writing his or her own progress notes, the progress note should be co-signed by each party to the documentation. Verbal orders should be co-signed in a timely manner. Response to medical and mental health emergencies require a progress note that adequately describes the inmate's condition, the response, and the treatment plan. Patient's returning from outside medical appointments or clinics should have a timely review of collateral health records for recommended treatment. This should also be reflected in the medical record.		

Paragraph Stern and Ruiz	CONSENT030 (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:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) There is a policy/procedure in place identifying how medical information is prepared for referral to an outside provider. • Audit Step b: (Inspection) When interviewed, staff involved in preparation of medical information for referral to an outside provider describe activities consistent with policy. • Audit Step c: (Chart Review) Referral forms contain all necessary information, including the reason for referral and sufficient history (including a relevant problem and medication list). • Audit Step d: (Chart Review) When a patient returns from an outside appointment, there is documented evidence of review (in person or via a nurse) of initial results by a practitioner prior to the patient's return to his/her living unit. This review occurs regardless of the presence of or nature of the recommendation. • Audit Step e: (Chart Review) Recommendations from an outside provider are a) ordered to be implemented by a practitioner, or b) modified by a practitioner, in which case the clinical justification is appropriate and is either documented or is obvious (e.g. therapeutic substitution of a non-formulary with a formulary medication). All orders are implemented in a clinically appropriate time frame. Mental Health: 1. Review of policy relevant to collateral information and implementation of recommended treatment. 2. Review of medical records. 3. Interview of staff and inmates.		
Steps taken by the County to Implement this paragraph:	Mental Health: CHS Policy J-E-12 states: 1. There is evidence in the record of the ordering clinician's review of results. If changes in treatment are indicated, the clinician notes clinical justification for an alternative course and the changes are implemented. The clinician reviews the findings with the patient in a timely manner. 2. When inmate returns from an Emergency Room visit, the providers sees the patient, reviews the discharge orders, and issue follow-up orders as clinically indicated. If the providers are not on site, designated health staff contact the provider on call to review ER findings and obtain orders as appropriate. 3. When an inmate returns from hospitalization, the provider sees the patient, reviews the discharge orders, and issue follow-up orders as clinically indicated. ***If (emphasis added)*** all inmates returning from the hospital as an inpatient are to be taken to Turner Guilford Knight Medical Housing for continued care and monitoring.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the	Medical Care: Not audited during this visit Mental Health: The medical record should document all mental health encounters with inmates. For example, if an inmate required treatment at the hospital secondary to a severe suicide attempt, upon his or her return, a QMHP and psychiatrist should		

factual basis for finding(s):	review the record, document that patient's status upon re-admission to the jail, and implement any new treatment that has been recommended by the outside specialist or hospital, as clinically appropriate. This should occur for all inmates upon their re-entry into the Jail.
Monitors' Recommendations:	Medical Care: None Mental Health: CHS should update policy to reflect timely re-assessment and documentation of such for all inmates following outside clinical appointments and returns from the hospital.

6. Discharge Planning

Paragraph Stern and Ruiz	CONSENT031 (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:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a: (Chart Review) Upon discharge from jail, all patients with chronic medical problems will receive appropriate and timely referrals to Jackson Memorial Hospital. Mental Health: 1. Policy and procedure regarding discharge planning 2. Referrals for inmates with chronic medical health problems or serious mental illness. 3. Providing a bridge supply of medications of up to 7 days to inmates upon release 4. 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:	Mental Health: CHS Policy J-E-13 states: Whenever possible, arrangements are made for access to community based organizations for serious medical, mental health and dental needs. All referrals for following care will be made to Jackson Memorial Hospital.		
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: Not audited during this visit Mental Health: CHS policy states it will make all referrals to Jackson Memorial Hospital. It does not state that it will make appointments for follow-up for patients with serious mental illness.		
Monitor's Recommendations:	Medical Care: None Mental Health: It is inadequate to state that inmates with serious mental illness are expected to make their own appointments, request transfer of information and place calls to access a bridge supply of their medications. As noted by the NCCHC[12], "Discharge planning includes the following: 1. Formal linkages between facility and community-based organizations, 2. Lists of community health professionals, 3. Discussions with the inmate that emphasize the importance of appropriate follow-up and aftercare, and ***4. Specific appointments and medication that are arranged for the patient at the time of release. (Emphasis***		

[12] Standards for Health Services in Jails, 2008, J-E-13, Discharge Planning, p.81

	added.)" I recommend policy be updated to reflect generally accepted principles of health services for jails. The updated policy should then be implemented, including adequate training as described in other portions of this report.

Paragraph Stern and Ruiz	CONSENT032 (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:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Releasing patients receive an adequate bridge supply of medications (up to 7 days-worth). Mental Health: 1. Policy regarding discharge planning 2. Referrals for inmates with chronic medical health problems or serious mental illness. 3. Providing a bridge supply of medications of up to 7 days to inmates upon release 4. 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: This topic was discussed during a conference call with CHS personnel after our visit. CHS is working on a strategy to fulfill this requirement. The Medical Monitor clarified expectations for fulfillment of this requirement with regard to the 7 day supply of medications: Patients need to be provided bridge medications for a maximum of 7 days. However, there are legitimate reasons to provide less medication. For example, if the patient confirms that he/she has the medication at home, no bridge medications are necessary. Or, if CHS has arranged for a follow up appointment at a community clinic that can address this medication need, then bridge medications are only necessary to cover the patient until that visit (or perhaps until the day after the visit). Mental Health: 1. CHS Policy J-E-13 states: Whenever possible, arrangements are made for access to community based organizations for serious medical, mental health and dental needs. 2. A 7-day bridge supply of medication will be provided to inmates upon release. ***All inmates will be provided with a 24-7 local phone # to request medications upon release. (Emphasis added)***		
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: Not audited during this visit Mental Health: This policy as written is not in compliance with national standards.		
Monitor's Recommendations:	Medical Care: None		

	Mental Health: It is inadequate to state that inmates with serious mental illness are expected to make their own appointments, request transfer of information and place calls to access a bridge supply of their medications. As noted by the NCCHC[13], "Discharge planning includes the following: 1. Formal linkages between facility and community-based organizations, 2. Lists of community health professionals, 3. Discussions with the inmate that emphasize the importance of appropriate follow-up and aftercare, and ***Specific appointments and medication that are arranged for the patient at the time of release. (Emphasis added.)"*** The Mental Health Monitor recommends the policy be updated to reflect generally accepted principles of health services for jails. The updated policy should then be implemented, including adequate training as described in other portions of this report.

[13] Standards for Health Services in Jails, 2008, J-E-13, Discharge Planning, p.81

Paragraph Stern and Ruiz	CONSENT033 (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:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Custody staff notify medical staff at least 2 weeks prior to planned releases. • Audit Step b: (Inspection) The Inmate Handbook and Intake Awareness Paper inform patients that they may request bridge medications and community referral within 24 hours after release. • Audit Step c: (Chart Review) Patients with serious illness or communicable diseases not addressed during incarceration will be contacted at their last known address by CHS within 7 days of release. Mental Health: 1. Policy regarding discharge planning 2. Evidence of referrals for inmates with chronic medical health problems or serious mental illness. 3. Evidence of providing a bridge supply of medications of up to 7 days to inmates upon release 4. 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: Not evaluated by the Medical Monitor during this visit. Mental Health: CHS reported plans to implement adequate mental health discharge planning.		
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: Not evaluated by the Medical Monitor during this visit. Mental Health:		
Monitor's Recommendations:	Medical Care: None Mental Health: Please see III.A.6.a.(2)		

7. Mortality and Morbidity Reviews

Paragraph Stern and Ruiz	CONSENT034 (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:	Partial Compliance: July 2013	Non-Compliance:
Mental Health Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) All medical deaths or near deaths undergo a review which is provided to the Medical Monitor within 45 days of the event (or upon receipt of the medical examiner's report, whichever is later). The review has the following components: a) review team is multidisciplinary, including the disciplines appropriate for the case at hand, e.g. practitioners, nurses, MH staff, custody, community EMS, etc. b) identifies the root cause of all significant problems (whether or not they were causally related to the event) c) corrective action plan addresses both short-term and sustainable fixes. Mental Health: 1. Review of comprehensive mortality reviews and corrective action plans for each inmate's death 2. Review of comprehensive morbidity review and corrective action plan for all deaths of inmates with severe mental illness and/or serious suicide attempts. 3. Within 45 days of each death or serious suicide attempt, provide report for review to Monitor and United State 4. 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. 5. Interviews with staff. 6. Receipt of timely mortality reviews which reflect an interdisciplinary review and corrective action plan. This will include inclusion of the Chief Psychiatrist among the interdisciplinary team.		
Steps taken by the County to Implement this paragraph:	Medical Care: MDCR provided a list of the 11 in-custody deaths between early February, 2012 and April, 2013, including the place and cause of death, along with CHS's mortality review of each. Mental Health: CHS Policy J-A-10-a states: In the event of an inmate death, the following will be carried out: 6. The responsible health authority audits the incident to determine the appropriateness of clinical care. 7. The medical examiner or coroner is notified as required by law. 8. A postmortem examination is requested. 9. The Correctional Authority or designee will be responsible for all additional notifications.		

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 medical mortality reviews conducted by CHS are cursory and sloppy. The narratives of most of the reviews amount to 3 or 4 sentences. Some are unsigned. Three medical deaths were rated as Category 3 ("an unexpected death in which possible contributing factors necessitate a more focused review to identify opportunities for improvement in systems and processes"), however, no further analysis was provided. Almost all the reviews were conducted by a single person, not an interdisciplinary team. Mental Health: Neither the policy nor procedure prescribes that an interdisciplinary team will conduct a comprehensive mortality review. Mortality reports and psychological autopsies were reviewed. I am quite concerned regarding timely notification of both psychiatry team members, myself as Mental Health Monitor, and the United States. In addition, the mortality reviews are of poor quality with little qualitative analysis and diagnostic information. The mortality reviews had no corrective action plans and no evidence of learning following the adverse events.
Monitors' Recommendations:	Medical Care: 1. Medical mortality reviews should be carefully executed, thorough, and meaningful in content, and then leveraged as opportunities for improvement. 2. The reviews should be interdisciplinary. 3. CHS policy should be updated to reflect the requirements of this paragraph. Mental Health: Policy for both CHS and MDCR should be updated. Notification to the Monitor and the United States should include prompt notification of all inmate deaths. It should also include a timely and qualitative corrective action plan that incorporates the input of local qualified mental health professionals, such as the Chief Psychiatrist for all inmates' deaths that reflect a history of severe mental illness and/or substance misuse diagnosis.

Paragraph Stern and Ruiz	CONSENT035 (II.IA.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:	Partial Compliance:	Non-Compliance: not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) The fixes developed as part of the corrective action plan following a medical death (see CONSENT034/IIIA7a) will be implemented within 90 day of the event. Mental Health: 1. Review mortality reviews and corrective action plans for each inmate's death 2. 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. 3. 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:	Mental Health: Current CHS Policy J-A-10 states: A death review consist of: a. An administrative review within 72 hours. b. A clinical mortality review within 72 hours. c. A psychological autopsy if death is by suicide within 72 hours.		
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 Medical Monitor was unable to evaluate compliance with this paragraph because there were a paucity of problems identified by CHS as a result of mortality reviews. Please see comments and recommendations in CONSENT034 (III.A.7.a.). Mental Health: This policy is inadequate. The policy does not address qualitative review, corrective action plans or the inclusion of qualified mental health professionals in an interdisciplinary fashion for all deaths of patients with severe mental illness. For example, a psychological autopsy and/or input by mental health may be useful to identify patients at risk of detoxification (and seizure), sudden death related to inmate-inmate assault, and delay in treatment of co-morbid medical issues. However, the psychological autopsy is not sufficient to address systemic or administrative issues that may be identified during analyses to prevent future adverse events. No policy addressed training of staff regarding lessons learned from adverse events.		
Monitors' Recommendations:	Medical Care: None Mental Health: Both CHS and MDCR should update policy regarding mortality review to reflect qualitative analysis and corrective actions plans within 90 days. This should include training as appropriate for involved staff and policy revisions as clinically indicated. Mental health, including the Chief/Lead Psychiatrist, should be informed and involved in all mortality reviews of patients with mental illness.		

Paragraph Stern and Ruiz	CONSENT036 (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:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Records reflect that bi-annually MDCR reviews and monitors the progress it's making in response to system changes made as a result of the mortality and morbidity [suicide attempt] reports generated under CONSENT035/IIIA7b and CONSENT034/IIIA7a and is making additional system changes/adjustments as needed. Mental Health: 1. Review minutes of morbidity and mortality reviews biannually 2. Review evidence of risk management system 3. Review corrective action plan for each serious suicide attempt or inmate death		
Steps taken by the County to Implement this paragraph:	Mental Health: • CHS policy does not require review of mortality and morbidity reports and corrective action plans bi-annually. • DCOP 14-007 outlines medical compliance inspections. It states: • It is the policy of Miami-Dade Corrections and Rehabilitation Department (MDCR) to conduct periodic medical compliance inspections to ensure that healthcare services are being provided in accordance with established medical protocols, standard procedures, and accreditation standards. All facilities shall be inspected on a quarterly basis by the Mental Health and Medical Services (MHMS) Unit. • The Compliance Unit policy does not specify whether it conducts review of adverse events on a bi-annual basis.		
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: Not audited during this visit Mental Health: CHS policy does not require bi-annual reviews of suicides and deaths of inmates with mental health issues. These reviews may be conducted via the Mental Health Review Committee and/or Quality Improvement. As alluded to previously, I recommend that reviews related to adverse events include representative members of the interdisciplinary team, including medical, nursing, custody, and mental health.		
Monitors' Recommendations:	Medical Care: None Mental Health: These reviews may be conducted via the Mental Health Review Committee and/or Quality Improvement. As alluded to previously, I recommend that reviews related to adverse events include representative members of the interdisciplinary team, including medical, nursing, custody, and mental health. Results of the reviews and corrective action plans should be shared with all staff. They should also be shared with the Monitor and the United States in a timely manner.		

B. MEDICAL CARE

1. Acute Care and Detoxification

Paragraph	CONSENT037 (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:	Non-Compliance: July 2013
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) When interviewed, COs report that when a detainee orally requests health care that the detainee says cannot wait to be processed via a routine health request slip, COs immediately transmit such requests to nurses without filtering or triage, regardless of how minor the problem may appear to the CO. • Audit Step b: (Inspection) When interviewed, nurses report that when receiving calls from COs for urgent detainee health care needs, a patient assessment (in person or by phone, as appropriate) is conducted that is a) timely, b) performed by or under the direct supervision of an RN or practitioner, and c) is documented. • Audit Step c: (Inspection) When interviewed, with occasional exception, detainees report that when they have a need for urgent care that cannot wait to be processed via a routine health request slip: a) they can get attract the attention of a CO immediately, b) their request is accepted by the CO without further screening (beyond "Do you feel this cannot be handled through a health request slip?"), c) they are assessed by a nurse soon thereafter (NB: 1. This assessment may be done in person or telephonically, if clinically appropriate. 2. Assessment does not imply that treatment must be rendered if treatment can be reasonably deferred.) • Audit Step d: (Inspection and Chart Review) When the living unit's officer log shows that a call was made to CHS for an urgent inmate request, there is a corresponding clinical entry in the inmate's record reflecting timely and adequate triage. • Audit Step e: (Inspection) The number of grievances for barriers to urgent care is fewer than 3 per 1000 ADP/year. • Audit Step f: (Chart Review) Urgent and non-urgent episodic care is appropriate: a) the care is timely b) it is delivered by appropriately trained and licensed staff c) the content of the care is clinically appropriate. • Audit Step g: (Chart Review) Orders (other than for medications, which is addressed elsewhere) are executed timely, reviewed timely, and result in appropriate and timely clinical response. • Audit Step h: (Inspection) The number of upheld grievances for poor quality episodic care is low. • (duplicate) CONSENT018/IIIA3a(4) Audit Step b: (Inspection) Review of emergency medical grievances shows that they are handled immediately and appropriately.		
Steps taken by the County to Implement this paragraph:	In the past several months, CHS leaders have made a number of positive changes at MDCR, including making important personnel changes among front line nursing staff and local managers.		
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):	This paragraph is broad and covers key aspects of the 3 elements of constitutionally adequate correctional health care, viz. 1) access to care, 2) once care is accessed, the benefit of a professional opinion, and 3) execution of the orders resulting from that opinion. It is therefore a paragraph to which the Medical Monitor attaches significant importance. The Medical Monitor did not systematically address all the dimensions of this paragraph during the first visit. However, several areas of possible concern emerged.		

1. Timeliness of access to care

Based on patient charts and grievance files reviewed by the Medical monitor, access to care can be delayed or not happen at all at MDCR. Some examples found in grievances appear in the narrative introduction of this report. Other examples follow:

- Patient 1 submitted a health request slip on 7/12/13. It was not triaged until 7/16/13 (CHS policy requires triage within 24 hours). The triage decision was for the patient to see an NP, but as of 7/17/13 (the day of the Monitor's visit) there was no record of a visit with the NP either having occurred or on any list to be scheduled in the future.
- Patient 4 submitted a health request slip on 7/14/13 for heartburn. He was not seen by a nurse until 7/18/13.

2. Quality of care in nurse Sick Call

The Medical Monitor observed sick call at MWDC and reviewed sick call records from PDTC and MWDC. The Medical Monitor saw numerous areas for improvement:

-Nurses are required to see a large number of patients in a short amount of time (e.g. 35 patients in 5.5 hours). This leaves 9.5 minutes per patient for rooming, history taking, examination, explaining to the patient, teaching, and documentation, which is not adequate to provide safe care.

-Charts are not pulled for the nurse, so the nurse does not have adequate medical information to make informed clinical decisions.

-Nurse examinations are not adequate. A few examples follow:

- Patient 4 was seen by an RN in sick call for heartburn. He was evaluated under a Gastrointestinal Nursing Protocol. Based on the Medical Monitor's review of the case, the patient's heartburn could have been due to a cardiac cause and would have been missed by the nurse's evaluation due to the use of a protocol focusing on a different organ system. The nurse did refer the patient to a physician, but the referral was routine, so the patient might not be seen for another week.
- Patient 6 submitted a health request slip on 7/14/13. (He was not seen by the nurse until 7/18/13.) The nurse examined the patient without his medical record, treated him, and released him without referral. When the Medical Monitor reviewed the patient's medical record, he found that the patient had already been seen for the same problem by a practitioner on 7/8/13 and 7/11/13. This history indicates that the patient's problem was complex and required evaluation by a practitioner, not a nurse, when the problem persisted on 7/14/13.
- Patient 8 was seen by a nurse in sick call for a cough productive of yellow-green sputum. The nurse evaluated the patient under an Upper Respiratory Infection protocol and without the patient's chart. The nurse did not know if the patient suffered from diabetes (which might alter management of his infection) and was not sure if she asked him about it. She did not question the patient about any history of fever, sweats, or shaking chills, which, if present, might also alter the diagnosis and management.
- Patient 10 was seen urgently by a nurse due to a diminished level of responsiveness. The nurse documented his blood pressure as "84/45→184/96." Not only is it not clear what this documentation means, the nurse failed to measure the patient's pulse, oxygen saturation level, or conduct any neurologic assessment.

-Nurses are supposed to make nursing diagnoses, but by virtue of their selecting nursing protocols for use during an encounter, they are, *de facto*, making medical diagnoses. For example, Patient 5 requested cream for his feet. The nurse chose to evaluate the patient under the "Athlete's Foot" protocol. Thus, by choosing and treating according to that protocol, the nurse effectively made a medical diagnosis of Athlete's Foot.

	3. The effectiveness of the system for executing orders (Audit Step g) was not systematically evaluated during this visit. The Medical Monitor encountered a single case (Patient 10) containing three failures to follow through on non-medication orders. The significance of three examples of a deficiency from a single case in the absence of a systematic evaluation may be questioned. 4. Adequacy of clinic equipment Of the few examination rooms the Medical Monitor visited, there were deficiencies. The head of the exam table in the clinic room on the 9th floor of PTDC is stuck in upright position; the positioning handle is broken (and apparently has been for some time). It is thus difficult if not impossible to examine a patient lying down. Basic clinical equipment, such as a light source, is not available in the nurse's sick call room at MWDC; to examine the throat of Patient 3, the nurse had to have the patient open his mouth facing the ceiling light. The effectiveness of the system for executing orders (Audit Step g) was not systematically evaluated during this visit. The Medical Monitor encountered a single case containing three failures to follow through on non-medication orders. The significance of three examples of a deficiency from a single case in the absence of a systematic evaluation may be questioned. However, it is notable that the patient was one of the patients who recently died at MDCR. Other parts of this paragraph were not systematically evaluated during this visit.
Monitor's Recommendations:	1. Health request slips must be triaged in a timely manner. According to CHS Policy, this triage should take place within 24 hours, which is reasonable. 2. Following triage, patients with clinical needs should be seen in a timely manner. Neither CHS policy nor the Consent Order define the time frame in which this should happen. NCCHC standards define the time frame as 24 hours on weekdays, 72 hours on weekends. This time frame is reasonable, though good nursing judgment during triage is essential. 3. Practitioners need to play a larger role in sick call. Sick call that is entirely managed by RNs using protocols is insufficient to provide safe patient care. 4. Rooms used for clinical evaluations must be adequately equipped. Policy J-D-03 has a reasonable list of essential equipment. 5. Except in emergencies, CHS staff should always have and refer to a patient's chart during a clinical encounter. 6. If not already existing, CHS needs to assure that there is a reliable system in place to assure that non-medication orders are executed. If the order is for a test or consultation, the system must ensure that the test was completed and the results reviewed by a practitioner.

Paragraph	CONSENT038 (III.B.1.b.) (Covered in CONSENT037 (IIIB1a)) 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:	Non-Compliance: July 2013
Measures of Compliance:	Medical Care: • (duplicate) CONSENT018 (IIIA3a(4)) Audit Step b: (Inspection) Review of emergency medical grievances shows that they are handled immediately and appropriately. • (duplicate) CONSENT037 (IIIB1a) Audit Step a: (Inspection) When interviewed, COs report that when a detainee orally requests health care that the detainee says cannot wait to be processed via a routine health request slip, COs immediately transmit such requests to nurses without filtering or triage, regardless of how minor the problem may appear to the CO. • (duplicate) CONSENT037 (IIIB1a) Audit Step b: (Inspection) When interviewed, nurses report that when receiving calls from COs for urgent detainee health care needs, a patient assessment (in person or by phone, as appropriate) is conducted that is a) timely, b) performed by or under the direct supervision of an RN or practitioner, and c) is documented. • (duplicate) CONSENT037 (IIIB1a) Audit Step c: (Inspection) When interviewed, with occasional exception, detainees report that when they have a need for urgent care that cannot wait to be processed via a routine health request slip: a) they can get attract the attention of a CO immediately, b) their request is accepted by the CO without further screening (beyond "Do you feel this cannot be handled through a health request slip?"), c) they are assessed by a nurse soon thereafter (NB: 1. This assessment may be done in person or telephonically, if clinically appropriate. 2. Assessment does not imply that treatment must be rendered if treatment can be reasonably deferred.) • (duplicate) CONSENT037 (IIIB1a) Audit Step d: (Inspection and Chart Review) When the living unit's officer log shows that a call was made to CHS for an urgent inmate request, there is a corresponding clinical entry in the inmate's record reflecting timely and adequate triage. • (duplicate) CONSENT037 (IIIB1a) Audit Step e: (Inspection) The number of grievances for barriers to urgent care is fewer than 3 per 1000 ADP/year. • (duplicate CONSENT037 (IIIB1a) Audit Step f: (Chart Review) Urgent and non-urgent episodic care is appropriate: a) the care is timely b) it is delivered by appropriately trained and licensed staff c) the content of the is clinically appropriate. • (duplicate) CONSENT037 (IIIB1a) Audit Step g: (Inspection) The number of upheld grievances for poor quality episodic care is low.		
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	See CONSENT037 (IIIB1a)		

factual basis for finding(s):	
Monitor's Recommendations:	See CONSENT037 (IIIB1a)

Paragraph	CONSENT039 (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:	Partial Compliance:	Non-Compliance: not audited
Measures of Compliance:	*The measures of compliance from the Settlement Agreement and/or Consent Agreement and/or what you will use to measure compliance* • Audit Step a (Chart Review) Patients in withdrawal or at risk for withdrawal receive appropriate monitoring and care, including, but not limited to the provisions of NCCHC Jail Standard J-G-06 and Appendix H. In general, these provisions fall into the following items: a) monitoring and treatment is conducted pursuant to patient-specific orders from a practitioner, b) monitoring is conducted by trained staff, c) monitoring is conducted using validated instruments (e.g. COWS) if they exist, and otherwise under clear and specific orders, d) while clinical data collection may be collected by any appropriately trained staff, assessments may only be made by RNs or practitioners, e) appropriate treatment is provided.		
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):	Not audited during this visit		
Monitor's Recommendations:	None		

2. Chronic Care

Paragraph	CONSENT040 (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:	Non-Compliance: Not audited
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Practitioners have access to, and either know, or demonstrate the skills to access, nationally accepted chronic disease guidelines. • Audit Step b: (Chart Review) Practitioners provide chronic care consistent with nationally accepted chronic disease guidelines, including the frequency and content of care.		
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):	Not audited during this visit		
Monitor's Recommendations:	None		

Paragraph	CONSENT041 (IIIB2b) (Covered in CONSENT040 (IIIB2a)) 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:	Non-Compliance: Not audited
Measures of Compliance:	Medical Care: • (duplicate) CONSENT041 (IIIB2b) Audit Step b: (Chart Review) Practitioners provide chronic care consistent with nationally accepted chronic disease guidelines, including the frequency and content of care.		
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):	Not audited during this visit		
Monitor's Recommendations:	None		

3. Use of Force Care

Paragraph	CONSENT042 (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.		
Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) The clinical restraint policy states that restraints are used for the minimal amount of time clinically necessary, are observed every 15 minutes by medical and custody staff. • Audit Step b: (Inspection) The custody restraint policy states that qualified medical staff shall be notified immediately after application of restraints in order to review the health record for any contraindications or accommodations required and to initiate health monitoring. • Audit Step c: (Chart Review) For patients placed in clinic restraints: a) the restraints are clinically necessary, b) the restraints are ordered by a practitioner, c) custody and medical staff document 15 minute safety checks. • Audit Step d: (Chart Review) For detainees placed in custody restraints, qualified medical staff are notified immediately after application of restraints, review the health record for any contraindications or accommodations required and conduct 15 minute safety monitoring.		
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):	Not audited during this visit		
Monitor's Recommendations:	None		

Paragraph	CONSENT043 (III.B.3.b.) The Jail shall ensure that inmates receive adequate medical care immediately following a use of force.		
Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: not audited
Measures of Compliance:	Medical Care: • Audit Step a: (Chart Review) Detainees subjected to Use of Force are evaluated immediately afterwards: a) documentation reflects the nature of the force and any patient symptoms, b) evaluation is conducted by, or under the direct supervision of, an RN or practitioner, c) the content of the evaluation is clinically appropriate, including evaluation of reasonably possible injuries based on the nature of the force, symptoms, or findings.		

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):	Not audited during this visit
Monitor's Recommendations:	None

Paragraph	CONSENT044 (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:	Partial Compliance:	Non-Compliance: Not audited
Measures of Compliance:	<u>Medical Care:</u> • Audit Step a: (Inspection) Detainees interviewed following evaluation for an injury report being questioned by Qualified Medical Staff regarding the cause of the injury outside the hearing of other inmates or officers • Audit Step b: (Inspection) When interviewed, nurses and practitioners on staff report that when they evaluate patients with any injury, they always consider whether the injury might be the result of staff-on-inmate abuse, and if so, (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.		
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):	Not audited during this visit		
Monitor's Recommendations:	None		

C. MENTAL HEALTH CARE AND SUICIDE PREVENTION (All jointly assessed with MH Monitor)

3. Suicide Assessment and Prevention

Paragraph Stern and Ruiz	CONSENT068 (III.C.3.g.) 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:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) There is an emergency response bag in close proximity to all housing units. The bag contains, at a minimum, a CPR mask or bag-mask ventilator, material to control bleeding, gloves, eye protection, and a cut-down tool. [If unit officers have been trained in compression-only CPR, the Medical Monitor will accept, instead, that a CPR mask or bag-mask ventilator is brought to the scene of all emergencies by responding CHS staff. If all staff carry CPR masks, the Medical Monitor will accept this in lieu of placement of the masks in the emergency response bag.] • Audit Step b: (Inspection) There is an inventory mechanism in place to ensure that emergency response bags are where they should be, have the proper contents, and the contents are operational. [Tamper seals may be used to decrease the frequency of verification of the contents of each bag.] • Audit Step c: (Inspection) When interviewed, custodial and medical staff correctly describe the location of emergency response bags. • Audit Step d: (Inspection) Policy specifies an appropriate first aid training strategy for housing unit officers (e.g. who is trained, how often). • Audit Step e: (Inspection) An effective curriculum is used during first aid training that addresses qualifications of trainers, curriculum, assessment of competency. • Audit Step f: (Inspection) Training records show that housing unit officers receive first aid training as specified in policy. Mental Health: 1. On-site review of first aid kit and resources. 2. Review of record of education / training to CHS and officers in emergency response 3. Review of adverse events		
Steps taken by the County to Implement this paragraph:	Mental Health: MDCR policy regarding emergency bags does not assign responsibility to the Jail for maintaining emergency and first aid equipment. It states, "MDCR and IMP/IMP mental health staff responding to the scene shall bring emergency rescue/medical equipment, e.g., rescue tool, medical supplies, resuscitation breathing mask, Ambu bag, AED, etc. If the incident is an inmate suicide or suicide attempt, immediately upon notification, the Shift Supervisor/Commander shall call and advise 911 staff of the emergency."		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the	Medical Care: Not evaluated by the Medical Monitor during this visit. Mental Health: During the on-site inspection, spot checks at several different facilities were completed. These spot checks included a		

factual basis for finding(s):	cut down tool, Ambu bag and first aid kit. However, the materials were not located in one specific bag or location. I did not review training materials and records of current CPR certification. The Quality Director plans to audit files intermittently for mandatory education / training and competencies. These audits have not started. Review of adverse events demonstrated inadequate and problematic documentation of response times and treatment in urgent and emergent cases.
Monitors' Recommendations:	Medical Care: None Mental Health: The Mental Health Monitor concurs with plans to maintain track and audit training records for suicide prevention and emergency response. Medical emergency response bags should be put together and available on all housing units. In addition to this, adverse events should be reviewed for evidence of timely response, use of appropriate life-saving tools, and identification of at-risk individuals.

Paragraph Stern and Ruiz	CONSENT088 (III.C.6.a.(10)) 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:	Non-Compliance: Not completely audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a1: (Inspection) Training curricula for nurses who perform daily welfare checks in segregation units includes the description of an adequate encounter, i.e. that there is a meaningful verbal and visual engagement with the inmate, sufficient for the nurse to determine that patient's general condition is adequate and that the inmate has an opportunity to express any unmet health care needs. • Audit Step b: (Inspection) With occasional exception, interviewed inmates report that when in segregation, nurses make adequate daily welfare checks. • Audit Step c: (Inspection) Nurses make adequate daily welfare checks on all inmates in segregation as measured by one or more of the following: interviews with nurses, interviews with segregation unit officers, nurse documentation of encounters, and review of video recordings. • Audit Step d: (Inspection) With occasional exception, interviewed inmates report that they have timely access to care for non-urgent medical concerns. • Audit Step e: (Chart Review) Non-urgent requests for health care from patients in segregation results in timely and clinically appropriate care. • Audit Step f: (Inspection) With occasional exception, interviewed inmates report that they have timely access to care for urgent medical concerns. • Audit Step g: (Chart Review) Urgent requests for health care from patients in segregation results in timely and clinically appropriate care. • Audit Step h: (Inspection) The setting for clinical care for inmates in segregation affords as much privacy as reasonable security precautions will allow. • Audit Step i: (Inspection) Segregation unit officers receive training in rules regarding the confidentiality of health care information they acquire during health care encounters. • Audit Step j: (Inspection) When interviewed, segregation unit officers correctly describe the rules regarding their handling of confidential health care information they acquire during health care encounters. Mental Health: 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:	Mental Health: MDCR policy on access to health care states inmates shall have adequate access to timely medical and mental health care. Specifically in segregation, a medical staff member will perform rounds daily on all inmates.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals	Medical Care: • Daily welfare checks at the segregation unit of at least one facility are insufficient to satisfy this paragraph. During the Medical Monitor's tour of the MWDC segregation unit, for many of that day's health care welfare		

interviewed, verification of the County's representations, and the factual basis for finding(s):	checks, the nurse documented "moved." When interviewed, the nurse reported that "moved" meant that the nurse looked in the window of the cell and noted some physical movement of the patient; there was no meaningful encounter. • CHS policy does not specify the nature of the welfare check. • Other parts of this paragraph were not systematically evaluated during this visit. <u>Mental Health:</u> Inmates in custodial segregation have the opportunity to contact medical staff either during pill pass (if they are prescribed medication) or during medical staff rounds that occur three times per week. They do not have adequate privacy to contact and receive treatment from a mental health perspective. Interviews are conducted via the sally port in the door in full view and within close range to custodial officer, other patients, and other staff. Further, current policy states that all patients on 9C shall have no recreation for the first seven days of his or her incarceration until the IDTT. Given that recreation and showers are integral to mental health, such a blanket policy is not appropriate.
Monitors' Recommendations:	<u>Medical Care:</u> 1. When conducting welfare checks, nurses should engage in a meaningful interaction with the patient such that staff are "able to ascertain the [patient's] general medical and mental health status" (NCCHC Standard J-E-07). 2. CHS policy should specify the nature of a nurse welfare check. <u>Mental Health:</u> • Medical staff should round on all inmates within disciplinary segregation daily. I recommend developing and implementing a policy to ensure this. • Audits should track and assess the adequacy of treatment of all inmates with severe mental illness in custodial segregation. Requests for care by inmates should be tracked for evidence of adequate and timely follow-up. Information that should be checked includes access to treatment, consistency in care, and implementation of orders in a timely manner.

D. Audits and Continuous Improvement

1. Self Audit Steps

Paragraph Stern and Ruiz	CONSENT110 (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:	Non-Compliance: not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Review of appropriate documents (e.g. meeting minutes) reveal that at least quarterly CHS staff review data regarding medical care to identify potentially harmful patterns or trends. Such review will include not only the active cause of the patterns or trends, but also the underlying (or root) cause(s). Mental Health: 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:			
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: Not audited during this visit Mental Health: CHS reports plans to implement the Mental Health Review Committee and Risk Management and Quality Improvement Committee.		
Monitor's Recommendations:	Medical Care: None Mental Health: The Risk Management and Quality Improvement Committee for CHS should systematically review and analyze serious incident reports, use of force reports, and inmate grievances for allegations of staff misconduct, particularly as hey relate to inmates with mental illness, development delay and cognitive disorder secondary to profound substance misuse.		

Paragraph Stern and Ruiz	CONSENT111 (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:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Review of appropriate documents reveals that within 30 days of quarterly reviews, MDCR staff have developed and implemented corrective action plans addressing potentially harmful patterns or trends in medical care. The corrective action plans address the active and underlying (or root) cause(s) in a sustainable manner (e.g. changes to policy, procedures, job descriptions, training curricula.) Mental Health: 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: Not evaluated by the Medical Monitor during this visit. Mental Health: NA.		
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: Not audited during this visit Mental Health: NA.		
Monitor's Recommendations:	Medical Care: None Mental Health: NA.		

2. Bi-annual Reports

Paragraph Stern and Ruiz	CONSENT113 (III.D.2.a.) (2) 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. 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:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: Not audited / not due yet
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) The Medical Monitor receives bi-annual reports of health care delivered to inmates including the volume of and reason for episodic clinic visits, chronic care clinic visits, ER transfers, and hospitalizations. Mental Health: Review of bi-annual reports, to be submitted in a timely manner and to include accurate data.		
Steps taken by the County to Implement this paragraph:	Medical Care: Not evaluated by the Medical Monitor during this visit. Mental Health: NA.		
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: Not audited during this visit Mental Health: NA.		
Monitor's Recommendations:	Medical Care: None Mental Health: NA.		

Paragraph Stern and Ruiz	CONSENT117 (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:… 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:	Partial Compliance:	Non-Compliance: Not yet due
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) The Medical Monitor receives bi-annual reports of inmate injuries, medical emergencies and in-custody deaths. [NB: For the purpose of this report, MDCR should include deaths which occur outside the MDCR facility (e.g. hospital) and regardless of whether or not the inmate was in custody, if the death resulted from a health status/condition that existed while the inmate was at MDCR. Mental Health: 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 Care: Not evaluated by the Medical Monitor during this visit. Mental Health: Bi-annual reports related to medical, mental health and suicide prevention have not started.		
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: Not evaluated by the Medical Monitor during this visit. Mental Health: Inmate deaths that were reviewed for the period July 2012 through April 2013 are concerning. Five of the eleven inmate mortality reviews indicated that patient has either mental illness and/or substance misuse issues. Another four out of fifteen persons were transferred to the hospital for seizure. No corrective action plan or analysis of these events was included. Reportable incidents should include severe adverse medical events involving patient s with mental health issues and substance use issues.		
Monitors' Recommendations:	Medical Care: Not evaluated by the Medical Monitor during this visit. Mental Health: Reportable incidents should include severe adverse medical events involving patients with mental health issues and substance use issues. It is imperative that the County tracks these issues, analyze systemic problems and implement plans to correct them.		

Paragraph Stern and Ruiz	CONSENT118 (III.D.2.b.) (Covered in CONSENT111 (IIID1c)) 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:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Measures of Compliance:	Medical Care: • (duplicate) CONSENT111 (IIID1c) Audit Step a: (Inspection) Review of appropriate documents reveals that within 30 days of quarterly reviews, MDCR staff have developed and implemented corrective action plans addressing potentially harmful patterns or trends in medical care. The corrective action plans address the active and underlying (or root) cause(s) in a sustainable manner (e.g. changes to policy, procedures, job descriptions, training curricula.) Mental Health: 1. Review of Quarterly Reviews 2. Review of corrective action plans 3. Review of implementation of CAP 4. Review of policy and procedure, as applicable		
Steps taken by the County to Implement this paragraph:	Medical Care: Not evaluated by the Medical Monitor during this visit. Mental Health: NA		
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 CONSENT111 (IIID1c) Mental Health: No documentation was provided for review of this provision.		
Monitors' Recommendations:	Medical Care: None Mental Health: Please implement quarterly reviews and corrective action plans, as indicated. As stated in other sections of this report, I strongly recommend that both CHS and MDCR collaborate to comprehensively review each adverse events and each of the inmate deaths in a systematic and organized fashion. A qualitative review should include an examination of the cause of death, contributing factors, and an analysis of what may have been preventable or what may be improved. Trends should be analyzed and systemic issues identified for improvement.		

IV. COMPLIANCE AND QUALITY IMPROVEMENT

Paragraph Stern and Ruiz	CONSENT119 (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:	Non-Compliance: Not yet due
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due
Measures of Compliance:	Medical Care: • Audit Step a: (Other) This compliance measure will be assessed by exception, i.e. failure to meet any of the 3 requirements below as they pertain to any other provision of the Consent Agreement. a) Develop/revise operational documents to implement the Consent Agreement, b) Provide initial and in-service training to relevant jail staff with respect to new/revised policies and procedures, c) Send new policies and procedures to Medical Monitor for approval. Mental Health: 1. Policies and procedures 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. Lesson plans 5. Evidence training completed and knowledge gained (e.g. pre and post tests) 6. Observation 7. Staff interviews.		
Steps taken by the County to Implement this paragraph:	Mental Health: CHS has hired Rachel Rodriguez, RN, MSN, LHRM as Associate Director of Quality Assurance. Together with Kevin Andrews, Vice President of Quality and Patient Safety and Bill McKeon, new interim Director of Health Services, CHS has reported plans to revise policy, implement training, and track continuous quality improvement. Mental Health		
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: Not yet due Mental Health		
Monitor's Recommendations:	Medical Care: None		

	Mental Health: None

Paragraph Stern and Ruiz	CONSENT120 (IV.B) The County and CHS shall develop and implement written Quality Improvement policies and procedures adequate 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:	Partial Compliance: July 2013	Non-Compliance:
Mental Health: Compliance Status:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) CDCR has policies and procedures governing its quality improvement process • (duplicate) CONSENT110 (IIID1b) Audit Step a: (Inspection) Review of appropriate documents (e.g. meeting minutes) reveal that at least quarterly CHS staff review data regarding medical care to identify potentially harmful patterns or trends. Such review will include not only the active cause of the patterns or trends, but also the underlying (or root) cause(s). • (duplicate) CONSENT111 (IIID1c) Audit Step a: (Inspection) Review of appropriate documents reveals that within 30 days of quarterly reviews, MDCR staff have developed and implemented corrective action plans addressing potentially harmful patterns or trends in medical care. The corrective action plans address the active and underlying (or root) cause(s) in a sustainable manner (e.g. changes to policy, procedures, job descriptions, training curricula.) Mental Health: 1. Policies and procedures regarding incident reports, including criteria for screening for critical incidents and suicide attempts (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:	Medical Care: See Monitor's analysis below. Mental Health: The Agreement requires the implementation of a Mental Health Review Committee and a Risk Management & Quality Improvement Committee. These committees have not been implemented to date. CHS Policy J-A-04- addendum states: The Mental Health Review Committee members will include CHS Director, CHS Medical Director, CHS Lead Psychiatrist, Mental Health Program Director, Quality Risk Management Representative, and MDCR Medical Liaison. MDCR has no companion policies for Mental Health Review Committee or Quality Improvement / Risk Management. DSOP 14-007 speaks to medical compliance, but it does not outline or prescribe the need to maintain open collaboration and communication with CHS to improve mental health care delivery and suicide prevention.		
Monitors' analysis of conditions to assess compliance, including	Medical Care: CHS has a policy governing its quality improvement process.		

documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Other parts of this paragraph were not systematically evaluated during this visit. <u>Mental Health:</u> CHS has not yet implemented the Mental Health Quality Review Committee or Quality Improvement Committee.
Monitors' Recommendations:	<u>Medical Care:</u> 1. Three important elements should be added to the policy governing quality improvement (J-A-06). First, the policy should specifically cite some of the key sources of input for its review, including, but not limited to: a) grievances, b) near misses reported through the error reporting system or discovered in other ways, c) suspected preventable adverse events, d) complaints from other sources, and e) mortality reviews. Second, the policy should specify that quality improvement efforts based on complaints or adverse events (near misses + preventable adverse events) should be evaluated thoroughly to determine all underlying (root) causes. Third, any remedial action generated by such reviews needs to also have a sustainable component. A sustainable component is usually a change to policy, procedure, training curriculum, job description, post orders, or other permanent vehicle that outlives the immediate remedies, such as memos, emails, counselings, discussions at staff meetings, etc. 2. MDCR might consider adding another valuable source of input for its quality improvement process: scheduled living unit meetings between CDCR staff (optimally a pair of representatives, one each from CHS and custody) and inmates. Such meetings can be a low cost, low risk, high yield opportunity for upper and mid level managers (and even front line staff) to "keep a finger on the pulse" of health care delivery. <u>Mental Health:</u> MDCR and CHS should revise policy and implement a plan to ensure adequate communication between custody, medical and mental health. CHS plans to implement the Quatros Incident Reporting System. This information will be useful to custody. The County should implement plans for the mental health review committee that include adequate representation from custody on a mandatory basis. This should review, on at least a monthly basis, data triggers at the individual and system levels. It should also analyze and aggregate mental health data to identify trends that present a risk of harm.

Paragraph	CONSENT121 (IV.C) [Joint audit with MH] 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.		
Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) There is evidence of annual review of policies and procedures for any needed changes. • (duplicate) CONSENT119 (IV.A) Audit Step a: (Other) This compliance measure will be assessed by exception, i.e. failure to meet any of the 3 requirements below as they pertain to any other provision of the Consent Agreement. c) Send new policies and procedures to Medical Monitor for approval. Mental Health: 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: Not evaluated by the Medical Monitor during this visit. Mental Health: Annual review not evaluated to date.		
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: Not yet due Mental Health: NA		
Monitor's Recommendations:	Medical Care: None Mental Health: None		

Appendix C-1
List of Documents Reviewed by Medical Monitor
(Patient medical records are listed separately in Appendix C)

1. Log of medical grievances from all 4 facilities, covering – depending on the facility - 2013 to July 2013
2. Medical grievances from all 4 facilities, May, 2013 to July 2013, either all grievance sampling, depending on the facility
3. CHS Policies
4. CHS's DOJ Response Action Plan dated July, 2013

Appendix C-2
List of Staff Interviews by Medical Monitor (Appendix B)

Rick Morse CHS Director
Calixto Calderon CHS Medical Director
Rachel Rodriquez CHS Assoc Dir QA
Mary Mites, CHS H.S.A.
Mercy Yero Rodriquez, Jackson Nurse Educator assigned to CHS
Donna Benjamin, RN, Jackson IT Cerner
Wayne Wilbright, MD, CMIO Jackson
Mike Garcia, VP CIO
Eric Leal, Jackson IT – MASS (Medical Appt Scheduling System)
Ginger Adler, Jackson IT – MASS
John Repique, VP Jackson Behavioral Health
Eli Medina, CHS Financial Officer
Jayme Shmidt, Sapphire
Nikki Tuskey, Sapphire
Tarig Rasheed, Jackson IT, MASS
Practitioners, nurses, and officers at TGK, TTC, Intake, PTDC, and MWDC

Appendix C - 3
List of Patients Reviewed by Medical Monitor

This is a list of medical documents reviewed by the Medical Monitor. Each review may be more or less extensive. Documents reviewed may be complete medical records, parts of medical records, or facility compilations of medical information (e.g. mortality review).

Patient 1
Patient 2
Patient 3
Patient 4
Patient 5
Patient 6
Patient 7
Patient 8
Patient 9
Patient 10
Patient 11
Patient 12
Patient 13
Patient 14
Patient 15
Patient 16
Patient 17
Patient 18
Patient 19
Patient 20

Report D
Compliance Report # 1
Mental Health Care
Report of Tour of Week of July 15 – 19, 2013

Executive Summary

Because the first tour was spent familiarizing ourselves with the physical plant, personnel and operations of the MDCR, several of the relevant compliance measures of the two Orders were not formally evaluated. Relevant findings are contained within the body of the report. In this introductory section, however, the Mental Health Monitor focuses on two topics: access to adequate mental health care and suicide prevention.

The most significant findings regarding access to mental health care and suicide prevention are presented here because these are the subject of several separate paragraphs of the Orders.

While on site, I visited the PTDC, where inmates with Severe Mental Illness (SMI) that are designated Level I and II are housed. It was clear that both the lead psychiatrist and psychologist knew the patients well. They were concerned about patient care and this was evident.

I also spoke to inmates and reviewed medical records. These sources confirmed that patients with mental illness are not being tracked throughout their movement within the various MDCR facilities. As a result, patients with SMI are not routinely able to access timely and adequate mental health care. Examples include the following:

1. Patient A: Staff indicated a delay in access to care due to inadequate mental health staffing at night.
2. Patient B: Although a qualified mental health professional made a referral to medical for treatment, the patient did not receive adequate and timely care.
3. Patient C: A middle-aged patient with a history of alcohol abuse and SMI was adequately screened upon admission. He was subsequently transferred to Metro West; when I requested his chart there to confirm that he had been seen by a psychiatrist, I was told the chart did not exist or could not be located.

The physical plant of the PTDC has numerous tie off points for suicidal inmates. There is no therapeutic space. Access to mental health care, recreation, and showers are inadequate. Because plans for a new mental health facility have not been confirmed, I strongly recommend that the inmates with severe mental illness (SMI) on the 9th, 10th, and over-flow floors be moved to a safe and humane environment. Failure to move the inmates and/or provide adequate supervision places both the facility and the inmates at risk:

inmates with severe mental illness and/or suicidal ideation are less likely to disclose their serious symptoms if he or she realizes it will automatically result in seven days of 'therapeutic lock down.'

1. A number of the Mental Health paragraphs could not be rated as Complaint/Partially Compliant/Non-Compliant, either because the provision is not yet due, because the Mental Health Monitor did not assess it during the visit, or because the Mental Health Monitor assessed only part of the paragraph and that part was non-compliant (but there is insufficient information about other parts of the paragraph).

2. The Mental Health Monitor reviewed the charts of patients who recently died. Some examples in this report are drawn from those cases. However, the Mental Health Monitor did not provide any more formal feedback on these cases as they are still under investigation by the County.

List of Documents Reviewed by Medical Monitor (Appendix D-1)
List of Staff Interviews by Medical Monitor (Appendix D-2)
List of Patients Reviewed by Medical Monitor (Appendix D-3) (not available in the public version of this document)

Abbreviations:

MAR	Medication Administration Record
PA	Physician Assistant
NP	Nurse Practitioner (APRN)
ML	Midlevel practitioner (PA or NP)
PRN	Medications prescribed "as needed"
SMI	Severe Mental Illness

A. MEDICAL AND MENTAL HEALTH CARE (All jointly assessed with Medical Monitor)

1. Intake Screening

Paragraph	III. A. 1. Intake Screening: b. 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:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	*NA*		
Measures of Compliance:	Mental Health: 1. Results of internal audits demonstrating compliance with NCCHC indicator J-E-05 2. Results of internal audits demonstrating completion of intake screening upon admission 3. Result of internal audit demonstrating 90% or more of inmates who screen positively shall be referred to qualified mental health professionals for further evaluation 4. Record review 5. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	CHS has written policy, J-E-05, Mental Health Screening and Evaluation. It states: "Inmates receive a mental health screening. Inmates with positive screens receive a mental health evaluation." MDCR policy (DSOP 14) regarding access to mental health care states, "It is the policy of the Miami-Dade Corrections and Rehabilitation Department (MDCR) to provide inmates with medical, dental and mental health services while housed in a MDCR detention facility. All inmates in need of health services shall be identified and given access to care in a timely manner as well as afforded continuity of care. Healthcare encounters, including medical and mental health		

assess compliance, verification of the County's representations, and the factual basis for finding(s)	**Evaluation."** This form includes all compliance indicators of National Commission on Correctional Health Care J-E-05. This form is administered by a social worker.
Monitor's Recommendations:	CHS reported plans to train all medical staff on intake procedure and process. The Mental Health Monitor concurs with the proposed audits and review of records to assess adherence to the intake screening policy.

Paragraph	III. A. 1. Medical and Mental Health Care, Intake Screening: c. 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Record review of adherence to screening, assessment, and trigger events as described in Appendix A 2. Review of housing logs; 3. Review of observation logs for patients placed on suicide precaution. 4. Review of adverse events and deaths of inmates with mental health and substance misuse issues.		
Steps taken by the County to Implement this paragraph:	1. CHS has written policy, J-G-05, Suicide Prevention Program states, "The facility identifies suicidal inmates and intervenes appropriately." 2. MDCR policy (DSOP 12-003) outlines Suicide Prevention and Response Plan. It covers the responsibility of all staff to identify inmates at risk of suicide. In reference to housing, it states: 3. If an inmate displays signs of suicidal tendencies, he/she shall be placed in a single suicidal non-stripped cell separate from other inmates. The inmate shall be under direct observation until IMP mental health staff has evaluated the inmate's degree of risk. A Physical Sight Check Sheet shall be documented at intervals not to exceed 15 minutes by sworn staff and/or medical staff. Checks may be documented more than 4 times per hour.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS policy requires "appropriate intervention" for inmates at risk of suicide and urgent or emergent mental health referrals. Both CHS and MDCR state actively suicidal inmates will be placed on constant observation. Despite current policy, recent deaths in the mental health section of PTDC and other inmates on the mental health caseload are cause of grave concern.		
Monitor's Recommendations:	The Mental Health Monitor concurs with the proposed audits and review of records to assess adherence to the suicide screening, supervision and housing policy. In addition, I recommend review of all adverse events related to inmates with mental health and/or and substance use issues for qualitative analysis and corrective action.		

Paragraph	III. A. 2. Health Assessments: b. 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:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Review of policy regarding mental health evaluation and screening 2. Record review for adherence to screening, assessment and trigger events as described in Appendix A. 3. Interview of staff and inmates.		
Steps taken by the County to Implement this paragraph:	CHS Suicide Prevention policy is covered in J-G-05. Form CHS-MHSE 3/12 is the Mental Health Screening and Evaluation form. It includes the screening factors described in Appendix A of the Consent Agreement. This form is utilized to screen inmates upon entry or booking into TGK.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	There is no specific suicide risk assessment form for inmates that present with suicidal ideation or require assessment mid-incarceration. Suicide risk screening is not equivalent to suicide risk assessment, which is a comprehensive assessment.		
Monitor's Recommendations:	It is recommended that CHS consider developing and implementing policy for suicide risk assessment by QMHPs. A form that outlines the procedure for suicide risk assessment, which is more detailed than suicide risk screening at booking and may be necessary at any point during incarceration may be helpful in guiding the implementation of suicide risk assessment.		

Paragraph	III. A. 2. Health Assessments: c. 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:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Review of policy regarding mental health evaluation and screening 2. Record review for adherence to trigger events, referral and assessment as described in Appendix A. 3. Interview of staff and inmates. 4. Review of all adverse events involving inmates with mental health and substance misuse issues.		
Steps taken by the County to Implement this paragraph:	CHS Suicide Prevention policy is covered in J-G-05. Form CHS-MHSE 3/12 is the Mental Health Screening and Evaluation form. It includes the screening factors described in Appendix A of the Consent Agreement. This form is utilized to screen inmates upon entry or booking into TGK.		
Monitor's analysis of conditions to assess compliance, verification of	As stated above, there is no specific suicide risk assessment form for inmates that present with suicidal ideation or require assessment mid-incarceration. Suicide risk screening is not equivalent to suicide risk assessment, which is a		

the County's representations, and the factual basis for finding(s)	comprehensive assessment.
Monitor's Recommendations:	It is recommended that CHS consider developing and implementing policy for suicide risk assessment by QMHPs. A form that outlines the procedure for suicide risk assessment, which is more detailed than suicide risk screening at booking may be helpful. As noted by the NCCHC[14], suicide risk assessment should be viewed as an ongoing process, as it may be necessary at any point during incarceration. Staff should not rely exclusively on an inmate's denial of being suicidal or having a history of suicidal behavior, particularly when the inmate's actions or previous confinement behavior indicates the presence of elevated risk. To that end, a form that may be used to assess suicide risk as clinically indicated at different junctures throughout the inmate's confinement may be useful. The Mental Health Monitor concurs with CHS plans to review all adverse events by Quality / Risk within 72 hours. These events should also be reviewed with input from MDCR.

Paragraph	III. A. 2. Health Assessment: d. 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Review of policy regarding mental health evaluation, risk management and documentation 2. Record review for adherence to screening, trigger events, referral and assessment as described in Appendix A. 3. Interview of staff and inmates.		
Steps taken by the County to Implement this paragraph:	Treatment plans and their implementation are outlined in CHS policy, J-G-04 Addendum 1. <u>MDCR does not have a companion correctional policy for interdisciplinary treatment plans.</u>		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	1. Section 2 of J-G-04 states, "2. Inmates arriving to the jail and who are assessed as Level I or II and who remain in the jail for 30-days and who remain as Level I or II will have an interdisciplinary team meeting and assessment with a plan of care by day 45 of their initial evaluation and placement as Level I or II." 2. The policy as written is unclear as to interdisciplinary treatment team meetings and the requirement of a risk profile as per the factors in Appendix A. 3. I did not find specific treatment plans or evidence of their implementation. CHS indicated a plan to review treatment plans for their adherence to factors in Appendix A.		
Monitor's Recommendations:	The Mental Health Monitor concurs with plans to review and audit interdisciplinary treatment plans. As indicated previously, the development of a specific suicide risk assessment may assist with development of treatment plans. In		

[14] Standards for Mental Health Services in Correctional Facilities 2008, Appendix D, Guide to Developing and Revising Suicide Prevention Protocols p.123

	addition, MDCR should develop policy regarding interdisciplinary treatment plans, participation in interdisciplinary treatment team (IDTT) meetings, and train staff to the specifics required of the policy and Appendix A.

Paragraph	III. A. 2. Health Assessment: g. All individuals performing health assessments shall receive comprehensive training concerning the policies, procedures, and practices for medical and mental health assessments and referrals.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Review of policy regarding mental health and mental health staff training 2. Review of records, including sign-in sheets, for any training performed 3. Review of training materials, including power point slides and the training of the presenters		
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 Response to Consent Agreement reflects plans to train medical, mental health and custodial staff on relevant mental health policies and procedures. This training has not occurred to date. No lesson plans were submitted. An outline of the CIT lesson plan was reviewed. This lesson plan did not include the suicide prevention training curriculum topics as outlined in the Consent Agreement.		
Monitor's Recommendations:	Please implement adequate annual training protocols for all mental health staff. In reviewing the documentation provided on CIT, the training program is a general outline of procedures to be followed. The training syllabus needs to be based on the CHS and /or MDCR policies, or law or regulations. If management expects officers, medical and mental health staff to be competent to administer the written policies, then the training plan and specific course syllabuses needs to be consistent with those policies and include enough detail to assure management that all provisions of the policies are addressed in the required training. This should be the format for review of the mental health and suicide prevention training.		

Paragraph	III A 4. Medication Administration and Management b. By January 2014, CHS shall develop and implement a medication continuity system so that incoming inmates receive medications for serious medical and mental health needs in a timely manner, as medically appropriate and as follows: (1) 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; (2) 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.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due

Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 1. Review of policy on medication orders and administration 2. Review of records demonstrating Qualified Mental Health Professional's clinical justification to continue, discontinue, or change an inmate's reported medication for serious medical or mental health needs. 3. Review of records demonstrating medication administrating timeline to first dose of any prescribed medication within 24 hours of entering the Jail 4. Review of records to demonstrating timeline for evaluation of inmates with serious mental health needs (48 hours)		
Steps taken by the County to Implement this paragraph:	CHS reported plans to implement computerized physician order entry and utilize Sapphire for medication review / reconciliation.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Examination of current pharmacy procedures for inmates with mental health illnesses demonstrated inadequate record keeping. CHS was unable to provide me documentation or tracking of numbers of inmates with mental health diagnoses, their medications, and evidence of adequate continuity of care.		
Monitor's Recommendations:	CHS anticipates that Sapphire will permit for reporting and auditing of timely medication administration, missed medications and compliance with medication reconciliation process. This will reportedly be audited by the Quality Department. If the Sapphire system is implemented, this may be adequate. A medical doctor, preferably a psychiatrist, should evaluate, in person, inmates with serious mental health needs within 48 hours of entry to jail. The doctor should review and decide whether to discontinue, change or continue an inmate's psychotropic medication. Medical technical assistants, psychologists, psychiatric technicians or social workers should not make medication decisions. Should implementation of Sapphire be delayed or aborted, another pharmacy tracking system should be implemented. This may require assigning one specific individual at each facility to track inmates with mental health disorders, their medications and accuracy of medication dispensation. Possible tools to assist with tracking include developing an Excel or Access database and intermittent review of medication administration records.		

Paragraph	III. A 4. Medication Administration and Management c. 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:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health:		

	1. Policy/procedure to track, analyze data, and review Levels of Care and access to care 2. Review of records to assess psychiatrist-patient visits 3. Interview with staff and inmates
Steps taken by the County to Implement this paragraph:	CHS Policy J-G-04 Addendum 2 defines level of care and follow-up by the psychiatrist: **Level I.** Psychiatrist will conduct follow-up encounter with the inmate on a daily basis, including weekends and holidays. **Level II & Level III.** Psychiatrist will conduct follow-up encounter at a frequency of no less than at least once every 30 days. **Level IV.** Psychiatrist will conduct follow-up encounter at a frequency of no less than once every 90 days.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The CHS policy is adequate. CHS appears to be following Level I patients on a daily basis. I was not provided evidence of psychiatric follow-up of patients on Level III and Level IV.
Monitor's Recommendations:	A psychiatrist should follow all patients with SMI on a regular basis, including patients not housed at the PTDC and patients on Levels II, III and IV. These patient visits should be adequately documented in the medical record, including treatment plans.

Paragraph	III A 4 Medication Administration and Management d. 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Policy regarding medication administration and reporting 2. Review of Medication Administration Records 3. Review of reports to Qualified Mental Health Professionals		
Steps taken by the County to Implement this paragraph:	CHS Policy J-D-02-e states: If an inmate refuses or missed a prescribed medication (s) for two consecutive time intervals, the nurse must notify the physician/ARNP/PA or psychiatrist promptly (not to exceed eight hours) for timely medical psychiatric interventions. If a psychotropic medication is missed 24 hours or greater than the psychiatrist must be notified. CHS reported plans to have the Health System Administrator perform weekly rounds and observations to validate proper medication preparation and delivery.		
Monitor's analysis of conditions to	Although CHS policy requires that the psychiatrist be notified if a patient misses a psychotropic medication for two		

assess compliance, verification of the County's representations, and the factual basis for finding(s)	consecutive intervals, there is no policy that prescribes that the patient must be seen by a QMHP within twenty-four hours. Regular and routine delivery of psychotropic medication has been problematic. Review of medication administration records was notable for gaps in dispensation as well as documentation of the reason for refusals, etc. There was no evidence of notification to the QMHP of refusals and follow-up care.
Monitor's Recommendations:	Policy should be updated to reflect that not only should the psychiatrist be informed of consecutive medication misses, but also a QMHP should follow-up within 24 hours of notice. This follow-up should be documented. If the patient is refusing medication or missing doses secondary to side effects or other (non-systemic) issues, a psychiatric assessment should be conducted and documented in the medical record. This assessment should reflect an individual plan that addresses medication concerns. For example, if a patient is non-adherent secondary to psychosis or mania, it is possible that the patient may require referral to a higher level of care or may require administration of injectable (rather than oral) psychotropic medication.

Paragraph	III. A. 5. Record Keeping b. 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:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Policy regarding scheduling and documentation 2. Review of medical and mental health records for access to care 3. Review of scheduling system 4. Review of Mental Health grievances		
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 does not have an electronic scheduling system. Plans to implement an Appointment Scheduler System (MASS) are underway.		
Monitor's Recommendations:	Please implement an electronic scheduling system.		

Report # 1 of Compliance
Report of Tour Week of July 15 – 19, 2013

Executive Summary

The attached report is submitted in accordance with the consent agreement in the case of United States of America, Plaintiff vs. Miami-Dade County, Miami-Dade County Board of Commissioners; and Miami-Dade County Public Health Trust, Defendants case 1:13-CV-21570-xxxx. From July 16-20, I conducted a tour of the Miami-Dade Corrections and Rehabilitation Department (MDCR) facilities including Boot Camp, Pretrial Detention Center (PTDC), Training & Treatment Center (TTC; also referred to as Stockade), and Metro West Detention Center (MWDC).

The purpose of the tour was to assess compliance with the Miami Dade Settlement Agreement Section III C Mental Health Care and Suicide Prevention. This initial report outlines the actions taken by Miami-Dade Correction and Rehabilitation Department (MDCR) to provide constitutionally adequate mental health treatment and protection from self harm including the following remedial measures regarding: (1) Referral Process and Access to Care; (2) Mental Health Treatment; (3) Suicide Assessment and Prevention; (4) Review of Disciplinary Measures; (5) Mental Health Care Housing; (6) Custodial Segregation; (7) Staffing and Training; (8) Suicide Prevention Training; and (9) Risk Management. [1]

Both prior to the review and afterwards, I reviewed numerous Correctional Health System policies related to access to medical and mental health care, suicide prevention, continuous quality improvement and mortality review. I also reviewed the companion MDCR policies as applicable. Most policies had been updated within the prior year. In addition, I reviewed a document submitted by Correctional Health Services entitled, "Department of Justice Response to Consent Agreement April 2013" dated June 2013. While significant work had been completed on writing policies related to mental health care according to National Commission of Correctional Health Care guidelines, several inconsistencies were noted between the policies as written and the requirements of the consent agreement for compliance. Recommendations include further review to enhance the specificity of both MDCR and CHS the policies and procedures and identifying specific persons responsible with accountability for implementing specific steps. For example, procedures should include a percentage of mandatory attendance for Interdisciplinary Treatment Team, Mental Health Quality Review, and Quality Improvement and Risk Management meetings. In this way, one group is not at the table without another much-needed representative from medical, mental health, or custody.

While on site, I visited the PTDC, where inmates that are designated Level I and II are housed. I also spoke to inmates and reviewed medical records. These sources confirmed

[1] Case 1:13-cv-21570-XXXX Document 1-5 Entered on FLSD Docket 05/01/2013 Page 16 of 37

that patients with mental illness are not routinely able to access timely and adequate care. One chart I reviewed with staff indicated a delay in access to care due to inadequate mental health staffing at night. Another chart demonstrated that although a qualified mental health professional made a referral to medical for treatment, the patient did not receive adequate and timely care. A third patient was adequately screened upon admission, yet he was subsequently transferred to Metro West; when I requested his chart there to confirm that he had been seen by a psychiatrist, I was told the chart did not exist or could not be located. I recommend tracking all patients with mental health disorders, including those with substance use issues, throughout their movement in the facility. Follow-up care should include a face-to-face assessment by a psychiatrist on a timely basis as clinically indicated.

The physical plant of the PTDC has numerous tie off points for suicidal inmates. There is no therapeutic space. Access to mental health care, recreation, and showers are inadequate. Because plans for a new mental health facility have not been confirmed, I strongly recommend that the inmates with severe mental illness (SMI) on the 9th, 10th, and over-flow floors be moved to a safe and humane environment. Failure to move the inmates and/or provide adequate supervision places both the facility and the inmates at risk: inmates with severe mental illness and/or suicidal ideation are less likely to disclose their serious symptoms if he or she realizes it will automatically result in seven days of 'therapeutic lock down.'

In subsequent visits, once training, policies, and procedures are fully implemented, I will be monitoring for clear documented evidence of their implementation. I will look specifically at access to care, quality analysis of adverse events and the implementation of corrective actions.

Thank you for the excellent participation, hard work, attention to detail and responsiveness that has gone into improving the provision of medical and mental health care. I applaud Correctional Health System and MDCR for their motivation and commitment to ensuring adequate mental health care and protection from self-harm.

Mental Health Care and Suicide Prevention

1. **Referral Process and Access to Care:** The referral process and access to mental health care is in partial compliance.

Paragraph	III. C. 1. Mental Health Care and Suicide Prevention: 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:		
Compliance Status this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour			
Measures of Compliance:	<u>Mental Health:</u> b. 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: (1) "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. (2) "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. (3) "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, or sooner, if clinically indicated. (4) Review of medical records for implementation of policy. (5) Review of internal audits. (6) Review of emergency, urgent and routine referral logs.		
Steps taken by the County to Implement this	1. CHS has written policy, J-E-02, Receiving Screening. Section 3 of this policy states, "Utilizing the criteria from		

	for incarceration. Inmates who are unconscious, semiconscious, bleeding profusely, mentally unstable, or otherwise urgently in need of medical attention are referred appropriately for care." 2. Booking and screening was moved to Ted Guildford Knight Correctional Center (TGK) in the LEO Lobby on June 18, 2013. 3. MDCR policy (DSOP 14) regarding access to mental health care states, "It is the policy of the Miami-Dade Corrections and Rehabilitation Department (MDCR) to provide inmates with medical, dental and mental health services while housed in a MDCR detention facility. All inmates in need of health services shall be identified and given access to care in a timely manner as well as afforded continuity of care. Healthcare encounters, including medical and mental health interviews, examinations and procedures shall be conducted in a private setting and in a manner that encourages the inmate's subsequent use of health services. In accordance with Departmental Standard Operating Procedure (DSOP) 17-005 "Limited English Proficiency," MDCR shall provide assistance to an inmate whose primary language is not English and requires an interpreter/translator." 4. Regarding the responsibility to provide constitutionally adequate care, MDCR policy states, "The Medical Director of the Medical Care Provider (IMP) shall be the health authority responsible for providing medical, dental and mental health services for all inmates. Health services provided by IMP shall be in compliance with required federal, state and local regulations and providers shall be properly credentialed to provide healthcare services in accordance with standards of the American Correctional Association (ACA), Florida Corrections Accreditation Commission (FCAC), Florida Model Jail Standards (FMJS) and National Commission on Correctional Healthcare (NCCHC) Standards for Health Services in Jails." MDCR states a physician will be available 24 hours. In addition, it states "IMP shall ensure that a mental health professional is available 24 hours a day for crisis intervention and emergency consultations when an inmate reports or demonstrates signs of serious psychological or psychiatric difficulties."
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The specific definitions of "emergency referrals" and "urgent referrals" have not been embedded into the MDCR or CHS policy. The CHS Action Plan states "all identified inmates as emergency referral for medical or mental health will be expedited for a medical evaluation within 30 minutes of emergency referral and 2 hours for mental health evaluation by a QMHP." Summary and disposition elements have been placed on the initial intake screening and mental health screening evaluation forms; 'emergency referrals' and 'urgent referrals' are checked under the same box.
Monitor's Recommendations:	1. Update MDCR and CHS Mental Health policy to reflect intended definitions and timelines for access to care, including designating between urgent and emergent referrals. 2. Consider separating 'emergent referrals' from 'urgent referrals' on the initial intake form and other medical triage referral forms. 3. Run continuous quality improvement / audits on a regular basis for validation of system and to assess timely access to care.

Paragraph	III. C. 1. Mental Health Care and Suicide Prevention: Referral Process and Access to Care b. CHS will ensure referrals to a Qualified Mental Health Professional can occur: 1. At the time of initial screening; 2. At the 14-day assessment; or 3. At any time by inmate self-referral or by staff referral.		
Compliance Status this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour			
Measures of Compliance:	Mental Health Care: 1. Review manual of mental health policies and procedures 2. Results of internal audits 3. Review of medical records		
Steps taken by the County to Implement this paragraph:	CHS has written policy, J-E-02, Receiving Screening and policy, J-E-07, Non-emergency Health Care Requests and Services. These policies encompass "opportunity for daily requests" for mental health services. Per policy, verbal and written requests for service are to be triaged within twenty-four (24) hours. Inmates with positive screens "are referred to a qualified mental health professional."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The CHS intake screening form was edited to include disposition to the QMHP. CHS anticipates scheduling sick call via an electronic system, "Medical Appointment Scheduling System." This system has yet to be implemented.		
Monitor's Recommendations:	1. Consider maintaining log of all emergency, urgent and routine referrals for mental health care, date of referral and date seen in order to track access to care while the MASS system is being implemented. 2. Audit referrals to QMHP and to psychiatry for both false negatives and false positives to ensure current procedure is capturing patients with mental illness and referring them appropriately. 3. Audit referrals to QMHP for evidence in delays in access to care.		

2. Mental Health Treatment

Paragraph	III. C. 2 Mental Health Care and Suicide Prevention: a. 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour			
Measures of Compliance:	Mental Health: 1. Review of manual of mental health policies and procedures 2. Level of care and provision of mental health services including medication management, group therapy and discharge planning 3. Review of mental health staffing vs. mental health population 4. Review of internal audits 5. Review implementation of projected changes in mental health services including: Medical Appointment Scheduling System (MASS), Sapphire (Physician Order Entry System and Electronic Drug 6. Monitoring) and the Electronic Medical Record, Cerner, all projected in August 2014.		
Steps taken by the County to Implement this paragraph:	CHS policy for basic mental health care is outlined in J-G-04. This policy states patients' mental health needs will be addressed "by a range of mental health services of differing levels and focus, including a special mental health housing unit when indicated."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The number of patients that are currently on the mental health caseload was not provided in writing, although the prior Director of CHS, Mr. Morse, estimated that the mental health caseload was approximately 2000 to 2500. The total population on the date of inspection was 5,087. Level I and Level II patients are housed primarily at the Pre-Trial Detention Center. The following numbers of patients on Levels I, II and III were provided: May -290 June- 242 July- 12 Average monthly numbers at PTDC were estimated as follows: Level I- 100-140 Level II- 140		

	Level III- 20-40 CHS has five (5) FTEs of psychiatry, two psychologists, and seven social workers. The American Psychiatric Association has recommended one FTE of psychiatry time for every 75-150 patients with severe mental illness on psychotropic medication within a jail. Interdisciplinary treatment plans have been limited to only those patients on Level I or Level II that remain in the jail for greater than seven days. Insufficient information was available to assess group therapy and discharge planning. Internal audits were not available for review.
Monitor's Recommendations:	A formal staffing plan is pending. However, given current estimated mental health caseload and staffing data, the facility is understaffed as determined by the following: The American Psychiatric Association has recommended one FTE of psychiatry time for every 75-150 patients on psychotropic medication in a jail / correctional facility with severe mental illness. That said, one could safely say that MDCR and CHS are understaffed psychiatrists by 3-6 FTEs. If one similarly extrapolated that social workers and psychology staff are expected to provide groups and other services to Level III and IV inmates (not just screening and assessment on 9C), then FTEs would also need to be increased for those positions, as well. Jackson and MDCR websites demonstrate no current mental health openings.

Paragraph	III 2. C Mental Health Care and Suicide Prevention: b. 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Review of mental health policies and procedures 2. Review medical records, screenings, and referrals for concordance with Appendix A 3. CHS anticipates "100% achievement of compliance" for a minimum of 4 (four) consecutive quarters of retrospective random chart reviews. In my opinion, this target may be reduced to 90%.		

Steps taken by the County to Implement this paragraph:	CHS has a policy for mental health screening and treatment.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS policy for basic mental health care is outlined in J-G-04. During this on-site tour, I interviewed various staff and inmates. I also reviewed several medical records. These sources confirmed that patients with mental illness are not routinely able to access timely and adequate care. One chart I reviewed with staff indicated a delay in access to care "because there is no social worker at night." Another chart I reviewed demonstrated that although the QMHP made a referral to medical for treatment, the patient did not receive adequate and timely care. A third patient was screened in the LEO Lobby and reported his history of mental illness. However, he was subsequently transferred to Metro West. When I requested the chart, I was told it did not exist or could not be located. Charts were also reviewed of patients on 9C at the Pre Trial Detention Facility; these patients had been screened and reviewed by the psychiatrist.
Monitor's Recommendations:	Tracking mechanisms are recommended to measure access to care and delays in treatment. Key performance indicators may include time to appointment (for sick call slips), follow up of Level II, III and IV patients, and an assessment of both quantity and content of mental health grievances.

Paragraph	III. C. 2. Mental Health Care and Suicide Prevention: c. 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: <date>	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Review of manual of mental health policies and procedures 2. Results of internal audits 3. Review of medical records for presence of treatment plans and evidence of their implementation		
Steps taken by the County to Implement this paragraph:	CHS policy J-E-12, Section 5 outlines the use of individualized treatment plans to guide patient care.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	During the tour of the PTDC, I requested that CHS nursing staff randomly select cases for me to review, including the medical record. The medical record documentation of these cases included typical progress notes. None of the cases reviewed had formal treatment plans, including inmates that had been present for seven days or longer.		

	CHS policy J-G-04, Addendum 2 Section 2 states, "Psychiatrist will document each follow-up encounter on the *Psychiatric Progress Note* (C- 255Nb). The progress note will then be filed on the inmate's unified medical and mental health record." The progress notes I reviewed were written by a medical staff member and co-signed by the psychiatrist.
Monitor's Recommendations:	Progress notes and medical records of patients with severe mental illness (SMI) should reflect individualized treatment planning. Further, it is recommended that if the psychiatrist is not writing his or her own progress notes, each writer sign the progress note and date it.

Paragraph	III. C. Mental Health Care and Suicide Prevention: d. 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:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour			
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Results of internal audits 3. Review of medical records for presence of treatment plans and evidence of their implementation		
Steps taken by the County to Implement this paragraph:	Treatment plans and their implementation are outlined in CHS policy, J-G-04 Addendum 1. MDCR does not have a companion correctional policy for interdisciplinary treatment plans.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	1. Section 2 of J-G-04 states, "2. Inmates arriving to the jail and who are assessed as Level I or II and who remain in the jail for 30-days and who remain as Level I or II will have an interdisciplinary team meeting and assessment with a plan of care by day 45 of their initial evaluation and placement as Level I or II. If the inmate remains in the jail and remains classified as Level I or II, then that inmate will have their second (2nd) IDT and plan of care within 45-days of the first IDT in order to have a minimum of two (2) IDT's within the first 90-days of admission." 2. The policy as written is unclear as to the specific timelines for treatment plans and IDT. For example, this portion of the policy reflected the second anticipated treatment plan; provision e.1 (below) refers to inter-disciplinary plans of care for inmates on Level I who are housed seven continuous days or longer. 3. As indicated above, I did not find specific treatment plans or evidence of their implementation. CHS indicated a plan to audit orders for level identification and scheduled appointment for IDT. It also planned to revise the policy and procedure to include a schedule for IDT meetings 30-35 days after first housing and treatment plan.		

Monitor's Recommendations:	I agree with plans to revise the CHS policy and audit for adherence to it and its recommended timelines. It is recommended that MDCR also have a companion policy that speaks to the specific requirements of the Consent Agreement.

Paragraph	III. C. 2. Mental Health Care and Suicide Prevention: e. 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour			
Measures of Compliance:	<u>Mental Health:</u> 1. Review of manual of mental health policies and procedures 2. Results of internal audits 3. 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		
Steps taken by the County to Implement this paragraph:	Treatment plans and their implementation are outlined in CHS policy, J-G-04 Addendum 1. No corrections policy was available in reference to definition and procedure for IDT.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As indicated above, the current policy as written is unclear as to the specific timelines for treatment plans and IDT.		
Monitor's Recommendations:	I agree with plans to revise the policy and audit for adherence to it and its recommended timelines. A companion policy should be written and implemented by custody. This policy should be specific enough to include the requirement of participation in IDT.		

Paragraph	III. C. 4. Mental Health Care and Suicide Prevention: e. 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.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour			
Measures of Compliance:	<u>Mental Health:</u> 1. Review of manual of mental health policies and procedures 2. Results of internal audits 3. Review of log of inmates referred to Forensic Mental Health Facility placement 4. Interview with diversion program stakeholders		
Steps taken by the County to Implement this paragraph:	No current CHS policy was identified that outlined the policy or procedure for referral and tracking of inmates through the criminal justice competency determination process. MDCR outlines the following: "The competency of an inmate to stand trial is determined by the court system. The courts may order a competency evaluation, which is performed by the IMP Forensic Health Services, Mental Health Division, and/or a private mental health provider. Whenever MDCR receives a court order that renders an inmate incompetent, it shall be forwarded to the Accreditation and Inspections Bureau (AIB). The AIB shall ensure written notification is sent to the Department of Children and Families in accordance with applicable legal requirements."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Although no CHS policy was identified that outlined the policy or procedure for referral and tracking of inmates through the criminal justice competency determination process, several of the inmates reviewed in the PTDC had been referred to additional care as noted by their medical records and / or cell designations through the Baker Act. The Baker Act allows for involuntary examination (at times call involuntary commitment). Judges, law enforcement officials, physicians, or mental health professionals can initiate it. CHS reported plans to develop and design a tracking log of inmates in need of Forensic Mental Health Facility placement. This tracking log was not available for review at the time of the on-site tour July 2013.		
Monitor's Recommendations:	The Mental Health Monitor concurs with plans to develop a Forensic Mental Health Facility tracking log. In addition, I recommend development of a specific policy to guide and ensure its implementation. This policy may wish to identify accountable parties for its implementation. It may also include identification and coordination with local stakeholders.		

Paragraph	III. C. 4. Mental Health Care and Suicide Prevention: e.3 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: <date>	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour			
Measures of Compliance:	Mental Health Care: 1. Review of manual of mental health policies and procedures 2. Review of medical record for signed interdisciplinary treatment plan 3. Review of internal audits, if any		
Steps taken by the County to Implement this paragraph:	Treatment plans and their implementation are outlined in CHS policy, J-G-04 Addendum 1. No corrections policy was available in reference to definition and procedure for IDT.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As indicated above, the current policy as written is unclear as to the specific timelines for treatment plans and IDT.		
Monitor's Recommendations:	I agree with plans to revise the policy and audit for adherence to it and its recommended timelines.		

Paragraph	III. C. Mental Health Care and Suicide Prevention: f. 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 1. Manual of mental health policies and procedures 2. Review of medical records for evidence of implementation of policies 3. Review of internal audits		

	4. Review of mental health roster / log to be managed by Program Director of Mental Health
Steps taken by the County to Implement this paragraph:	Psychiatric level of care and follow-up is outlined in CHS policy J-G-04 Addendum 2.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS has written a policy for classification of inmates with mental illness. It also reported plans to verify documentation of levels via chart audits.
Monitor's Recommendations:	It is recommended that chart audits include not only verification of the level of mental health care required, but evidence of implementation of necessary treatment. For example, if a patient is Level I, the chart should reflect that he or she is level one and that the treating psychiatrist has followed the patient daily. Orders may be reviewed for their implementation as well as possible gaps in care.

Paragraph	III. C. 2. Mental Health Care and Suicide Prevention: g. 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:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures. 2. Results of internal audits, if any 3. 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:	CHS policy J-G-04 Addendum 4 describes individual and group counseling services. "Qualified Mental Health Professional (QMHP) will provide individual and group counseling as deemed clinically appropriate by the psychiatrist."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Although CHS policy J-G-04 Addendum 4 describes individual and group counseling services, it does not specify that the psychiatrist will provide the individual or group counseling services. Rather, it indicates that the psychiatrist will determine the frequency of the individual or group counseling and it implies that another provider will perform it. "Inmates that are deemed clinically appropriate by the psychiatrist to participate in individual and/or group counseling will have the opportunity to participate according to the Level of Care the inmate is placed in and		

	based on the Consent Decree requirement." I reviewed several medical records and interviewed treatment staff. I did not see records of group or individual counseling by the psychiatrist, psychologist, or social worker. I was informed that no groups or individual counseling are occurring secondary to lack of treatment time, facilities and staff.
Monitor's Recommendations:	As reflected in the Agreement, "Group and counseling sessions targeting education and coping skills will be provided as clinically indicated by the treating psychiatrist." It is recommended that each element of adequate care: psychotropic medication, visit frequency with the psychiatrist, individual counseling, group counseling, and implementation of orders be audited to ensure adherence to the Agreement.

Paragraph	III. C. g. (1) Mental Health Care and Suicide Prevention: Level IV- (1) Inmates classified as requiring Level IV level of care will receive: i. Managed care in the general population; ii. Psychotropic medication, as clinically appropriate; iii. Individual counseling and group counseling, as deemed clinically appropriate, by the treating psychiatrist; and iv. Evaluation and assessment by a psychiatrist at a frequency of no less than once every 90 days.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. 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:	CHS policy J-G-04 Addendum 2 and Addendum 4 describe frequency of follow-up, individual and group counseling services for each level in general terms.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The response to the Consent Agreement dated April 2013 specifically outlines the elements of adequate care of inmates in Level IV. CHS reported plans to monitor these provisions via the Appointment Scheduler System, Sapphire (the anticipated electronic physician order and medication provider), training and audits. These audits were not available for review and/or had not been completed at the time of our on-site tour in July 2013.		
Monitor's Recommendations:	Policy should be updated to reflect each element of Level IV treatment. It is recommended that each element of adequate care: psychotropic medication, visit frequency with the psychiatrist, individual counseling, group counseling, and implementation of orders be audited to ensure adherence to the Agreement.		

Paragraph			
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:			
Steps taken by the County to Implement this paragraph:	CHS policy J-G-04 Addendum 2 and Addendum 4 describe frequency of follow-up, individual and group counseling services for each level in general terms.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The response to the Consent Agreement dated April 2013 specifically outlines the elements of adequate care of inmates in Level III. CHS reported plans to monitor these provisions via the Appointment Scheduler System, Sapphire (the anticipated electronic physician order and medication provider), training and audits. These audits were not available for review and/or had not been completed at the time of our on-site tour in July 2013.		
Monitor's Recommendations:	Policy should be updated to reflect each element of Level III treatment. It is recommended that each element of adequate care: psychotropic medication, visit frequency with the psychiatrist, individual counseling, group counseling, and implementation of orders be audited to ensure adherence to the Agreement.		

	v. access to individual counseling and group counseling as deemed clinically appropriate by the treating psychiatrist.		
Compliance Status this tour:	Compliance: <date>	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
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 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:	CHS policy J-G-04 Addendum 2 and Addendum 4 describe frequency of follow-up, individual and group counseling services for each level in general terms.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The response to the Consent Agreement dated April 2013 specifically outlines the elements of adequate care of inmates in Level II. CHS reported plans to monitor these provisions via the Appointment Scheduler System, Sapphire (the anticipated electronic physician order and medication provider), training and audits. These audits were not available for review and/or had not been completed at the time of our on-site tour in July 2013. While I did not see evidence of group therapy being conducted, patients in Level II were being followed by psychiatry and QMHPs for follow-up and medication.		
Monitor's Recommendations:	Policy should be updated to reflect each element of Level II treatment. It is recommended that each element of adequate care: psychotropic medication, visit frequency with the psychiatrist, individual counseling, group counseling, and implementation of orders be audited to ensure adherence to the Agreement.		

Paragraph	III. C. g. (4) Mental Health Care and Suicide Prevention: Level I: 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:	Partial Compliance: July 2013	Non-Compliance:

Unresolved/partially resolved issues from previous tour:	
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 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:	CHS policy J-G-04 Addendum 2 and Addendum 4 describe frequency of follow-up, individual and group counseling services for each level in general terms.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The response to the Consent Agreement dated April 2013 specifically outlines the elements of adequate care of inmates in Level I. CHS reported plans to monitor these provisions via the Appointment Scheduler System, Sapphire (the anticipated electronic physician order and medication provider), training and audits. These audits were not available for review and/or had not been completed at the time of our on-site tour in July 2013. While I did not see evidence of group therapy being conducted, patients in Level I were being followed by psychiatry and QMHPs for follow-up and medication.
Monitor's Recommendations:	Policy should be updated to reflect each element of Level I treatment. It is recommended that each element of adequate care: psychotropic medication, visit frequency with the psychiatrist, individual counseling, group counseling, and implementation of orders be audited to ensure adherence to the Agreement.

Paragraph	III. C. 2. Mental Health Care and Suicide Prevention: h. 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:	Non-Compliance: Not due yet.
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 1. Manual of correctional and mental health policies and procedures 2. Per CHS, Phase I of the Mental Health Treatment Center is anticipated December 2014. 3. Review of building plans		
Steps taken by the County to Implement this paragraph:	The Response to the Consent Agreement by CHS dated April 2013 outlined plans to implement: "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." Plans include: "Increase staffing (based on designed staffing matrix) with capability of managing 150 inmates and Phase II will capture 350 inmates. The Quality Department will support CHS with the project management and time line of the project and regular (biannually) reporting of project status to the monitor."
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The timeline and staffing matrix for this plan were not submitted for review.
Monitor's Recommendations:	Insufficient material was provided for recommendations on this provision.

Paragraph	III. C. 2. Mental Health Care and Suicide Prevention: i. 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:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
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		
Steps taken by the County to Implement this paragraph:	CHS policy J-G-04 Addendum 5 describes the procedures for follow-up from Level I to Level II. CHS plans to train the mental health staff and track this via the Medical Appointment Scheduler. Chart audits are to be conducted for review of implementation of this policy.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Insufficient material was provided and reviewed specific to this provision.		
Monitor's Recommendations:	The Mental Health Monitor concurs with plans to track follow-up and monitor for adherence to policy via chart audits. As indicated previously, it is recommended that chart audits include not only verification of the level of mental health care required, but evidence of implementation of necessary treatment. For example, if a patient is Level I, the chart should reflect that he or she is level one and that the treating psychiatrist has followed the patient daily. It should also reflect the 'step-down' level of care as appropriate. Orders may be reviewed for their implementation as well as possible gaps in care.		

Paragraph	III. C. 2. Mental Health Care and Suicide Prevention: j. 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:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 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:	Acute and Level I mental health care is currently provided in the PTDC on units 9C and 10. MDCR and CHS policies did not specifically define nor make reference to this provision of mental health care in a therapeutic environment.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Pretrial Detention Center is not a therapeutic environment. Elements of a therapeutic environment include access to consultation in a private setting and access to group therapy. Patients are held for the first seven days of 'treatment' without access to recreation or showers. No group therapy or individual counseling was documented. Review of unit census numbers reflected periods of overcrowding. Patients interviewed complained of soiled mattresses and unsanitary conditions. The only mental health service currently provided is psychotropic medication management. Additionally, records demonstrated that inmates in need of urgent medical aid were provided delayed access to care in part due to physical plant issues. Also of concern is the fact that TGK and the TTC were not therapeutic environments. I was informed that in the event a patient became suicidal or acutely psychotic and the facility becomes aware of it, the inmate is placed in a holding cell and provided direct observation until he can be transferred to the PTDC.		
Monitor's Recommendations:	It is recommended that patients with severe mental illness be moved to a therapeutic environment, which can afford showers, recreation, and necessary mental health treatment in a confidential setting. MDCR may consider moving units, retrofitting the current structure, and or providing constant supervision until such an environment can be provided.		

Paragraph	III. C. Mental Health Care and Suicide Prevention: k. 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:	Non-Compliance: Not due yet
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 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:	CHS reported plans to develop a dashboard to manage Key Performance Indicators. This dashboard will be submitted six months from the Agreement and every six months thereafter.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Insufficient information was provided to formally review this provision at this time. It will be reviewed with submission of the staffing analysis, dashboard and Key Performance Indicators.		
Monitor's Recommendations:	Insufficient information was provided to formally review this provision at this time. It will be reviewed with submission of the dashboard and Key Performance Indicators.		

3. Suicide Assessment and Prevention

Paragraph	III. C. 3. Suicide Assessment and Prevention: a. 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 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:	CHS Suicide Prevention policy is covered in J-G-05. MDCR specific to suicide prevention is outlined in DSOP 12-03, Inmate Suicide and Response Plan. While this policy outlines specific provisions such as the Ferguson Safety Garment and first aid response tools, it does not state that inmates will have access to suicide-resistant mattresses or blankets.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and	The current policy does not specify the following provisions of the Consent Agreement: - Property granted to inmates upon clinical determination of QMHS - Inmates have suicide resistant mattresses		

the factual basis for finding(s)	- Inmates have proper suicide resistant clothing - Staff do not retaliate against inmates by sending them to suicide watch cells - Specifications for suicide risk As stated above, there are no CHS policies related to what happens in the event a patient becomes psychotic or suicidal while at Metro West, TGK and the TTC. MDCR policy states, "If the detention facility has no on-duty IMP/IMP mental health staff, the Shift Supervisor/Commander shall contact the Pre-Trial Detention Center (PTDC) Clinic and advise the on-duty IMP staff (available 24 hours) of the situation and arrange for the inmate to be transported to the PTDC for an assessment." I was informed that patients in need of Level I care 'are immediately transferred' to the PTDC. MDCR policy states, "If an inmate displays signs of suicidal tendencies, he/she shall be placed in a single suicidal non-stripped cell separate from other inmates. The inmate shall be under direct observation until IMP mental health staff has evaluated the inmate's degree of risk. A Physical Sight Check Sheet shall be documented at intervals not to exceed 15 minutes by sworn staff and/or medical staff. Checks may be documented more than 4 times per hour." Review of current MDCR training materials failed to demonstrate adequate suicide prevention training for medical and correctional staff.
Monitor's Recommendations:	1. Update CHS policy to specify that patients at risk of suicide shall be assessed by the QMHP on an individualized basis. This means that blanket policies for all inmates on Level I restricting reading materials, access to recreation and showers are not appropriate. 2. Update policy with CHS or MDCR to include provision of sanitary conditions, including clean suicide resistant mattresses. Current CHS policy states, "Suicidal inmates should not be stripped naked;" it provides no direction or reasonable alternative to custody or staff. Accordingly, I saw inmates that were unclothed and was informed this was due to 'their mental illness.' The patient(s) did not have suicide-resistant smocks or blankets; this is inappropriate. 3. Implement mental health and suicide prevention training for all staff that work directly with inmates, including custody, medical and mental health. 4. Audit medical records and tour acute unit periodically to assess implementation of Consent provisions. This may include review of the quality of suicide risk screening, assessment, implementation of treatment plans, orders, and access to appropriate care, including recreation, counseling and showers.

Paragraph	III. C. Mental Health Care and Suicide Prevention: 3.b. 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. b2. 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Suicide prevention policy and procedures 2. Results of internal audits. CHS anticipates "100% compliance for a minimum of 4 (four) consecutive quarters." 3. Review of medical records for implementation of policies, in accordance with triggers found in Appendix A. 4. Review of adverse events and screening to audit against false negatives.		
Steps taken by the County to Implement this paragraph:	CHS Suicide Prevention policy is covered in J-G-05.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Form CHS-MHSE 3/12 is the Mental Health Screening and Evaluation form. It includes the screening factors described in Appendix A of the Consent Agreement. This form is utilized to screen inmates upon entry or booking into TGK. There is no specific suicide risk assessment form for inmates that present with suicidal ideation or require assessment mid-incarceration.		
Monitor's Recommendations:	It is recommended that CHS consider developing and implementing policy for suicide risk assessment by QMHPs. A form that outlines the procedure for suicide risk assessment, which is more detailed than suicide risk screening at booking and may be necessary at any point during incarceration may be helpful in guiding the implementation of suicide risk assessment.		

Paragraph	III. C. Mental Health Care and Suicide Prevention: Suicide Assessment and Prevention c. 1. 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. c 2. 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 1. Review of suicide prevention policies and procedures to include observations of inmates at risk of suicide at staggered checks every 15 minutes and 1:1 as clinically necessary 2. Results of internal audits and adverse events, including MDCR audits of custody observation checks 3. Review of medical records for implementation of policies		
Steps taken by the County to Implement this paragraph:	CHS Suicide Prevention procedure states, "Potentially suicidal inmates are monitored on an irregular schedule with no more than 15 minutes between checks. If, however, the potentially suicidal inmates are placed in isolation, constant observation is required." Regarding observation levels, as indicated above, MDCR's policy states that before evaluation by the mental health staff, the patient will be placed on direct observation. MDCR policy equates constant observation with direct observation. It also identifies "close supervision" or every 15-minute checks as the 'default' for suicidal inmates. "An inmate with suicidal tendencies, statements or attempts shall not be stripped, unless requested and documented by IMP or IMP mental health staff. Unless otherwise authorized in writing by the appropriate medical authority, inmates determined by IMP or IMP mental health staff to have suicidal tendencies shall be assigned to quarters that provide close supervision in accordance to the facilities' classification plan."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS policy J-G-05 outlines the Suicide Prevention Program and its procedures. Monitoring, including designation of constant vs. close observation, is outlined in Section 7. I was informed that MDCR utilizes the terms direct observation and constant observation interchangeably. A case described as a completed suicide was reviewed. This case did not specifically document the time and quality of observation of the inmate at head count(s) in the hours before his death.		
Monitor's Recommendations:	Specific to monitoring and auditing this provision of the agreement, CHS anticipates it will be the responsibility of MDCR. It is recommended that concurrent audits be conducted to assess the adequacy of monitoring and staggered checks. This information may be reviewed during Mental Health Review Committee.		

Paragraph	III. C. Mental Health Care and Suicide Prevention: d. 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:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
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 screening and suicide risk assessments.
Steps taken by the County to Implement this paragraph:	CHS policy J-G-05, Section 2 covers the Suicide Prevention Program, intake screening and identification of patients at risk for suicide. CHS Suicide Prevention procedure states, "Potentially suicidal inmates are monitored on an irregular schedule with no more than 15 minutes between checks. If, however, the potentially suicidal inmates are placed in isolation, constant observation is required."
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Inspection of the LEO Lobby at Ted Guilford Knight indicated that intake screening, mental health screening and evaluation are completed by nurses. If the screen is positive, the patient is referred to a social worker. CHS reported plans to perform monthly audits to ensure adherence to suicide screening.
Monitor's Recommendations:	In addition to audits which review adherence to suicide screening, timely referral to QMHPs / psychiatry and implementation of treatment plans, audits are recommended to evaluate the quality of suicide risk assessment in patients that develop depression and / or suicidal ideation mid-incarceration. Risk assessment factors that are documented should include those outlined in Appendix A, such as command auditory hallucinations to harm self, recent self-injurious behavior, and major Axis I diagnoses.

Paragraph	III. C. Mental Health Care and Suicide Prevention: e. 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. 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:	CHS policy J-G-05, Section 5 covers the Suicide Prevention Program and treatment. Individualized treatment plans are not specified.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS policy J-G-04, Addendum 2 Section 2 states, "Psychiatrist will document each follow-up encounter on the *Psychiatric Progress Note* (C- 255Nb). The progress note will then be filed on the inmate's unified medical and mental health record." CHS plans monthly chart audits to ensure adherence with the suicide prevention policy.		
Monitor's Recommendations:	Each suicidal inmate should be evaluated by a QMHP. This evaluation should be documented on a specific		

	form or in a progress note. It is recommended that if the psychiatrist is not writing his or her own progress notes, each writer sign the progress note and date it. Progress notes, IDT treatment plans and SOAP notes should reflect individualized treatment plans and goals. These plans should also identify specific signs and symptoms for suicide risk that are targeted for improvement.

Paragraph	III. C. 3 Mental Health Care and Suicide Prevention: f. 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:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. On-site check for cut-down tool. 2. Manual of mental health policies and procedures 3. Results of internal audits or on-site inspections, if any 4. Incident reports documenting use of cut-down tool		
Steps taken by the County to Implement this paragraph:	This provision is covered b CHS policy J-G-05, Section 9.C. MDCR policy 12-003 section J states, "Rescue tools shall be secured and maintained in all facilities in designated locations prescribed in each facility's SOP."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	During the on-site inspection, spot checks at several different facilities were completed. These spot checks included a cut down tool, Ambu bag and first aid kit. Of note, these supplies were not maintained together in some facilities and were scattered in various locations of the control office. This reflects that the plan to implement Medical Response Bags with 'Cut Down Tools' in them has yet to be fully implemented. CHS plans to maintain records of education/training to CHS by the education department regarding emergency response bags and medical response kits.		
Monitor's Recommendations:	The Mental Health Monitor concurs with plans to maintain, track and audit training records for suicide prevention and emergency response. This should include whether cut down tools and emergency response bags are adequately stocked and available on all units. In addition to this, all adverse events including deaths should be reviewed for evidence of timely response, use of appropriate life-saving tools, and identification of at-risk individuals.		

Paragraph	III. C. 3 Mental Health Care and Suicide Prevention: g. 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.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 1. On-site review for first aid kit and resources. 2. Review of record of education / training to CHS and officers in emergency response 3. Review of adverse events		
Steps taken by the County to Implement this paragraph:	MDCR policy regarding emergency bags does not assign responsibility to the Jail for maintaining emergency and first aid equipment. It states, "MDCR and IMP/IMP mental health staff responding to the scene shall bring emergency rescue/medical equipment, e.g., rescue tool, medical supplies, resuscitation breathing mask, Ambu bag, AED, etc. If the incident is an inmate suicide or suicide attempt, immediately upon notification, the Shift Supervisor/Commander shall call and advise 911 staff of the emergency."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	During the on-site inspection, spot checks at several different facilities were completed. These spot checks included a cut down tool, Ambu bag and first aid kit. However, the materials were not located in one specific bag or location. I did not review training materials and records of current CPR certification. The Quality Director plans to audit files intermittently for mandatory education / training and competencies. These audits have not started. Review of adverse events demonstrated inadequate and problematic documentation of response times and treatment in urgent and emergent cases.		
Monitor's Recommendations:	The Mental Health Monitor concurs with plans to maintain track and audit training records for suicide prevention and emergency response. Medical emergency response bags should be put together and available on all housing units. In addition to this, adverse events should be reviewed for evidence of timely response, use of appropriate life-saving tools, and identification of at-risk individuals.		

Paragraph	III. C. 3 Mental Health Care and Suicide Prevention: h. 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:	Non-Compliance: Not yet due
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 1. Result of internal quarterly review and dashboard with key performance indicators 2. Review of morbidity and mortality reports from inmate death.		
Steps taken by the County to Implement this paragraph:	CHS is in the planning phases to comply with this provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Quality Department and Director of CHS plan to develop a dashboard of key performance indicators related to the 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. This report is anticipated in November 2013.		
Monitor's Recommendations:	In addition to adequate screening, suicide risk assessment for patients that have screened positive is recommended. This may include a separate form or section on the progress note which targets the factors outlined in Appendix A.		

4. Review of Disciplinary Measures

Paragraph	III. C. 4. Mental Health Care and Suicide Prevention: 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 (1) 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. b. 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:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of MDCR and mental health policies and procedures 2. Review of tracking mechanism reflecting inmates for whom mental health has provided opinion in disciplinary proceeding and final decision. 3. 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 is aware this policy is needed and is in the process of development. There is no companion policy for MDCR regarding consultation with mental health in disciplinary matters. MDCR Policy 16 V A describes the procedure for consulting mental health when a mentally ill inmate is behaving in an odd manner and disciplinary infractions are being reported. A QMHP is not a routine member of the disciplinary committee for inmates with SMI.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the	MDCR and CHS do not currently have a policy to routinely consult with Qualified Mental Health Staff to determine if it is appropriate to initiate disciplinary proceeding for inmates with sign or symptoms of SMI. CHS plans to develop this policy and a log that tracks disciplinary actions and QMHS consultation.		

factual basis for finding(s)	CHS stated that plans there are plans for MDCR to provide a counselor to assist the mentally ill with the disciplinary review procedure. The training of the counselor is not specified.
Monitor's Recommendations:	It is recommended that any counselor appointed for the disciplinary review procedure have adequate training specific to the identification of mental illness and management of these patients. This should include a minimum of eight hours of initial training and annual training thereafter. The Mental Health Monitor concurs with MDCR and CHS plans to develop a log to track disciplinary actions and QMHS consultation.

5. Mental Health Care Housing

Paragraph	III. C. 5. Mental Health Care and Suicide Prevention: a. 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:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health Care: 1. Manual of MDCR and mental health policies and procedures 2. 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:	Policy J-G-02 states, "A proactive program exists that provides care for special needs patients who require additional medical supervision or multidisciplinary care." It does not designate where these patients will be housed. MDCR policy 12-005 states, "It is the policy of the Miami-Dade Corrections and Rehabilitation Department (MDCR) to establish and maintain guidelines for the health, safety, welfare, treatment, and special housing of inmates with mental illness in our custody." It subsequently outlines the housing assignment of suicidal inmates. There is no policy that specifies 'therapeutic environments' for inmates with SMI.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This on-site inspection included tours of the Stockade, Ted Guilford Knight, the Pre Trial Detention Center, and sections of facility in which inmates are placed in custodial segregation. The physical plant of the PTDC was not intended for mental health treatment. As such, direct visibility is limited and there are numerous points between the cells and the recreation area in which mentally ill patients could harm themselves if not properly supervised. Physical plant issues are further complicated by narrow stairwells that we were informed hinder rescue efforts, periods of over-crowding, and lack of private or semi-private treatment space. In the other facilities such as the Stockade, patients on the mental health caseload are not being tracked. As such, these patients do not appear to be receiving treatment other than psychotropic medication.		
Monitor's Recommendations:	All inmates that screen positive for mental health issues or developmental disabilities should be tracked and placed on the mental health caseload list throughout the course of their incarceration regardless of whether the patient is prescribed psychotropic medication. Because inmates with SMI and developmental disabilities may be vulnerable in the general population, all inmates with SMI, particularly those inmates with psychosis and/or designated at Level I and II, should be housed in a therapeutic environment. Inmates identified with SMI should have adequate access to recreation, showers, and treatment.		

Paragraph	III. C. 5. Mental Health Care and Suicide Prevention: b. 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:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health Care:</u> 1. 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. 2. Manual of mental health policies and procedures 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:	I was informed that inmates at risk of suicide are placed on suicide precaution; this did not always include constant observation. Specifically, as per DSOP 12-003, Inmate Suicide Prevention and Response Plan indicates that "inmates with suicidal tendencies (suspected or diagnosed) that are separated from the general population are considered to be in administrative confinement. An inmate who is identified as a suicide risk shall not be housed in a 'single occupancy cell' unless direct observation is utilized 24 hours a day and sworn staff and/or IMP/IMP mental health staff document checks at intervals not to exceed 15 minutes." In the same paragraph, I was informed, "Inmates with suicidal tendencies, as determined by IMP/IMP mental health staff, may be assigned to housing that has close supervision with documented physical sight checks by sworn staff and/or medical staff at intervals not to exceed 15 minutes." As a result, it remained unclear whether the responsibility of the checks was that of mental health, medical or custody and how frequently (constant observation or less frequent observation) was required for patients was suspected suicidal tendencies.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This on-site inspection included tours of the Stockade, Ted Guilford Knight, the Pre Trial Detention Center, as well as sections of the facilities in which inmates are placed in custodial segregation. There are innumerable tie-off points for suicidal inmates including but not limited to holes in the bunk bed platforms and bars that have not been retrofitted with Plexiglas.		
Monitor's Recommendations:	Given the current physical plant, inmates with acute severe mental illness (including depression, psychosis and disorganized behavior) and actively suicidal inmates require constant observation and frequent, staggered checks after step-down. MDCR and CHS policy should be updated to reflect this.		

	Inmates in custodial segregation are monitored via camera. It is recommended that the duties assigned to the officer watching these cells are restricted such that adequate observation may be maintained.

Paragraph	III. C. 5. Mental Health Care and Suicide Prevention: c.1 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. c. 2 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:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log or forms documenting individual recreation / activity while on the unit 3. 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:	Current CHS policy J-G-05 Addendum A specifically states that all patients on units 9C or 10A1 will not be allowed to leave their cells for recreation until the IDT meets. MDCR policy 12-005 regarding recreation states that "mentally ill inmates will be eligible to participate in recreational activities in accordance with the directives of IMP mental health staff."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Current CHS policy J-G-05 Addendum A specifically states that all patients on units 9C or 10A1 will not be allowed to leave their cells for recreation until the IDT meets. This policy may deter patients from disclosing suicidal ideation. A limited number of medical records were reviewed. These medical records did not reflect individualized treatment planning related to recreation, showers, and access to mental health treatment outside the cell in a confidential setting. CHS reports plans to develop policy and procedure that reflects the initial treatment plan. It also plans to create a 'recreation / activity' form that delineates recreation, shower and mental health treatment as well as the duration of time in these activities. It is unclear whether this will be an individual form, as opposed to a form that is used document multiple patients on the same sheet. It is also unclear where this information will		

	be available for review and how it will be captured in the medical record.
Monitor's Recommendations:	The failure to provide individualized treatment planning and adequate recreation and showers to inmates with SMI and / or suicidal ideation may prevent inmates from disclosing their symptoms, thus placing both the Jail and the inmate at risk. Treatment plans and privileges for patients on suicide watch should be made on a case-by-case basis and in an individualized manner. Inmates with SMI may require constant observation so that they may access adequate recreation time.

Paragraph	III. C. 5. Mental Health Care and Suicide Prevention: d. 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:	Non-Compliance: Not yet due
Unresolved/partially resolved issues from previous tour:			
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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	A quarterly report has not been submitted specific to the Mental Health Treatment Center. Building plans dated April 8, 2012 were reviewed entitled, "Mental Health Treatment Facility." These plans were not obtained from MDCR. The status of this structure and its financing is unclear.		
Monitor's Recommendations:	I recommend a formal, documented collaboration be developed and implemented for the care and treatment of these inmates. This may include documentation of decisions, action plans, and responsible parties / assigned persons involved.		

Paragraph	III. C. 5. Mental Health Care and Suicide Prevention: e. 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:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health Care: 1. Manual of mental health policies and procedure 2. Results of internal audits, if any 3. 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:	This provision is covered by CHS's policy J-G-04, Addendum 1. MDCR policy does not define or provide a procedure for interdisciplinary treatment plans.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Interviews of staff indicated that they are aware of the IDT and its intent. I reviewed approximately five charts on 9C; none had an IDT. Staff indicated that time constraints make IDT difficult to convene and implement.		
Monitor's Recommendations:	MDCR policy should be updated to include a companion policy to the medical policy for IDT. Consider scheduling a block of time either daily or bi-weekly for IDT and covering the required cases of the day at that time, within reason. If time disallows completing some cases secondary to high caseload or other factors, these trends should be noted for referral to the Mental Health Review Committee. Policy should specifically reflect the required members of IDT and frequency / level of participation.		

6. Custodial Segregation

Paragraph	III. C. 6. Mental Health Care and Suicide Prevention: a. 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: (1.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: <date>	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 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:	This provision is covered by CHS policy J-E-09. It states, "Upon notification that an inmate is placed in segregation, a qualified health care professional reviews the inmate's health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation. Such review is documented in the health record." DSOP 12-002 outlines procedures for inmates in disciplinary confinement. "IMP staff shall be immediately notified when an inmate is placed in administrative or disciplinary confinement. An inmate placed in administrative or disciplinary confinement (single cell) shall be given a psychosocial evaluation by IMP mental health staff at the following intervals: 24 hours, 5 days, 30 days, 6 months, and every 6 months thereafter."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The CHS policy as currently written is quite general and does not include the specificity required of the agreement, such as face-to-face visits, etc. The Response to the Consent Agreement reports plans to implement a policy and procedure and audit the custodial segregation logs and medical records for adherence. DSOP 12-002 states the results of the psychosocial evaluation will be documented on the Psychosocial Evaluation Check Sheet. This sheet was not available for review and it is unclear where this sheet will be kept. Relevant information, assessments and observations (or a copy) should be available in the patient's medical record.		

Monitor's Recommendations:	CHS and the Jail should update and implement a policy and procedure to track all inmates with severe mental illness and those on the mental health caseload, including those in custodial segregation. This will facilitate identifying patients in high-risk situations, providing adequate care, providing adequate follow-up and prevent adverse events.

Paragraph	III. C. 6. Mental Health Care and Suicide Prevention: (1.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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
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:	This provision is covered by CHS policy at this time J-E-09. The current policy does not address what happens if Qualified Staff have concerns regarding the patient in custodial segregation with SMI. DSOP 12-002 Section C states that suicidal and acute psychiatric inmates will be checked as follows: "Sworn staff shall visit each confinement cell to conduct and document physical sight checks of the following classifications of inmates at intervals, not to exceed 15 minutes."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This provision is covered by CHS policy at this time J-E-09. The policy as currently written is quite general and does not include the specificity required of the agreement, such as face-to-face visits, the frequency of required checks, etc. The Response to the Consent Agreement reports plans to develop and implement a policy and procedure and audit the custodial segregation logs and medical records for adherence.		
Monitor's Recommendations:	The Mental Health Monitor concurs with the plan to update policy and audit custodial segregation logs and medical records for adherence.		

Paragraph	III. C. 6. Mental Health Care and Suicide Prevention: (2) 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
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:	This provision could be covered by CHS policy at this time J-E-09. Section 1 states, "Upon notification that an inmate is placed in segregation, a qualified health care professional reviews the inmate's health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation. Such review is documented in the health record." DSOP 12-002 states that inmates placed in disciplinary segregation will have a psychosocial eval with 24 hours. This policy, the CHS policy and the anchors of the consent agreement are inconsistent.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	I recommend updating CHS and MDCR policy so that they contain the required specify of the consent agreement and so that inconsistencies are eliminated. The Response to the Consent Agreement reports plans to train staff to the policies and to audit the custodial segregation log for adherence.
Monitor's Recommendations:	The Mental Health Monitor concurs with the plan to update policy and audit custodial segregation logs and medical records for adherence. In addition, it may be helpful to place a qualified mental health professional on the Department Safety Cell Committee.

Paragraph	III. C. 6. Mental Health Care and Suicide Prevention: (3) If a Qualified Mental Health Professional finds that 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health Care:</u> 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:	As indicated above, DSOP 12-002 V Section C outlines that acute psychiatric inmates will be observed every 15 minutes.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This provision is not specifically covered in CHS policy at this time. The Response to the Consent Agreement reports plans to develop a policy and procedure. This may include a log of patients within custodial segregation with SMI and their observation checks.		
Monitor's Recommendations:	I recommend that policy and procedure for J-E-09 be updated to reflect the Agreement (i.e. If a QMHP finds the patient has SMI, adequate checks should be implemented.) CHS and MDCR policies should be consistent.		

Paragraph	III. C. 6. Mental Health Care and Suicide Prevention: (4) 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
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 J-E-09 Section 5B states: "The health professional's monitoring of a segregated inmate is based on the inmate's degree of isolation: a. Inmates under extreme isolation with little or no contact with other individuals are monitored daily by medical staff and at least once a week by mental health staff b. Inmates who are segregated and have limited contact with staff or other inmates are monitored 3 days a week by medical or mental health staff." DSOP 12-002 does not specifically address this anchor. It identifies that medical providers, not QMHP, will conduct rounds at least once per day. The policy for psychosocial evaluations specified a separate frequency for rounds.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This provision of the CHS policy does not specify that QMHPs will round on the patients three times per week; it indicates *medical* or mental health staff will perform the three-day per week rounds. The Response to the Consent Agreement reports plans to develop a policy and procedure.		
Monitor's Recommendations:	MDCR and CHS policy should be updated to reflect that QMHPs would provide rounds three times per week; these rounds do not substitute for treatment. In monitoring adherence to the developed policy and procedure, it is recommended CHS and MDCR consider creating a log of patients within custodial segregation with SMI and a log sheet on each inmate (that tracks food, showers, recreation, other pertinent behavior) to determine if continual placement is clinically appropriate and to identify if patients may be decompensating. Policy should specify how often the log will be reviewed and by whom.		

Paragraph	III. C. 6. Mental Health Care and Suicide Prevention: (4) 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health Care: 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:	CHS has not developed policy specific to the requirement of a heightened level of care and review of custodial segregation. Section 5c states, "Medical or mental health staff check inmates who are allowed periods of recreation or other routine social contact among themselves while being segregated from the general population, are checked weekly by medical or mental health staff." DSOP 12-002 Section VI specifies the requirements for Confinement Documentation. These requirements do not include documentation of out-of-cell time.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This provision is not covered in CHS or MDCR policy at this time. The Response to the Consent Agreement reports plans to develop a policy and procedure. This may include the creation of a log of patients within custodial segregation with SMI, including information on each inmate (that tracks food, showers, recreation, other behavior) to determine if continual placement is clinically appropriate.		
Monitor's Recommendations:	As indicated above, it is recommended that both CHS and MDCR develop coordinating policies that target tracking of patients in custodial segregation with mental illness, pertinent behaviors, and out of cell time. Specifically, J-E-09 should be updated to reflect these provisions of the agreement. As indicated above, I also recommend that adherence be tracked via a log and medical record reviews. Current CHS policy states that documentation of segregation rounds "is made on individual logs, cell cards, or in an inmate's health record." Placing the documentation in several different places as opposed to one consistent log tends to make it difficult to find, track, analyze, and elicit patterns.		

Paragraph	III. C. 6. Mental Health Care and Suicide Prevention: 5. 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:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
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:	MDCR does not specifically address this provision. One section of DSOP 12-002 states: "An inmate may be placed in administrative confinement when deemed necessary by the Medical Care Provider (IMP) Director or designee (e.g., the inmate has a diagnosed contagious disease, or is in psychological distress, etc.). " Another section of the policy states that the Facility/Bureau Supervisor has the authority to place an inmate in administrative confinement in order to protect the inmate or others. A review does not occur for 72 hours.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This provision is not covered in CHS or MDCR policy at this time. The Response to the Consent Agreement reports plans to develop a policy and procedure.
Monitor's Recommendations:	Both MDCR and CHS should develop both a policy and a procedure for placement of inmates with SMI in custodial segregation. These policies should be consistent with one another. A consideration may by placing the Mental Health Director on the disciplinary committee and/or alerting him or her each time a patient with SMI is being disciplined. This procedure carries the advantage that the MH Director 'red flags' the inmate and ensures adequate mental health follow-up. Audits are recommended to assess adherence to this provision of the agreement. These may include audits of log sheets, housing rosters, and a log that tracks patients with SMI in custodial segregation. A random sample of these charts would be reviewed for written approval by the Facility Supervisor and Director of MH for continued placement in segregation.

Paragraph	III. C. 6. Mental Health Care and Suicide Prevention: 6. 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:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
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:	MDCR policy on custodial segregation does not limit the amount of time a patient with SMI may be placed in custodial segregation. Section IV states that the maximum sanction for a rule violation(s) is no more than 60 days for all violations arising out of one incident. Continuous confinement for more than 30 days requires the review and approval of the Facility/Bureau Supervisor.		

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As stated above, there is no specific provision in MDCR or CHS policy that limits the amount of time an inmate with SMI can spend. No mental health representation is present at disciplinary or safety cell committee meetings. The Response to the Consent Agreement reports plans to develop a policy and procedure.
Monitor's Recommendations:	Policy updates are recommended that specifically state inmates with acute SMI shall not be placed in long-term custodial segregation. A mechanism should be implemented to prevent this from occurring and to ensure adequate access to timely mental health care. This includes proper identification, referral and treatment of patients with active and acute serious mental illness that may be playing a role in disciplinary infractions. Audits are recommended to assess adherence to this provision of the agreement. These may include audits of log sheets, housing rosters, and any log that tracks patients with SMI in custodial segregation. A random sample of these charts would be reviewed for written approval by the Facility Supervisor and Director of MH for continued placement in segregation beyond 72 hours.

Paragraph	III. C. 6. Mental Health Care and Suicide Prevention: 7. 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
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:	DSOP 12-002 does not address this provision specifically. As indicated above, it states that inmates with acute psychiatric issues will be monitored be sworn staff and they will have a psychosocial assessment at 24 hours, 5 days, 30 days and every six months thereafter. The policy does allude to referral for treatment: "In the event that a Psychosocial Evaluation Check Sheet needs to be completed and IMP mental health staff is not available at the facility, the inmate shall be transported to a facility conducting mental health assessments (e.g., the Pre-Trial Detention Center)."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Current MDCR and CHS policy does not specifically address identification and management of inmates that develop new symptoms of severe mental illness while in custodial segregation. It is also does not define or provide guidance on the identification of signs of SMI in segregation. It does not identify triage or timelines for referrals other than under the general policy of 'emergency referrals.' CHS Response to the Consent Agreement states that, "All identified inmates as 'decompensated' for mental or medical will be expedited for a		

	medical evaluation within 30 minutes of emergency referral and 2 hours for mental health evaluation by a QMHP."
Monitor's Recommendations:	Updating current policy to reflect the edits and updates placed in the Response to Consent Agreement 2013. It is recommended that policy be specific and provide guidance on the identification of severe mental illness so that training can be completed to both this policy and others. Audits are recommended to assess adherence to this provision of the agreement. These may include audits of log sheets, housing rosters, any log that tracks patients with SMI in custodial segregation, and samples of incident reports from custody. [The incident reports can be crosschecked against the list of patients with SMI. Analysis is then recommended to assess for referral to treatment in a timely manner.] A random sample of these charts would also be reviewed for evidence of timely and appropriate triage and implementation of treatment.

Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
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)	Current MDCR and CHS policy does not specifically address identification and management of inmates with severe mental illness or suicide risk in custodial segregation.		
Monitor's Recommendations:	As indicated above, MDCR and CHS should consider updating current policy to reflect identification and management of patients with SMI in custodial segregation. Training for custody and medical / mental health staff should be implemented that is reflected and reinforced by policy. Audits are recommended to assess adherence to this provision of the agreement. These may include audits of		

	any logs that track patients with SMI in custodial segregation against referrals to both urgent and emergent mental health evaluation. A random sample of these charts would be reviewed for evidence of timely and appropriate treatment.

Paragraph	III. C. 6. Mental Health Care and Suicide Prevention: 9. 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: July 2013	Partial Compliance:	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health Care: 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.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Samples of custody segregation rounds were reviewed on site. Several were identified that described the inmate in descriptive terms.		
Monitor's Recommendations:	As recommended previously, CHS and the Jail should periodically review custody segregation rounds for adequacy of documentation. This may be accomplished via coordination of the Medical Compliance Unit of MDCR and the Quality Mental Health Review Committee.		

Paragraph	III. C. 6. Mental Health Care and Suicide Prevention: 10. 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.		
Compliance Status this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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	MDCR policy on access to health care states inmates shall have adequate access to timely medical and mental		

Implement this paragraph:	health care. Specifically in segregation, a medical staff member will perform rounds daily on all inmates.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Inmates in custodial segregation have the opportunity to contact medical staff either during pill pass (if they are prescribed medication) or during medical staff rounds that occur three times per week. They do not have adequate privacy to contact and receive treatment from a mental health perspective. Interviews are conducted via the sally port in the door in full view and within close range to custodial officer, other patients, and other staff. Further, current policy states that all patients on 9C shall have no recreation for the first seven days of his or her incarceration until the IDTT. Given that recreation and showers are integral to mental health, such a blanket policy is not appropriate.
Monitor's Recommendations:	Medical staff should round on all inmates within disciplinary segregation daily. I recommend developing and implementing a policy to implement this. Audits should track and assess the adequacy of treatment of all inmates with severe mental illness in custodial segregation. Requests for care by inmates should be tracked for evidence of adequate and timely follow-up. Information that should be checked includes access to treatment, consistency in care, and implementation of orders in a timely manner.

Paragraph	III. C. 6. Mental Health Care and Suicide Prevention: Custodial Segregation 11. Mental health referrals of inmates in custodial segregation will be classified, at minimum, as urgent referrals		
Compliance Status this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health Care:</u> 1. MDCR, mental health policies and procedures 2. 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. 3. Review of mental health grievances		
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)	Current CHS policies J-E-07 and J-E-08 describe the procedures for non-emergency and emergency referrals in general. However, these policies do not give examples of what might be an 'urgent' referral vs. and 'emergent' referral. In addition, as discussed above, the screening and mental health evaluation appear to utilize the same 'check box' for urgent and emergent referrals, which may make them difficult to track. Neither CHS nor MDCR identify a triage timeline for mental health care for inmates in disciplinary segregation. CHS reports plans to provide education to staff on the triage level criteria, i.e. "emergency," "urgent," and "routine referrals."		

Monitor's Recommendations:	Policy should be updated to reflect the increased risk of the development of mental illness in custodial segregation and the anchors for adequate care, including triage timelines. This may include specific examples of urgent vs. emergent referrals and coordinating training on the identification of mental illness.

7. Staffing and Training

Paragraph	III. C. 7. Mental Health Care and Suicide Prevention: a. 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:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 1. Review of staffing plan, average census and mental health population. 2. CHS, mental health policies and procedures		
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 staffing plan is due by approximately November 2013. No staffing plan was available at the time of this visit.		
Monitor's Recommendations:	Please submit the March 2012 with the next staffing plan.		

	b. Within 180 days of the Effective Date, and annually thereafter, CHS shall submit to the Monitor and DOJ for		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due
Unresolved/partially resolved issues from previous tour:			
	_____		
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 staffing plan is due by approximately November 2013. No staffing plan was available at the time of this visit.		
Monitor's Recommendations:	Please submit the March 2012 with the next staffing plan.		

Paragraph	III. C. 7. Mental Health Care and Suicide Prevention: c. 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:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 1. Review of staffing plan, average census, projected census and mental health population. 2. Review of timetable for hiring, as needed		
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 staffing plan is due by approximately November 2013. No staffing plan was available at the time of this visit.		
Monitor's Recommendations:	Please submit the March 2012 with the next staffing plan.		

Paragraph	III. C. 7. Mental Health Care and Suicide Prevention: d. 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:	Partial Compliance:	Non-Compliance: Not yet due
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	A staffing plan is due by approximately November 2013. No staffing plan was available at the time of this visit.		
Monitor's Recommendations:	Please submit the March 2012 with the next staffing plan.		

Paragraph	III. C. 7. Mental Health Care and Suicide Prevention: e.1 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. e.2 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:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 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:	CHS has a lead psychiatrist.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Based on an interview of the staff, MDCR has a lead psychiatrist. His primary function is to see patients on the acute floors, 9C, at TGK. He estimated he saw 30-40 patients daily. There is no Chief Psychiatrist, per se. The lead psychiatrist has no current administrative duties, nor would he have time to complete them. A psychologist performs the functions of the mental health program director. He stated he maintained general oversight of the mental health professionals (the social workers) at the Ted Guilford Knight facility. In practice, the Director and Associate Director make administrative and policy decisions regarding the mental health program.		
Monitor's Recommendations:	The chief or lead psychiatrist and the Director of Mental Health Programs should have input into decisions regarding administrative and quality issues related to the Mental Health Program, including but not limited to: formulary decisions, information regarding adverse events, and scheduling and treatment programming.		

Paragraph	III. C. 7. Mental Health Care and Suicide Prevention: f. 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:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 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:	
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Response to Consent Agreement reflects plans to train medical, mental health and custodial staff on relevant mental health policies and procedures. This training has not occurred to date. No lesson plans were submitted. An outline of the CIT lesson plan was reviewed. This lesson plan did not include the suicide prevention training curriculum topics as outlined in the Consent Agreement.
Monitor's Recommendations:	Please implement adequate annual training protocols for all mental health staff. In reviewing the documentation provided on CIT, the training program is a general outline of procedures to be followed. The training syllabus needs to be based on the CHS and /or MDCR policies, or law or regulations. If management expects officers, medical and mental health staff to be competent to administer the written policies, then the training plan and specific course syllabuses needs to be consistent with those policies and include enough detail to assure management that all provisions of the policies are addressed in the required training. This should be the format for review of the mental health and suicide prevention training.

Paragraph	III. C. 7. Mental Health Care and Suicide Prevention: g. 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:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour			
Measures of Compliance:	<u>Mental Health:</u> 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:	In reference to training, DSOP 12-005 states, "It is imperative that good judgment be exercised when dealing with mentally ill inmates. All staff assigned to supervise mentally ill inmates, (suicidal and non-suicidal as determined by IMP/mental health staff), must have previously received in-service training or specialized training in the management and supervision of inmates with conditions of mental illness; e.g., crisis intervention, human behavior, etc. The hours of training and the training content shall be in accordance with current requirements, standards and guidelines."
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Response to Consent Agreement reflects plans to train custodial staff in the proper identification of patients with serious mental health needs and timely referral. This training has not occurred to date.
Monitor's Recommendations:	Please implement adequate pre-service and biennial training for mental health and suicide prevention or all correctional officers. In reviewing the documentation provided, the training program is a general outline of procedures to be followed. However, the training syllabus needs to be based on the MDCR and CHS policies, or law or regulations. For officers, medical and mental health staff to be competent to administer the written policies, the training plan and specific course syllabuses needs to be consistent with those policies and include enough detail to assure management that all provisions of the policies are addressed in the required training. Mock suicide response drills and practicums are recommended. Testing post-training should be completed. This should be the format for review of the mental health and suicide prevention training.

Paragraph	III. C. 7. Mental Health Care and Suicide Prevention: h. 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: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the	MDCR policy on medical compliance inspections is covered in DSOP 14-007. It states, "Although the provision of healthcare services is the responsibility of the IMP, assuring that services are provided according to policy and procedures, and in accordance with all applicable standards is a collaborative effort. This collaboration		

factual basis for finding(s)	can only be achieved through mutual trust and cooperation." There is no specific reference to the Mental Health Review Committee or another specific plan to achieve coordination of care and communication.
Monitor's Recommendations:	Please implement a mechanism to ensure regular and effective communication between custody, medical and mental health staff. This may include adequate representation and participation in Mental Health Review Committee and / or other forms of dialogue / problem-solving.

8. Suicide Prevention and Training

Paragraph	III. C. 8. Mental Health Care and Suicide Prevention: a. The County shall ensure that all staff has 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 property response to a suicide attempt; and (9) the proper use of emergency equipment.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Review of training logs for Correctional Crisis Intervention program for all staff 2. Review of training materials and teaching staff for inclusion of the following items: (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.		
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 Response to Consent Agreement reflects plans to train medical, mental health and custodial staff in suicide prevention. This training has not occurred to date. No lesson plans were submitted. As indicated above, DSOP 12-005 refers to adequately training assigned staff in the forensic units in the identification of mental illness and suicide prevention. It does not specifically state in what venue training in suicide		

	prevention and identification of mental illness will occur. An outline of the CIT lesson plan was reviewed. This lesson plan did not include the suicide prevention training curriculum topics as outlined in the Consent Agreement. It also did not specify the specific number hours reserved for mental health training.
Monitor's Recommendations:	Please implement adequate training for medical, mental health and custodial staff in the identification of mental illness and suicide prevention. As indicated previously, the training syllabus needs to be based on the MDCR and CHS policies, or law or regulations. If management expects officers, medical and mental health staff to competent to administer the written policies, then the training plan and specific course syllabuses needs to be consistent with those policies and include enough detail to assure management that all provisions of the policies are addressed in the required training. This should be the format for review of the mental health and suicide prevention training. There is also a need for developing a training DSOP which establishes the basis for a training plan, assigns responsibility for training, identify how training manuals, syllabuses, method of validation of the training, and verification of training will be documented, accordingly a process and time frame to review training process, and training programs, review and change process for testing, a process to assure through supervision and management review to identify areas of re-training where drills, inspections, or interviews demonstrate that need. A training plan should include at a minimum the following: 1. The competency to be achieved; 2. The time frame for achieving the competency; 3. Training to be taken; 4. Delivery method; 5. Who is responsible for the delivery and/or assessment of the competency; 6. Assessment details and arrangements; 7. And a record of acceptable prior learning for qualification; and 8. Name of the qualification or Certificate to be issued. Competency based training and completion is an approach that places emphasis on what a person can do in MDCR because of completing a training program. It is comprised of competency standards that each participant is assessed against to ensure all outcomes required have been achieved. As a result, progression through a competency based program is determined by the participant demonstrating that they have met the competency standard through the training program and related work, not just by time spent in training. I suggest that in the overall training SOP, there be a matrix created within MDCR that identifies all of the

	training that is required for each position, including contracted services. With that documentation in place, MDCR can have assurance of the specifically needed training for each position. The training matrix may include at a minimum, title of training course, the date of the training, training time, the trainer or training organization, verification of attendance, and test results or other documentation that demonstrates that the training was effective.

Paragraph	III. C. 8. Mental Health Care and Suicide Prevention: b. 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 1-3), and custodial segregation units and biannually for all other officers.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Review of training logs and sign-in sheets for correctional custodial who work in intake, forensic (Levels 1-3), and custodial segregation units, medical, and mental health staff 2. Review of lesson plans and training material		
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 Response to Consent Agreement reflects plans to train medical, mental health and custodial staff. This training has not occurred to date. An outline of the CIT lesson plan was reviewed. This lesson plan did not include the suicide prevention training curriculum topics as outlined in the Consent Agreement. It also did not specify the specific number hours reserved for mental health training.		
Monitor's Recommendations:	Please implement adequate training in suicide prevention for all staff as outlined in the previous paragraph.		

Paragraph	III. C. 8. Mental Health Care and Suicide Prevention: c. 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 1-3), and custodial segregation units and biannually for all other officers.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: July 2013
Unresolved/partially resolved issues from previous tour:			

Measures of Compliance:	Mental Health: a. Review of training logs and sign-in sheets for correctional custodial who work in intake, forensic (Levels 1-3), and custodial segregation units, medical, and mental health staff b. Review of mental health training materials
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)	As stated above, the Response to Consent Agreement reflects plans to train custodial staff. This training has not occurred to date.
Monitor's Recommendations:	Please implement adequate training in suicide prevention for all staff.

Paragraph	III. C. 8. Mental Health Care and Suicide Prevention: d. CHS and the County shall ensure all correctional custodial staff are certified in cardiopulmonary resuscitation ("CPR").		
Compliance Status this tour:	Compliance:	Partial Compliance: July 2013	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 1. Review of current CPR certification of all staff.		
Steps taken by the County to Implement this paragraph:	The MDCR training schedule reflects classes to train staff in CPR.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Current policy states all staff should be trained in CPR; it does not state that CPR certification should be current and active.		
Monitor's Recommendations:	1. Recommend update policy so that all medical and mental health staff maintains current CPR certification. 2. Audit and review certification of medical and mental health staff periodically.		

9. Risk Management

Paragraph	III. C. 9. Mental Health Care and Suicide Prevention: a. 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:	Non-Compliance: Not yet due
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. CHS has proposed implementation of Quantros Incident Reporting System. Quality / Risk Management is to meet monthly and will incorporate MDCR. 2. Review of minutes of monthly meetings, suicides, adverse events, and Quantros reports. 3. Review of morbidity and mortality reports for qualitative and systematic analysis		
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 has hired a Director of Quality Management and states it plans to begin implementing JHS risk management procedures. The Quantros incident reporting system has yet to be implemented. Plans have been made per policy to establish a Mental Health Review Committee and a Quality Improvement and Risk Management Committee. These committees have not begun meeting. Several adverse events were reviewed. The analysis of the events did not reflect implementation of changes to prevent recurrence and did not reflect adequate communication for problem-solving between custody, medical and mental health staff.		
Monitor's Recommendations:	In addition to the Quantros system, I recommend review of all inmate deaths of patients that have either been on the mental health caseload or received psychotropic medication for evidence of patterns and possible interventions at the individual and system levels to prevent or minimize harm to inmates.		

Paragraph	III. C. 9. Mental Health Care and Suicide Prevention: Risk Management b. 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:	Non-Compliance: Not yet due
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 1. CHS has proposed implementation of Quantros Incident Reporting System. Quality / Risk Management is to meet monthly and "will incorporate" JHS investigation criteria. 2. Review of minutes of monthly meetings, suicides, adverse events, and Quantros reports. 3. Review of medication error reports, false positives or negatives on screenings in triage and access to care issues, etc. for qualitative and systematic analysis		
Steps taken by the County to Implement this paragraph:	Plan to implement Quantros incident reporting system and incorporate Jackson Health System risk management procedures.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS has hired a Director of Quality Management and begun implementing JHS risk management procedures. The Quantros incident reporting system has yet to be implemented. Plans have been made per policy to establish a Mental Health Review Committee and a Quality Improvement and Risk Management Committee. These committees have not begun meeting.		
Monitor's Recommendations:	Implement Quantros and JHS risk management criteria in review of adverse events on regular monthly basis; perform qualitative and systematic analysis.		

Paragraph	III. C. 9. Mental Health Care and Suicide Prevention: Risk Management c. 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 ii. 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:	Partial Compliance:	Non-Compliance: Not yet due

Unresolved/partially resolved issues from previous tour:	
Measures of Compliance:	Mental Health: 1. Review of minutes of monthly meetings and agenda 2. Review of suicides and adverse events 3. Review of referrals process for at risk individuals 4. Review of Quantros reports. 5. Review of internal quality / risk audits
Steps taken by the County to Implement this paragraph:	Plan to implement Quantros incident reporting system.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Quantros incident reporting system has yet to be implemented. Plans have been made per policy to establish a Mental Health Review Committee and a Quality Improvement and Risk Management Committee. These committees have not begun meeting.
Monitor's Recommendations:	Implement plans for mental health review committee. This should review, on at least a monthly basis, data on triggering at the individual and system levels including analyzing and aggregating mental health data to identify trends that present a risk of harm.

Paragraph	III. C. 9. Mental Health Care and Suicide Prevention: Risk Management d. 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:	Non-Compliance: Not yet due
Unresolved/partially resolve issues from previous tour:			
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:	
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Quantros incident reporting system has yet to be implemented. Plans have been made per policy to establish a Mental Health Review Committee and a Quality Improvement and Risk Management Committee. These committees have not begun meeting.
Monitor's Recommendations:	Implement plans for mental health review committee and quality improvement committee. This committee should take meeting minutes, review and analyze risk management data for all of the facilities. This may include making recommendations for further investigation and for corrective action as well as implementation of recommendations.

Appendix D-1
List of items reviewed:

1. United States of America vs. Miami-Dade County Consent Agreement Case 1:13-cv-21570-XXXX, M 2013
2. Corrections Health Services Policies and Procedures
3. MDCR Policy 12-002, Inmate Administrative and Disciplinary Confinement, 6/12
4. MDCR Policy 12-003, Suicide Prevention and Response Plan, 5/12
5. MDCR Policy 12-005, Recognizing and Supervising Mentally Ill Inmates, 2/13
6. MDCR Policy 12-007, Inmates with Disabilities Act, 6/11/12
7. MDCR Policy 14-001, Inmate Injury Request for Services, 6/07
8. MDCR Policy 14-007, Medical Compliance Inspections, 12/12
9. MDCR Policy 14-008, Healthcare Services, 8/12
10. Response to United States Department Consent Agreement, April 2013
11. Emergency Hospital and Transfer Log, January 2012 through April 2013
12. Attempted Suicide / Self Harm Log, 2012 – April 2013
13. Grievance Log 2013
14. Mortality Log February 2012 through June 2013
15. Mortality reviews Forms:
    a. CHS Medical Screening
    b. CHS Mental Health Screening and Assessment
    c. CHS Physical Assessment
    d. CHS Initial Psychiatric Evaluation
    e. Discharge Summary
    f. Health Insurance
    g. Master Problem List
    h. Relocation Form
    i. Sick Call Request
    j. Social Worker Progress Note
    k. Authorization for Psychotropic Medication
16. Crisis Intervention Training Lesson Plan, April 201
17. Patient medical records

Appendix D-2
List of Interviews by Mental Health Monitor

Rick Morse CHS Director
Calixto Calderon CHS Medical Director
Ignacio Bobes, M.D., Lead Psychiatrist
Jose Sanchez, PhD, Lead Psychologist
Rachel Rodriquez CHS Assoc Director Quality Assurance
Kevin Andrew, Vice President Quality and Patient Safety
Mary Mites, CHS H.S.A.
Mercy Yero Rodriquez, Jackson Nurse Educator assigned to CHS
Donna Benjamin, RN, Jackson IT Cerner
Wayne Wilbright, MD, CMIO Jackson
Mike Garcia, VP CIO
Eric Leal, Jackson IT – MASS (Medical Appt Scheduling System)
Ginger Adler, Jackson IT – MASS
John Repique, VP Jackson Behavioral Health
Eli Medina, CHS Financial Officer
Jayme Shimdt, Sapphire
Nikki Tuskey, Sapphire
Tariq Rasheed, Jackson IT, MASS
Carolina Montoya, PsyD, Mental Health Services Manager

Judge Nashin
Judge Carlos Martinez
Judge Steven Leifman
Carlos Migoya, CEO Jackson Health System
Genaro "Chip" Iglesias, Chief of Staff / Deputy Mayor
District Attorney Kathy Rundle
Practitioners, nurses, and officers at TGK, TTC, Intake, PTDC, and MWDC

Appendix D-3
List of Patients Reviewed by Mental Health Monitor

This is a list of medical documents reviewed by the Mental Health Monitor. Each review may be more or less extensive. Documents reviewed may be complete medical records, parts of medical records, or facility compilations of medical information (e.g. mortality review).

A. Patient 1
B. Patient 2
C. Patient 3
D. Patient 4
E. Patient 5
F. Patient 6
G. Patient 7
H. Patient 8
I. Patient 9
J. Patient 10
K. Patient 11
L. Patient 12
M. Patient 13
N. Patient 14
O. Patient 15
P. Patient 16