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. 2

May 22, 2014

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Compliance Report # 2

USA v. Miami-Dade County
Consent Agreement
Settlement Agreement
May 22, 2014

Introduction

This is Compliance Report #2 regarding the Consent Agreement and Settlement Agreement referenced above. The monitors conducted a joint tour the week of March 23, 2014. Lead Monitor Susan McCampbell was on-site October 18, 2013, December 12, 2013, and along with monitors Dr. Amanda Ruiz and Harry Grenawitzke, toured February 17N18, 2014.

The monitors thank and acknowledge the hard work of the staff of the Miami Dade Corrections and Rehabilitation Department (MDCR), Corrections Health Services (CHS), and the Mayor's Office for their assistance in preparing for this tour.

This Introduction includes discussion of observations, findings and recommendations shared by all the monitors. There are then four individual reports, each of which each includes a summary.

> Report A – Protection from Harm, Inmate Grievances, Audits and Continuous Improvement, authored by Susan McCampbell, page 1 (Summary of compliance, pp. 9 N 10).
> Report B – Fire and Life Safety, authored by Harry Grenawitzke, page 75 (Summary of compliance, page 78).
> Report C – Medical Care, authored by Marc Stern, MD, page 96 (Summary of compliance for Reports C and D, pp. 89N95).
> Report D –Mental Health Care, authored by Amanda Ruiz, MD, 151.

The draft of this report was shared with all parties on April 25, 2014, with a request to provide all comments by the close of business on May 9, 2014. The monitors considered the comments of all parties in preparing this final report.

Monitors' Shared Concerns

The topics of shared concerns discussed in this Introduction are:

- Leadership
- Organization and Collaboration
- Move of inmates with mental illness to TGK
- Conditions of confinement, TTC and PTDC
- Coordination among the County's justice system
- Initiative, Problem Solving and the Data Driven Jail
- Use of Force

Each monitor's report may also comment on these topics.

I. Leadership

The monitors are very concerned about the status of the leadership in both CHS and MDCR. There has been "interim" leadership in CHS since July 2013, and "interim" leadership, with many individuals in "acting" status in MDCR, since January 2014. The County was aware of the previous MDCR director's retirement plans since October 25, 2013, and has yet to appoint individuals in permanent positions. CHS' leadership has been in a state of flux since the conclusion of the monitors' last tour in July 2013.

While the monitors support deliberate decision-making and due diligence regarding individuals to lead both organizations, we believe that decisions are long overdue. It is our belief that some of the frustration and lack of progress we see with attempts to comply with the Settlement Agreement and the Consent Agreement, and in day to day operations flow from the lack of permanent leadership.

We strongly urge the Mayor and the Public Health Trust to act to fill the vacant and acting positions as soon as possible.

II. Organization and Collaboration

It is critical that the organizational structures and commitment to collaborate for both MDCR and CHS is sincere and evidenced by the way in which daily operations evolve. We are concerned that both organizations, while stating that they are collaborating, have yet to break down all the historical barriers to meaningful cooperation.

We site as one example the conditions that monitors McCampbell and Ruiz found in Turner Guilford Knight in February 2014. CHS' lack of staffing had resulted in MDCR having to designate a new housing unit to hold arrestees awaiting medical screenings. The dynamics of the relationship between MDCR and CHS were such that only though the intervention of the monitors was the matter addressed. This should not happen. While we are somewhat hopeful that perhaps the corner has been turned to improve the relationship, communication and problem solving, we wait to be convinced by actions, and not just words.

III. Move of inmates with mental illness to TGK

The County is commended for finding other housing for inmates with mental illness than 9C unit at the Pre-Trial Detention Center. The cost of the renovations were accepted by the County, and the work moves forward with a completion date of December 2014. As with other initiatives that will be noted in this introduction, and throughout the monitors' reports, the defendants had the ability to problem solve and implement the results of brainstorming without the intervention of the monitors – but appeared to hesitate to engage in such strategic planning and implementation – unless pushed by outside forces. We are concerned about this culture that inhibits actions to

address critical issues.

IV. Conditions of Confinement, TTC and PTDC[1]

We find that the conditions of confinement in TTC (see below) and in the housing for inmate with mental illness at the Pre-Trial Detention Center continue not to meet constitutional standards.

Following the tour of the week of March 23, 2014, the monitors requested that CHS and MDCR immediately address the crowding in the 9C unit – where we found 4 actively psychotic male inmates in the same cell – meant for one or maybe two individuals. Obviously MDCR and CHS are long aware of this issue, but until the monitors insisted that problem-solving and relocation plans be developed, neither party took action.

V. Crowding and Criminal Justice System Collaboration

The Board of County Commissioners on February 4, 2014 official adopted an ordinance creating a public safety coordinating council, as suggested in Compliance Report #1. When the PSCC begins its work this will provide the point of collaboration needed to address short and long term issues related to the conditions in Miami Dade's Corrections and Rehabilitation Department. The PSCC is in the position of leading change regarding citizens with mental illness who become enmeshed in the justice system and jail, as well as looking at the long-term needs for beds in the system.

As noted in Compliance Report #1 (and above), the conditions of confinement in the Training and Treatment Center (TTC), previously known as the stockade, do not meet basic constitutional requirements. The County should decide how to allocate scarce resources; to renovation older buildings which may be past their life cycle, or investing in planning for more efficient new construction. The discussion and recommendation in Report A regarding the inmate classification system will impact what type of beds need to be constructed, and influence the costs (construction, operation and staffing).

VI. Initiative, Problem Solving, and the Data Driven Jail

The monitors express concern regarding what appears to us as a lack of initiative toward problem solving on a daily basis in the defendants' organizations. We have noted several examples herein in which the County had within its power to solve problems, but did not act.

Jails are data rich environments. MDCR generates reports with important data; but stops short of analyzing this data to determine the significance, the relationship to other indicators/data, or develop measurable plans of action, as needed. This is documented throughout this report –data about uses of force, data about grievances, data about inmate/inmate violence – all very useful information that somehow is not seen as

[1] See Compliance Report #1.

important, and not used in decision making. It seems as if the data is collected and reported as some compliance related activity –without acknowledging or perhaps even understanding how it can be used. Then some data is missed altogether. As noted in the Report A Summary, the uses of force involving inmates on the mental health caseload was not identified by MDCR, but by the monitors.

MDCR needs to develop the capacity not just to collect data, but to review its importance in a collaborative way – not only inside MDCR but with CHS, and act on the information. The data can be used in many, many ways, the least of which is to establish benchmarks for operations, and establishing accountability.

VII. Use of Force

The monitors find that MDCR's use of force incidents are too many for a jail population of their size, and that there is too much use of force involving inmates on the mental health caseload. This is a critical finding and requires the defendants to use the data they themselves have to develop plans of action. More information about uses of force is discussed in the Summary of Report A.

Conclusions

As the monitoring evolves toward more critical assessment of compliance, based on data generated by the defendants themselves, we look forward to helping with problem solving and encouragement. Above all, we urge the County, MDCR, and CHS to engage in pro-active management and innovation to ensure inmate and staff safety.

Report A
Compliance Report # 2
Protection from Harm
Inmate Grievances
Audits and Continuous Improvement
Report of Tour March 23 – 28, 2014

Summary

The sections of the Settlement Agreement regarding protection from harm (III. A.), inmate grievances (III. C.) and audits and continuous improvements (III. D.) are assessed in this report. There are 50 paragraphs. I assess Miami Dade County and Miami Dade Corrections and Rehabilitation (MDCR) as follows: compliance 6 paragraphs, the same number as in Report #1; 21 in partial compliance, up from 16 in Report # 1, and 21 in non-compliance, a change from 28 in Report # 1.

During the tour, I met with MDCR leadership and compliance team, Miami Dade Police Department's Special Victims Unit commander and staff, Judge Stephen Leifman, staff with the office of The Public Defender, Deputy Mayor Chip Iglesias, as well as toured all four facilities, and spoke with inmates and staff.

The areas that require the attention of County government, CHS, MDCR and MDPD are:

Findings/Overview:

1. Classification and Inmate Safety

   The inmate classification system at MDCR requires an overhaul. The system has been in place for some time, without the benefit of a validation study. The County requested and received technical assistance from the National Institute of Corrections to review the current procedures. The NIC consultants identified significant areas requiring attention, and 18 recommendations (see Attachment A to this report). In short, the totality of the recommendations support the findings in #1 Compliance Report that MDCR's classification procedures require immediate attention.

   The Settlement Agreement provides in Section III. A. 1. (2) that 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." Without waiting for the annual review, my opinion is that the system is not meeting basic needs for inmate safety, staff safety, and is not generating the data needs to more effectively manage housing assignments and inmate management. This opinion is based on reviewing the levels of disorder in the facilities, as well as an analysis of the current classification process, leadership, staffing, training, and organizational placement.

Recommendation: The County should develop a specific plan of action to address the 18 recommendations of the NIC's consultants. This plan of action must be *specific* including, but not limited the tasks to be completed, the individual(s) assigned, time lines/deadlines, and the documentation required to demonstrate the work is done.

Recommendation: The County should immediately retain a classification expert to guide the process and design, in cooperation with MDCR, the validation work. MDCR does not possess at this time the knowledge to do this work without assistance.

2. Prison Rape Elimination Act

MCDR continues to work on PREA compliance. I recommended to the Director that a full-time PREA Coordinator be named, as the work is now one of the responsibilities of a lieutenant. Given the work to be done, and the size of the organization, designating a full-time person at least until the audit is completed, will be a wise investment of resources. There remains significant inmate screening issues to be addressed (e.g. development and implementation of a valid screen, administered by trained employees), including collaboration with CHS' mental health services. While MDCR has engaged a consultant to provide inmate education, with the turn-over in the inmate population, and with the need to develop training modules for employees, alternatives to the current plans should be reconsidered and revised.

Recommendation: MDCR designate a full-time position responsible solely for PREA implementation, including coordination with training, security, CHS, MDPD, data collection, and preparing for the PREA audit.

3. Investigations

In Report #1 I noted concerns about the collaboration between the investigating agencies – the Miami-Dade Police Department (MDPC) N and MDCR. At that time, while MDPD responded, there was not sufficient leadership level collaboration, and investigative protocols specifically for a jail setting, including compliance with relevant PREA standards. Since that time monthly meetings have been held to work on a memorandum of agreement/understanding as well as consultation and information sharing about on-going investigations. This is critical and must continue. I acknowledge the leadership commitment to achieve this collaboration.

Additionally, MDPD must be given the resources to respond to high priority investigations, such as the death of inmate Joaquin Cairo (July 9, 2013), and allegations of sexual abuse and assault. The investigation into Mr. Cairo's death is still not completed, and has implications for the safety of inmates in the Pre-Trial Detention Center.

Recommendation: The County should conclude the initial MOU/MOA between MDCR and MDPD governing investigations, including those related to PREA compliance.

4. Treatment of Inmates with Mental Illness

   MDCR and the County are moving forward with plans to relocate housing for inmate with mental illness to Turner Guilford Knight TGK). In the interim, it is essential that conditions for inmates housed in 9C of PTDC be held in conditions that meet constitutional levels, and humane levels. MDCR and CHS is preparing to move inmates, improve processes, and heighten oversight to assure that basic conditions are met ahead of the move to TGK.

   Of importance is the establishment of a transition team to assure that when inmates with mental illness are moved, the conditions, care, oversight, staff, etc. is not replicated – that is – it is drastically improved. Member of this transition team are scheduled to be appointed in the near future, and the monitors look forward to reviewing their goals, timetables, membership and action plans.

   I am also concerned about the use of force involving inmates with mental illness. I reviewed 33 use of force reports for January 2014, in which 14 inmates on the mental health caseload were noted as involved (42%). The remaining reports either did not complete the information, or marked "unknown." In some incidents, the reporter contacted a nurse to determine if the inmate was taking psychotropic medication, and if a negative response was received, indicated the inmate was not on the mental health case load; an erroneous assumption. (See also recommendation about CIT training, review of use of force incidents, and revision to the classification system.)

   Recommendation: MDCR and CHS should use their monthly meetings to evaluate continued improvements in care, as well as assuring that when inmates are moved to TGK, the conditions at PTDC are not replicated.

5. CHS and MDCR Coordination N Thinking as one, not two organizations.

   There have been substantial and on-going changes in the delivery of medical and mental health care to inmates, starting from the time the monitors' first tour ended in July 2013, and continuing until today. While the two physicians on the monitoring team will address many of the substantive issues, the on- going instability is influencing inmate safety, and causing resource allocation issues – basically staffing – for both organizations.

   One example of the lack of system-wide thinking that impacts all parties, is the completed MDCR staffing analysis, required by the Settlement Agreement. The vendor did not interview or consult with CHS, although there are many areas of the Consent Agreement that relate directly to security staff being available, and certainly influencing inmate care. CHS' deliberations about staffing had not been shared with MDCR – clearly a critical piece in staffing. All parties are now working together to examine staffing, activity schedules, and other operations to ensure not only inmate safety and timely health and mental health care – but appropriately deploy expensive staff resources.

Dr. Stern will discuss this in his findings and recommendations.

The bottom line – the organizations need to see themselves as one; and act in that manner as well.

Recommendation: Continue with plans to assure that there is collaboration in terms of joint meetings, including MDCR staff in CHS meetings and vice versa.

6. Moving Forward with Constitutional Conditions – TTC

I conclude from this tour that the conditions in the TTC, although improved since the July 2013 tour, remain out of compliance with basic constitutional conditions of confinement. The Deputy Mayor indicated the County is looking at long-range planning to replace facilities that have past their life cycle, but this initiative needs to be accelerated. I appreciate the hard work of the MDCR staff in looking at ways to improve the safety of inmates held at TTC, such as installation of the cameras required by the Settlement Agreement, removing some bunks to provide more square footage per inmates, and insuring more accountability for repairs of plumbing. The issues with the inmate classification relate directly in TTC in terms of placing inmates in close quarter without the basic checks and balances provided by a classification system.

Recommendation: The County should develop a realistic plan to replace beds at TTC and plan for any future bed space not accommodated by the current facilities. (See also recommendation in Classification, above.) Until such time as the conditions in TTC are rectified, or the facility replaced, MDCR will not be operating a constitutional jail system.

7. Employee Training

MDCR devotes substantial resources to employee training, and these resources and documentation, as well as a review of results need re-evaluation. As will be noted in this report, lesson plans need to be revised not only to address the specific policy and procedure to be trained, but in terms of being able to document what was taught. Testing needs to be overhauled to provide measures that give the MDCR confidence that the participants are competent in what was taught. The number of hours provided for annual in-service training needs to be reviewed, and linked directly to the requirements of the Settlement Agreement and Consent Agreement. The number of hours is undetermined at this point; and a decision made as soon as possible. The number of in-service training hours required per year will impact the shift relief factor, hence the number of officers required. The staffing analysis cannot be concluded until these important training decisions are made.

MDCR should consider implementing Corrections Intervention Training (CIT) for the staff assigned to work with inmates with mental illness, and extend over the next few

years to as many employees as possible.[2] This is especially critical given the responses to resistance (use of force) involving inmates on the mental health caseload.

Recommendation: MDCR should consider working with a curriculum development specialist and a testing specialist to improve lesson plans and training delivery.

8. Staffing Analysis

The Settlement Agreement requires a comprehensive staffing analysis "to determine the correctional staffing and supervision levels necessary to ensure reasonable safety." (III.A.2.a.) The staffing analysis was produced to the monitors on January 15, 2014. As noted above, this staffing analysis was not coordinated with CHS. As such the monitors believe that a conclusion to the number of staff and supervisors needed must wait until CHS has completed their staffing plan, that the transition plan for the move of inmates to TGK is completed, and until the number of annual in-service staffing hours is determined. As such, we are recommending that the staffing analysis be reexamined in September 2014, along with the information required to made a credible staffing decision.

Recommendation: MDCR and CHS should continue their collaboration regarding staffing and deployment plans for both organizations for the initial report; and develop annual reviews of staffing and deployment.

9. Response to Resistance (Use of Force)

MDCR should continually evaluate uses of force to assure they are within the directives and that there were no lesser options available. This includes review of uses of force involving inmates on the mental health caseload, and uses of force in housing units that are not direct supervision (e.g. Metro West). This recommendation is linked to the need for more effective intervention training, such as CIT, noted above. While there are circumstances in a jail where the need to apply force occurs spontaneously, there are many that can be anticipated based on knowing the inmate's condition, and supervising inmate activities in housing units. Also related to use of force is a working classification system (see above).

I reviewed 33 use of force incident reports for the period January 1 – 31, 2014.[3] The questions I posed after that review included: why the inmate's mental health status was not always included in the report; why officers needed to result to punching

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[2] For more information see http://community.nicic.gov/blogs/mentalhealth/archive/2011/08/04/crisis intervention team cit training for correctional officers an evaluation of nami maine s 2005 2007 expansion program.aspx

[3] Of these 33 uses of force, 10 involved OC, 7 reports indicate that staff punched inmates during the altercation, 5 were reports involving handcuffing of resistant inmates, 5 inmates were otherwise restrained (for example "placed" in a chair), 3 inmates were tackled to the ground, 2 incidents involved separating inmate/inmate fights, and 1 was a cell extraction.

inmates in the face; why there was no indication or review of the cause of inmate/inmate assaults that required force to break-up; the need to more clearly indicate the housing unit type (e.g. single cells, dormitory) and the classification of the inmates involved in altercations, need for a more consistent summary of the event (e.g. cover memoranda), how documentation is noted when reports are "revised", and an explanation of why final reviews were delayed more than 6 weeks. A critical look at the uses of force, beyond the decision to administratively charge an inmate, or determine if staff followed procedures, is the determine if force was necessary at all, if there was better planning, a decision to delay action, or involvement of mental health staff.

I was provided with the summary of two resistance monthly meetings held on September 26, 2103 and November 27, 2013. The notes from the meeting demonstrate that the reports are being examined and deficiencies noted. What is needed in addition to this level of review, that should be done by the supervisor, of the facility's leadership, is a review of the actual incident, not just the paperwork.

Data provided by MDCR for 2013 indicates a total of 437 uses of force for that year. This same report, Inmate Violence Report FY 2013N2014 First Quarter, also notes the data regarding the type of force used, and the reason for the use of force. The data, however, is somewhat compromised by the analysis shortfalls detailed in the Summary.

If the uses of force (for January 2014) continue at the same rate for the remainder of 2014, there will be almost 400 uses of force, which I consider too many[4]. And if there is no mitigation of uses of force involving mental health clients, this will potentially result in 170 clients involved, not to mention injuries to staff who are involved. This is an unacceptable level of uses of force.

Recommendation: Based on the totality of circumstances regarding uses of force, I recommend that MDCR designate one person/position as the final reviewer of incident reports. This does not need to be a full-time position, but rather someone at a rank/position that will review all reports, maintain data, track incidents, develop action plans as necessary, and be responsible for initiatives related to use of force (such as implementation of CIT training). This person/person is not responsible for doing the work of supervisors or facility leadership in terms of assuring all policies regarding uses of force are following, included report writing, but rather this seeks to bring consistency and uniformity to final reviews, recommendations, and assures plans of action are implemented and evaluated. I further recommend that if MDCR establishes these responsibilities, the person have the ability to report to the Director without any intervening levels of review.

10. Inmate/Inmate Violence

Analysis of information from incidents of inmate/inmate violence/assaults also

[4] See above, there are 437 uses of force noted for CY 2013. In 2013, the uses of force involved OC 22% of the time.

requires more than just assuring the incident reports are completed, it requires the leadership at the facilities to evaluate the causes, and, as necessary, develop plans of action to mitigate systemic issues. (See above, training, classification, use of force). The Settlement Agreement includes provisions for this analysis. Action plans should be specific, assign responsibilities to individuals for work, establish due dates, and include measures to assess if the plans of action are meeting the goals of reducing inmate/inmate violence.

MDCR reported that there were 1,111 inmate/inmate assaults for CY 2013, as compared to 1.093 for the previous year. Adjusted for the decrease in inmate population, the rate for CY 2013 was 4.49, and for CY 2012 4.73, not a significant change.

I reviewed a sample (N=32) of incident reports for the last calendar year involving allegations of inmate/inmate sexual assault, inappropriate language, voyeurism, etc. I conclude that MDCR is appropriately responding in terms of separating inmates and taking complaints of inappropriate touching and harassment seriously. What remains to be completed to codify this response is a memorandum of agreement with MDPD regarding which allegations are referred to MDPD, which are referred and after review returned to MDCR for administrative review, and on-going communications. (See also PREA compliance.)

Recommendations: See use of force (above); and compliance documentation (below)

13. Compliance Documentation

I thank MDCR for providing on March 7, 2014 an update of their anticipated compliance for the tour that began on March 24th. This information was a helpful as a roadmap to evaluate compliance, was well organized, and provided the bases for productive discussions. I also thank MDCR for updating "Power DMS" with information related to the specific paragraphs of the Settlement Agreement.

There is a single point of contact for the monitors. MDCR should evaluate whether this position has the commensurate authority to compel, if necessary, other persons in the organization to assist with this effort.

Achieving compliance with the Settlement Agreement and the Consent Agreement is an exercise in improving the total operation in a sustainable way, so that when compliance is achieved, and the monitoring teams no longer tour – the organization is on "auto pilot" to continuous improvement. I'm not sure that this is the perspective of some managers at MDCR, who, in my view, see the compliance work as short-term – getting things "together" to address the monitors' concerns, rather than seeing this as the opportunity for improvements that mirror and adopt accepted correctional practice – and sustaining the initiatives.

Recommendation: MDCR needs to complete relevant written directives establishing the

data reporting, analysis, and documentation included in the Settlement Agreement. The reports generated via this directive need to meet the needs of the organization, in other words, while assuring compliance with the Settlement Agreement be usable data and is sustainable after the life of Agreement.

Report A: Protection from Harm Summary of Compliance for tour the week of March 23, 2014

Subsection of Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments:
III. A. Protection from Harm					
1. Safety and Supervision					
III.A.1.a. (1)	11		3/14, 7/13		
III.A.1.a. (2)	12			3/14, 7/13	
III.A.1.a. (3)	12		3/14, 7/13		
III.A.1.a. (4)	13		3/14, 7/13		
III.A.1.a. (5)	14		3/14, 7/13		
III.A.1.a. (6)	15	3/14	7/13		
III.A.1.a. (7)	15		3/14, 7/13		
III.A.1.a. (8)	16			3/14, 7/13	
III.A.1.a. (9)	17		3/14, 7/13		
III.A.1.a. (10)	18		3/14, 7/13		
III.A.1.a. (11)	20		3/14, 7/13		
2. Security Staffing					
III.A.2. a.	21		3/14, 7/13		
III.A.2. b.	21		3/14, 7/13		
III.A.2.c.	23		3/14, 7/13		
III.A.2.d.	23			3/14	
3. Sexual Misconduct					
III. A.3.	24		3/14, 7/13		
4. Incidents and Referrals					
III. A.4 a.	26		3/14, 7/13		
III.A.4. b.	26			3/14, 7/13	
III.A.4.c.	27			3/14, 7/13	
III.A.4.d.	28			3/14, 7/13	
III.A.4.e.	30		3/14, 7/13		
III.A.4.f.	31		3/14, 7/13		
5. Use of Force by Staff					
III.A. 5 a.(1) (2) (3)	32		3/14, 7/13		
III.A.5. b.(1), (2) i., ii, iii, iv, v, vi	33		3/14, 7/13		
III.A. 5. c. (1)	36	3/14		7/13	

Subsection of Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments:
III.A. 5. c. (4)	39	3/14	7/13		
III.A. 5. c. (5)	39	3/14	7/13		
III.A. 5. c. (6)	41			3/14, 7/13	
III.A. 5. c. (7)	43		3/14, 7/13		
III.A. 5. c. (8)	43			3/14, 7/13	
III.A. 5. c. (9)	44			3/14, 7/13	
III.A. 5. c. (10)	44	3/14	7/13		
III.A. 5. c. (11)	45			3/14, 7/13	
III.A. 5. c. (12)	46			3/14, 7/13	
III.A. 5. c. (13)	48	3/14		7/13	
III.A. 5. c. (14)	48			3/14, 7/13	
III.A.5. d. (1) (2) (3) (4)	49		3/14, 7/13		
III.A.5. e. (1) (2)	50		3/14	7/13	
III.A.6. a. (1) (2) (3) (4) (5)	52			3/14, 7/13	
III.A.6.b.	53			3/14, 7/13	
III.A.6.c.	53			3/14, 7/13	
iii. c. Inmate Grievances					
III.C. 1.,2.,3.,4.,5.,6.	54		3/14, 7/13		
D. Audits and Continuous Improvement					
III.D.1. a. b.	57			3/14, 7/13	
III.D. 2.a. b.	60			3/14, 7/13	
IV. Compliance and Quality Improvement					
IV. A.	63			3/14, 7/13	
IV. B.	65			3/14, 7/13	
IV. C.	67			3/14, 7/13	
IV. D.	69			3/14, 7/13	

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: 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	This paragraph addresses the totality of conditions throughout all facilities. The conditions that continue to require attention are PTDC 9C, TTC, classification, and uses of force, especially uses of force involving inmates on the mental health caseload.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Manual of security and control-related policies, procedures, written directives and practices, consistent with Constitutional standards and contents of the Settlement Agreement. 2. Internal audits. 3. Documentation of annual review(s). 4. Schedule of review for policies, procedures, practices.		
Steps taken by the County to Implement this paragraph:	MDCR is still in the process of finalizing written directives.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR either needs to devote more resources to completing policies and procedures and/or implement a more streamlined approach to accomplishing the work. Acknowledging the this is a large jail system, focus on the elements of the Settlement Agreement, and creating accountability within MDCR – which are intended to last long after there is compliance with the Settlement Agreement will assure long-term inmate and staff safety.		
Monitor's Recommendations:	Complete the required work. Assure implementation and staff training. Assure accountability.		

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: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See Executive Summary, Classification.		
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:	I reviewed the updated Classification and Bed Analysis dated 12/19/13. While the analysis shows that there are beds available by classification level, as the classification system needs substantial reworking, the analysis means little. I also reviewed a quarterly statistical report dated January 28, 2014 that sought to examine the range of data that can be currently generated from the information system. Finally, the County requested and received short-term technical assistance from the National Institute of Corrections to assess the current system and develop steps to revision of the classification system.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The additional information developed since Compliance Report #1 indicates that the classification system, process and staffing requires attention. Until the classification system (and related data and human resources) is "fixed" there cannot be any sustainable progress toward insuring inmate and staff safety, as well as determining future jail bed needs in the County.		
Monitor's Recommendations:	Develop an action plan based on the recommendations of the NIC consultants to implement possible interim changes to the current system to improve inmate classification in the short-term; and create a plan to begin the work needed to create a credible classification system that is supported by an appropriate number of trained staff.		

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: 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Protection from Harm: 1. Policies and procedures requiring conduct of rounds. 2. Review of housing unit logs. 3. Review of staffing in housing units through observation and logs. 4. Interviews with inmates, employees.		
Steps taken by the County to Implement this paragraph:	NA		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	I examined logs in TGK during a February 2014 tour. At that time I determined that in this unit holding inmates who were in detox protocols, and/or were awaiting further medical screening, that this standard, and the DSOP was not being met. While I acknowledge that this was one housing unit, the inmates held there was a significant enough risk to themselves (and others since most were double-celled) that these requirements should have been met in this unit.		
Monitor's Recommendations:	Continue supervisory vigilance, especially in special housing. Will reevaluate compliance on next tour.		

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: (4) Document all security rounds on forms or logs that do not contain pre-printed rounding times. Video surveillance may be used to supplement, but not replace, rounds by correctional officers.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	See III.A.1.a. (3) above. Additionally, as Compliance Report #1 noted, I did not believe there was sufficient detail in the governing written directive, DSOP:11b020, effective date 5/12/12. That written directive had not been modified at the time of this tour.		
Measures of Compliance:	Protection from Harm: 1. Policies and procedures on reporting and logging. 2. Policy on use of video surveillance. 3. Review of staffing in housing units through observation and logs.		

	4. Interviews with inmates, employees Examination of logs.
Steps taken by the County to Implement this paragraph:	
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See recommendation in Compliance Report # 1
Monitor's Recommendations:	See recommendation in Compliance Report # 1

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: 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Reclassification 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 continues installation on the scheduled noted above.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	One change was made to the installation on PTDC – 10B – which does not hold inmate in disciplinary status, but mental health female inmates. This unit will have cameras installed on a different schedule.		

Monitor's Recommendations:	Update monitor as work is completed.

Compliance Status this tour:	Compliance: 3/28/14	Partial Compliance: 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
	_____		
Steps taken by the County to Implement this paragraph:	MDCR has installed a "watchman" system and the policy and procedure (DSOP 14b013) was put in place effective 3/3/14.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The written directive is in place. I did not review the associated training materials, or a sample of the download from the software.		
Monitor's Recommendations:	Prior to next tour, provide the monitor with a copy of the training lesson plan related to this directive, evidence that training was conducted, and examples of the printouts. Additionally, if the printouts indicate that the there is not staff compliance with the requirements of this paragraph, provide a plan of action and/or employee re-training or disciplinary information.		

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: 3/28/14, 7/19/13	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) The revised draft directive is dated 3/13/14 and has not yet been reviewed by the monitor. It appears to be set for an implementation date of 4/26/14.		
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) During next tour examination of more floor logs will be conducted.		

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: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	Requires completion of the governing written directive, staff training.		
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:	Draft written directive completed
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR provided evidence of shakedowns being completed in all 4 facilities. Importantly, there is not a process in place that MDCR systematically examines contraband to determine, as appropriate, the source, need for changes to security procedures, need for improvement in maintenance, and/or other procedures – such as medication administration. In a system as large as MDCR this function needs to happen at both a facility level on a regular basis, with a review of the findings in the 4 facilities at the headquarters level. As an example, I reviewed a shakedown log from TTC dated 1/14/14 in which 8 pills were found in TTA8. The disposition of the pills was noted as given to the Clinic nurse (as was the same for 6 pills found in TTB4 on 1/6/14; and the same for 76 pills found in TTF4 on 1/26/14)). On 2/5/14 the contraband report form for TT TTB3 identified a piece of sharpened metal fence with a handle, which was disposed of in the dumpster. On 1/26/14 various potential weapons were found in TTF4 (pens, plastic knife, "sharpened" item – and disposed of in "outside dumpster. The same pattern continued with other contraband found at TTC – with no indication there was any analysis of what was being found, or how the contraband was introduced. For Metro West, the information regarding what was found in shakedowns was placed on a monthly consolidated list, although the information was not sufficient detailed to provide an opportunity for much analysis (for example, applies, organs, pears were noted as found, but no quantity).
Monitor's Recommendations:	Develop written policies/procedures and training lesson plans to comply with the paragraph. Assure that the written directive includes the process for the analysis of contraband, trends, sources, etc. to improve safety for inmates and staff.

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: 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	See recommendations in Compliance Report #1 and comments regarding training in the Summary, above. With the current bidding process, staff may change in these units every 6 months. This instability practically prevents MDCR from training almost on a continual basis. If the six month bid process is not required by the collective bargaining agreement, MDCR and the County should provide only an annual bidding process		
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 posttests) 6. Examples of remedial training, if any.
Steps taken by the County to Implement this paragraph:	See recommendations in Compliance Report #1
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See recommendations in Compliance Report #1
Monitor's Recommendations:	See recommendations in Compliance Report # 1 Provide for an annual bidding process, rather than a semi-annual process to stabilize the staffing in specialized housing units, and assure that training is provided.

Paragraph <u>Coordinate with Dr. Ruiz</u>	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: 3/28/14, 7/19/13	Non-Compliance:
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance: 3/29/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	See Training observations in the Summary. The defendants are planning on proposing time frames for when training is required – e.g. if an employee has not been assigned to a facility for less than a year, after being previously assigned, what training is required?		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training of staff assigned to special management units. 2. Lesson plans for the 8 hours of training. 3. Evidence training was held annually; evidence those working in the units attended. 4. Documentation of knowledge gained (e.g., pre and post-tests) 5. Remedial training, if any. <u>Mental Health:</u> 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 handouts, 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 posttests) 7. Remedial training, if any.
Steps taken by the County to Implement this paragraph:	Protection from Harm: The Special Management Unit lesson plan, 8 hours of training was prepared in May 2013. The lesson plan is marginally 6 pages, and is insufficient in detail to be able to determine what is taught. Additionally, the lesson plan addresses the mechanics of the unit's operations (e.g. shift$_{change,}$ cell checks, headcounts, control booth officer's responsibilities, observing the SMU inmates, with a scant 3 lines about communication with SMU inmates). Mental Health: I received a list of officers in PTDC that have received training. Information regarding the content and quality of the training was not provided. An 8bhour lesson plan based on the original 40-hour CIT course had been developed for training. When asked about the quality and the overall benefit of the training, officers were unable to describe it. CHS provided a report indicating that on March 19, 2014, greater than 90% of TGK and PTDC medical and mental health staff was trained on suicide policy and a suicide-warning card. This training was completed by Dr. Gonzalez and Dr. Razdan. CHS has hired a consultant, Ms. Judith Cox, to provide assessment and input on suicide screening and assessment.$_{Her}$ first visit occurred March 19b21, 2014. Her preliminary observations included recommendations that suicide prevention training should be practical and cross-disciplines between custody and mental health.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: See Compliance Report # 1. The lesson plan is not sufficiently detailed. Mental Health: The CIT lesson plan does not adequately outline the content of the course. I did not receive sign-in sheets or the results of testing at the end of the course demonstrating proficiency in mental health screening and suicide risk screening proficiency. On March 19b21, 2014, CHS had a consultant visit to examine the facility and provide feedback on suicide screening.$_{Her}$ initial summary noted: 1. Suicide training needs to have a more functional approach that crosses all disciplines 2. Mental Health training should be integrated and cross both corrections and medical i.e.; general training as well as are specific training by functional area
Monitors' Recommendations:	Protection from Harm: See Compliance Report # 1. Develop a more detailed lesson plan.$_{Assure}$ participants knowledge gained in included. Same for CIT lesson plans, and the CIT program.

	Mental Health: Implement adequate pre-service and biennial training for mental health and suicide prevention or all correctional officers. As previously identified, training should be administered to the policy and should be cross-discipline. Therefore, it is useful to first update the policy, outline working definitions, and subsequently cross-train to the policy. 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 handouts, power point, and video training that are used. It is useful for staff at PTDC to understand booking and screening criteria just as much as it is useful for correctional staff to understand the signs of detox and suicide risk.

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: 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	MDCR notes that it is developing a plan to address any increases in inmate/inmate violence based on quarterly and annual reports. (See also Classification in Summary).		
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 provided a report on inmate/inmate violence covering the first quarter of CY 2014, with comparisons of incidents to previous years.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The data is presented to note a decrease from 2012 to 2013 inmate/inmate assaults; but the data is not adjusted for the decrease in total inmate population. When I adjusted the number of assaults for the decrease in the average daily population, the decrease was marginal (4.4 v. 4.7/inmate). This is an example of the analysis that needs to be done by MDCR regarding data, as discussed in the Summary		
Monitor's Recommendations:	Further examine and refine the data to determine what plan of action is needed to address the critical areas. MDCR collects data, but conducts insufficient analysis and trend review.		

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: 3/28/14	Non-Compliance: Not yet due (11/27/13)
Unresolved/partially resolved issues from previous tour:	The staffing analysis was delivered on 1/15/14.		
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:	As noted in correspondence to the County (and see Summary, above), the staffing analysis is insufficient. The specific areas collaboration and further data analysis needed has been transmitted to the parties, and a review of the updated information is now scheduled for 9/15/14.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See Summary above.		
Monitor's Recommendations:	Engage in the collaboration and data collected needed to result in a credible staffing analysis.		

Paragraph <u>Coordinate with Drs. Ruiz and Stern</u>	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: 3/28/14	Non-Compliance: 7/19/13
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/13

Unresolved/partially resolved issues from previous tour:	See III.A.2.a.
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. See IIIA.2.a. Medical Care: Not audited by the Medical Monitor during this tour. Mental Health: The staffing plan that was provided did not solicit input from medical and mental health. It does not adhere to the above noted measures of compliance. Issues with staffing and the ability to provide adequate supervision continue to contribute to procedures at PTDC; mentally ill and suicidal inmates are prohibited from recreation and showers until the treatment team meeting occurs and/or the patient is stepped down to a lower level of care. This is problematic and 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: None. 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 is required for the provision of showers, recreation, and access to private treatment by mental health for patients.
Monitors' Recommendations:	<u>Protection from Harm:</u> See III. A. 2. a. <u>Medical Care:</u> A consultant assisted MDCR with developing as custody staffing plan. However, there was no evidence the consultant solicited input from CHS staff. This should be done. <u>Mental Health:</u> 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: 3/28/14	Non-Compliance: Not yet due 11/27/13
Unresolved/partially resolved issues from previous tour:	See III.A.2.a.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Completed staffing plan; discussion of recommendations by the monitor, if any. 2. Determination of the need for more hiring, if any. 3. Hiring plan, if needed, with timetable. 4. Results of hiring, if needed.		
Steps taken by the County to Implement this paragraph:	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.		
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: 3/28/14, Not yet due (3/26/14)
Unresolved/partially resolved issues from previous tour:	See III. A.2.		
Measures of Compliance:	<u>Protection from Harm:</u> 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.		
Monitor's Recommendations:	See III. A. 2. a. The County and MDCR need to develop the capacity to conduct periodic reviews of staffing to assure Long-term compliance with this provision.		

Paragraph <u>Coordinate with Drs. Ruiz and Stern</u>	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: 3/28/14, 7/19/13	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:	See the work program provided by MDCR		
Measures of Compliance:	<u>Protection from Harm:</u> 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: There is a policy in effect but significant more needs to be done in terms of staff training/education, and screening of inmates. 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: I reviewed the updated plan of action dated 3/26/14. The spreadsheet indicates the work remaining to be done. 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: See recommendation in Summary, above. It is my strong recommendation that MDCR assign a full-time PREA coordinator with the skills, knowledge, abilities and organizational authority to move toward compliance. The PREA works need to be coordinated with the classification initiatives. 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: 3/28/14,7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	See Compliance Report # 1		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding notifications to managers regarding critical incidents; actions required. 2. Policies and procedures regarding reportable incidents. 3. Documentation of notification managers; checklists/incident reports. 4. Review of incident reports. 5. Review of critical incidents. 6. Interview with supervisory and management staff. <u>Mental Health:</u> 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 is updating the policies; see Compliance Report #1, due on 6/13/14.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See Compliance Report #1. I am concerned that this important directive has not yet been updated.		
Monitor's Recommendations:	See Compliance Report # 1.		

Paragraph	4. Incidents and Referrals b. Staff shall report all suicides and other deaths immediately, but no later than one hour after the incident, to a supervisor, Internal Affairs ("IA"), and medical and mental health staff.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/14
Unresolved/partially resolved issues from previous tour:	See III.A.4.b.		
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:	The required updated procedure is due to be completed on 6/13/14.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III.A.4.b.
Monitor's Recommendations:	See III.A.4.b.

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: 3/28/14	Non-Compliance: 7/19/13
Unresolved/partially resolved issues from previous tour:	MDCR developed a reporting format, Incident Self Audit System (ISAS) to extract data from incident reports and produce documentation. I saw a demonstration and was impressed with the system's ability.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures to track analyze data, develop corrective action plans, as needed for all reportable incidents. 2. Definition of reportable incidents. 3. Review of reports, analysis, corrective action plans. 4. Review of elements in database. 5. Review of incident reports 6. Review of any external reviews/results. 7. Review of corrective action plan, if any.		

	8. Review of data/reports generated from the information in the system.
Steps taken by the County to Implement this paragraph:	See above.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The software initiative has been almost completed, what is missing for compliance is the accompanying policies and procedures guiding the self-audit process. More critical self-assessment is required; rather than a perfunctory review of data. An example of this need to alter the focus of these data collection and self-audits can be seen in reviewing the two self-audits provided. The reports are written for a third party, presumably the monitors, rather than for the leadership and management of MDCR. The recommendations from the self-audits are not specific, and have no time lines, or assigned responsibilities to be completed. Language such as the "team noticed" is not consistent with a data driven approach. Either the team had concrete findings or trends, or they did not. Importantly, the analysis of the uses of force did not identify the involvement of inmates on the mental health caseload as I found in reviewing the January 2014 incidents. While MDCR is new to the analysis of data, these self-audits are good first steps. It is important that the thinking about how these self-audits will be used changes – from an exercise to comply with the Settlement Agreement, to using the data to fix insufficiencies or inmate/staff safety concern. The goal is to establish not only recordkeeping, but also accountability for required/needed changes.
Monitor's Recommendations:	What is essential is for MDCR to develop not only the policies and procedures relevant to internal audit, but to ANALYZE and USE the data to make management decisions. Mere production of reports is insufficient to assure long term sustainability to inmate and staff safety.

<u>Paragraph</u> <u>Coordinate with Drs. Ruiz and Stern</u>	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: 3/28/14, 7/19/13 (not yet due)
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/28/14
Unresolved/partially resolved issues from previous tour:	MDCR policies being revised; CHS policy is being developed.		
Measures of Compliance:	<u>Protection from Harm:</u> 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. <u>Medical Care:</u> • 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. <u>Mental Health:</u> 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:	<u>Protection from Harm:</u> The policies and procedures were provided 10b003, 11b003 and 15b001. DSOP 10b003 is being revised due 6/13/14. <u>Medical Care</u>: Not audited. <u>Mental Health:</u> CHS policy JbAb11 addresses grievances.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	<u>Protection from harm:</u> No documentation of how these provisions are implemented; reports, incidents, etc. <u>Medical Care:</u> None <u>Mental Health:</u>

	The policy addressing grievances does not address triage for incident reports. I reviewed an MDCR Report on Grievances for fiscal year 2012b2012. While medical grievances were clearly the highest percentage of grievances (29.8%), there were no (zero) mental health grievances. There were also no grievances related to recreation (despite the fact that recreation at PTDC is limited) and no grievances from inmates with disabilities. This is unusual.
Monitors' Recommendations:	<u>Protection from Harm:</u> See above, revision of policies. <u>Medical Care:</u> None. <u>Mental Health:</u> 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 agency.

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: 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	Training continues; but see Summary, need to revise lesson plans. The self-audits also review incident reports related to high liability areas, make recommendations, but plans of action don't have time lines or assign responsibilities.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training on preparing incident reports; and notification criteria for critical incidents. 2. Lesson plans; pre-service and in-service. 3. Training schedule and attendance rosters. 4. Documentation of knowledge gained (e.g. pre and posttests) 5. Evidence of remedial training, if needed. 6. Review of incident reports.		
Steps taken by the County to Implement this paragraph:	See above, lesson plan revision necessary.		
Monitor's analysis of conditions to assess compliance, verification of	See Compliance Report # 1		

the County's representations, and the factual basis for finding(s)	
Monitor's Recommendations:	See Compliance Report #1. No revised lesson plan provided.

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: 3/28/14, 7/19/13	Non-Compliance:
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	See below, need for lesson plan revision		
Measures of Compliance:	<u>Protection from Harm:</u> 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 posttests) 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. <u>Medical Care:</u> • 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. <u>Mental Health:</u> See Protection from Harm		
Steps taken by the County to Implement this paragraph:	<u>Protection from Harm</u>: See Compliance Report # 1 <u>Medical Care:</u> Not audited. <u>Mental Health:</u> Specific training as to this provision was not audited. The policy was reviewed; it is in the process of being updated with the input of outside consultation as noted above. MAC Meeting minutes noted that this issue had been raised and		

	discussed in Fall 2013 between MDCR and CHS; no resolution or decision was noted.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: See Compliance Report # 1 Medical Care: None. Mental Health: MDCR DSOP 12b005 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 are in the process of being updated. The actual training materials, content, sign-in sheets and testing material were not provided.
Monitor's Recommendations:	Protection from Harm: See Compliance Report #1 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: 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	See Compliance Report #1		
Measures of Compliance:	Protection from Harm: 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:	See Compliance Report #1		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR provided all of the use of force reports for January 2014, along with a memo from each facility commander "sampling" the incident report package. If I had not reviewed all use of force reports for January 2014, I may have found this provision in compliance; however the questions raised by my review, and discussed in a meeting with MDCR (and in the above Summary) allow me to conclude that there is insufficient critical review of use of force incidents. Therefore, I propose the County and MDCR designate a use of force monitoring role, a position that has sufficient authority, to examine uses of force, prepare plans of action as necessary, and assure these plans of action are carried out. It is my belief that based on the data, MDCR relies too much on uses of force. Importantly, there seems to be a lack of awareness of these higher uses of force at the leadership or facility command level. The uses of force may be a function of a impaired classification system, lack of sufficient effective training for staff who work with inmates with mental illness, or housing decisions that are made as a result of faulty classification.		
Monitor's Recommendations:	See recommendation in the Summary section of this report.		

Paragraph Coordinate with Dr. Ruiz	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 12b005) to include the following minimum requirements: i. other than restraints for transport only, mechanical or injectable restraints of inmates with mental illness may only be used after written approval order by a Qualified Health Professional, absent exigent circumstances.

<table>
<tr><td></td><td colspan="3">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: 3/28/14, 7/19/14</td><td>Non-Compliance:</td></tr>
<tr><td>Mental Health: Compliance Status this tour:</td><td>Compliance:</td><td>Partial Compliance: 3/28/14, 7/19/13</td><td>Non-Compliance:</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="3">Written directive provided dated 4/9/14.</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.
3. Lesson plans and training provided.
4. Review of uses of restraints; required logs.</td></tr>
</table>

	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: Production of a new directive dated 4/19/14. Mental Health: DSOP 12b005 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. Restraint chairs have been purchased and implemented by MDCR. The training protocol I reviewed relative to the implementation of these chairs with mentally ill clients was inadequate. It did not differentiate between the use of the restraint chair for disciplinary reasons and the use of the restraint chair for psychiatric / behavioral ones.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Did not evaluate new 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 be 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, which 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 contraindications to restraint. CHS policy J-1-01 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. During the medical record review, I identified a medical record which referred to an inmate "received in the chair with suicidal thoughts." The record contained no order for restraint and no sign of checks every 15 minutes for circulation.
Monitors' Recommendations:	Protection from harm: I don't recall reviewing the draft directive dated 4/9/14. Provide for monitors' review.

	Mental Health: MDCR should revise its policy to remove inconsistencies with the Agreement, CHS policy, and nationally recommended practices. 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: 3/28/14	Partial Compliance:	Non-Compliance: 7/19/13
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:	NA		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	DSOP 11b041 requires reporting by end of shift, which meets the requirements of this paragraph. I did not find any instance where the policy was not being followed.		
Monitor's Recommendations:	MDCR should continue to monitor reporting to assure compliance with this requirement.		

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: 3/28/14	Non-Compliance: 7/19/13
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	Revised directive due.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force reports; specifications for reporting. 2. Review of incident reports. 3. Review of investigations. 4. Review of inmate disciplinary reports. 5. Review of lesson plans. 6. Review of Medical Care/mental health records regarding injuries, including any required off-site hospitalizations. 7. Review of sample of staff workers' compensation claim relating to uses of force, inmate/inmate altercations. 8. Remedial, corrective action if necessary. 9. Review of digitally recorded incidents. 10. Review of MDCR Inmate Violence Report <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:	<u>Protection from harm</u>: MDCR updating policy. <u>Medical Care:</u> Not audited. <u>Mental Health:</u> During the prior site visit, the County provided the MDCR Inmate Violence Report for 2012b2013; it did not do so for 2013b2014. I reviewed specific cases that indicated mental health patients were placed in restraint without a medical order.		
Monitors' analysis of conditions to	<u>Protection from Harm:</u>		

assess compliance, verification of the County's representations, and the factual basis for finding(s)	Pending updated policy. Partial compliance is noted as some of the requirements are included in the existing directive. Medical Care: None. Mental Health: In 2012b2013, 21% of custody response to violence included 4bpoint restraint and / or the restraint chair. The MDCR Inmate Violence 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. In 2013b2014, information specific to use of force against inmates with mental health issues, delirium and/or developmental delay was not provided for review.
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: 3/28/14, 7/19/13	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:	NA		

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See comments regarding III.A.5.a.
Monitor's Recommendations:	See comments regarding III.A.5.a. Complete updated lesson plans; due 4/6/14.

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: 3/28/14	Partial Compliance: 7/19/13	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:	NA		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	All use of force packages I reviewed were in compliance with this paragraph.		
Monitor's Recommendations:	None at this time. See recommendation in Summary for oversight of use of force incidents, reports, plans of action, etc.		

Paragraph <u>Coordinate with Dr. Stern and Dr. Ruiz</u>	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: 3/28/14	Partial Compliance: 7/19/13	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: 7/19/14
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: NA Medical Care: Not audited. Mental Health:		
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: All use of force packages I reviewed were in compliance with this paragraph. Medical Care: None. Mental Health:		

Monitors' Recommendations:	Protection from Harm: See recommendation regarding monitoring of uses of force. Medical Care: None. Mental Health: CHS has been asked to develop a system to track injuries specific to inmates with mental health issues, delirium, and/or developmental disabilities.

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: 7/19/13
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:	See Compliance Report #1		
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: See Compliance Report #1; directive currently being revised. Medical Care: Not audited. 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: See Compliance Report #1 Medical Care: None. Mental Health: In July 2013, a death case occurred that was labeled a Category 4, one in which preventable errors of omission were directly related to the patient ▪ s mortality. The investigation into the death of this case, nearly one year later, remains open.
Monitor's Recommendations:	Protection from Harm: See Compliance Report #1 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 the accountable 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: 3/28/14	Partial Compliance: 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	See Compliance Report #1		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding reporting, recording, photographing use of force incidents. 2. Review of job descriptions/post orders. 3. Review of training for those who may/will be photographers. 4. Review of incident reports; use of force packets. 5. Review of investigations; critique of utility of photographs. 6. Review of remedial or corrective action plans, if any. 7. Interview with IAB staff.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	All use of force packages I reviewed were in compliance with this paragraph.		
Monitor's Recommendations:	See recommendation in Summary.		

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: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See Compliance Report #1.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force; supervisory presence; location of recording equipment; supervision of recording equipment (batteries charged, repairs needed, etc.) 2. Policies and procedures regarding digitally recording incidents; training for users; instructions. 3. Review of incident reports; including exceptions in which digital recordings not made. 4. Review of investigations; review of digitally recorded incidents. 5. Review of remedial or corrective actions, if any. 6. Interview with IAB staff.		
Steps taken by the County to	See Compliance Report #1.		

Implement this paragraph:	
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See Compliance Report #1.
Monitor's Recommendations:	See Compliance Report #1.

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: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See Compliance Report #1.		
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:	See Compliance Report #1.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See Compliance Report #1.		
Monitor's Recommendations:	See Compliance Report #1.		

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: 3/28/14	Partial Compliance: 7/19/13	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: NA Medical Care: Not audited.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: All use of force packages I reviewed were in compliance with this paragraph. Medical Care: None.
Monitors' Recommendations:	Protection from Harm: None at this time. 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: 3/28/14, 7/19/13

Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Unresolved/partially resolved issues from previous tour:	See Compliance Report #1		
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. <u>Medical Care:</u> • [No medical audit step unless questions/issues are referred by the Security Monitor.]		
Steps taken by the County to Implement this paragraph:	<u>Protection from Harm:</u> See Compliance Report # 1. MDCR reports it is working on DSOP 4b108 which will incorporate this requirement. <u>Medical Care:</u> Not audited.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	<u>Protection from Harm:</u> See above <u>Medical Care:</u> No issues were referred to the Medical Monitor by the Security Monitor during this visit.		
Monitor's Recommendations:	<u>Protection from Harm:</u> See Compliance Report #1. <u>Medical Care:</u> None.		

Paragraph <u>Coordinate with Drs. Ruiz and Stern</u>	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: 3/28/14, 7/19/13
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See Compliance Report #1 and III.A.5.c.11.		

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 Compliance Report #1 and 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 Compliance Report #1 and 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, data relative to analysis of use of force with the mentally ill, delirious, and developmentally disabled has not been provided. CHS is in the process of updating policies and procedures as well as its qualitative analysis. Preliminary information provided by CHS, which was neither validated nor cross-checked, indicated that in December 2013, the Quality and Safety Department requested notifications from MDCR each time and inmate was involved in an altercation or use of force; initial compliance with this metric was reported at ▪▪40%.▪▪
Monitor's Recommendations:	Protection from Harm: See Compliance Report #1 and 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. Documentation and notification of incidents of use of force or altercations among inmates with mental illness should occur in writing. This information should be formally tracked and logged in a manner that can be qualitative analyzed for patterns and systematic improvement.

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: 3/28/14	Partial Compliance:	Non-Compliance: 7/19/13
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:	NA		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation provided with logs from Metro West.		
Monitor's Recommendations:	Continue self-audits.		

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: 3/28/14, 7/19/13

Unresolved/partially resolved issues from previous tour:	See Compliance Report #1.		
Measures of Compliance:	Protection from Harm: 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) See comments in Summary regarding use of force generally, and uses of force involving inmates with mental illness.		
Monitor's Recommendations:	*See* III.A.5.c. (11) See also Summary.		

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: 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	See Compliance Report #1.		
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:	See Compliance Report #1.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See Compliance Report #1.
Monitor's Recommendations:	See Compliance Report #1.

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 4b015) 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: 3/28/14	Non-Compliance: 7/19/13
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health Care: Compliance	Compliance:	Partial Compliance:	Non-Compliance: Not audited

Status this tour:			
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. Medical Care: 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:	NA		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: The investigation process requires further refinement and collaboration with MDPD. Mental Health: Not audited. Medical: None.		
Monitor's Recommendations:	Protection from Harm:		

	Partial compliance is noted because of DSOP 4b015, Complaints, Investigation and Dispositions. The MOU covering MDPD's investigations into allegations of excessive force is needed. Also needed is the final version of SIAB's policies and procedures. Mental Health: Not audited. Medical: None.

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: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See Compliance Report #1.		
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:	See Compliance Report #1. Draft due to be completed by 4/11/14.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See Compliance Report #1.
Monitor's Recommendations:	See Compliance Report #1.

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: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See Compliance Report #1.		
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 Compliance Report #1. See III.A.6.a.1b5		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See Compliance Report #1. See III.A.6.a.1b5		
Monitor's Recommendations:	See Compliance Report #1. See III.A.6.a.1b5		

Paragraph	III. A. 6. Early Warning System c. <u>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.</u>		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/13

Unresolved/partially resolved issues from previous tour:	See Compliance Report #1.
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 Compliance Report #1. See III.A.6.a.1b5
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See Compliance Report #1. See III.A.6.a.1b5
Monitor's Recommendations:	See Compliance Report #1. See III.A.6.a.1b5

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 Status this tour:	Compliance:	Partial Compliance: 3/28/14, 7/19/13	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: 3/28/14
Unresolved/partially resolved issues	See Compliance Report #1.		

from previous tour:	
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding inmate grievances per the specifications above. 2. Updated inmate handbook. 3. Review of grievance forms (Creole, English, Spanish) 4. Review of procedures for LEP inmates, and illiterate inmates. 5. Review of a sample of grievances. 6. Observation of grievances boxes and processing of grievances. 7. Interview with inmates. 8. Evidence of referral of grievances alleging use of force; sexual assault. 9. Quarterly tracking/data reporting; recommendations, if needed. 10. Documentation of collaboration between security and medical/mental health regarding inmate grievances. 11. Quarterly report of trends, by facility; corrective action plans, if any. Medical Care: • Audit Step a: (Inspection) The content of medical grievance replies is responsive and meaningful. As provided for in CHS Policy JbAb11, 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: The inmate handbook update has not been completed. Medical Care: Medical Grievance consolidated data are reviewed at an organizational level and at a facility level. At a Mini MAC meeting the Monitor attended, staff had raw numbers of grievances for their own facility, but not data of ADP adjusted

	trends over time for the facility or comparisons between facilities. The current grievance categories do not necessarily correspond to categories which should be of interest to management for diagnostic and planning purposes (e.g. Chest Pain is its own category). Mental Health: Specific to mental health, no grievances were filed. This is quite unusual. . 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: See Compliance Report #1. I reviewed the report: Inmate Grievance Reporting Briefing FY 2012 – 2013 Q3 (undated). The report noted an upward trend in inmate grievances. Recently monthly meetings are being held with CHS to compare information about grievances. Medical Care: None. 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:	Protection from Harm: The grievance reporting system needs to be modified to report inmate grievances connected to the requirements of the Settlement Agreement – specifically – uses of force or allegations of excessive force; sexual assault, voyeurism; staff sexual misconduct, as examples. Additionally categories where no grievances have been reported for at least 18 months should be considered for elimination. There are no opportunities for inmates to anonymously submit grievance forms. I recommend that MDCR try an experiment – probably best at Metro West, where grievance boxes are places so that inmates can drop their grievance, anonymously on the way to recreation, or the clinic. If that process was tried for a month, it will be apparent if there are barriers (comparing pre-box numbers) to inmates filing grievances. Inmates with whom I spoke said they get responses to their grievances. I followed-up on several medical grievances at Metro West. MDCR tracks medically related grievances (e.g. inmate complaints about medication, sick call, chest pains, medical diet, etc.), but it is unclear why this is done. There should be collaboration with CHS that makes the needs for MDCR to track medically related grievances; unless MDCR is not confident that CHS is responding appropriately to these grievances. MDCR produced a 22 page report of data regarding grievances, but that report did not include any conclusions,

	recommendations or plans of action. This is another example of how data is collected, graphed, and produced, but it is unclear how it is used to improve operations. I also reviewed the self-audit regarding grievances (second quarter CY 2013). The report noted that grievances were increasing but noted that without further detailed analysis the cause was undetermined. There is no recommendation that this work be done, and no substantive conclusions and recommendations. It appears that the facilities are tracking grievances in a log fashion, with no analysis, summaries, recommendations, or plans of action. MDCR should develop processes and procedures that not just collect data, but analyze it, develop plans of action as needed, and assure that recommendations are implemented. While looking at grievance data that is analyzed at the facility level is helpful, there needs to be a more concentrated effort to review the information collectively. The self-audit of the grievance process should include inmate interviews and/or surveys. The self-audits should also examine the need for any additional staff training and/or inmate orientation about the grievance process. <u>Medical Care:</u> MDCR should have access to facility and MDCR ADP adjusted grievance rates (e.g. #medical grievances/100 inmates/month) trended over time. <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: 3/28/14, 7/19/13
Fire and Life Safety: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/13
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited.
Mental Health Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See Compliance Report #1.		
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. <u>Medical Care:</u> 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	<u>Protection from Harm:</u>		

Implement this paragraph:	See Compliance Report #1. Fire and Life Safety: DSOP 10b022 establishes the weekly inspections by the FSSOs, of fire and life safety equipment, along with a quarterly review of fire drill reports and monthly inspections of fire and emergency equipment and procedures. MDCR has developed inspection forms for use by both FSSOs and CIAB. MDCR has not provided any evidence of a quarterly review of fire drills. Further there is no procedure established in the policy as to the format for the review. DSOP 10b 022 is currently being revised based on the comments provided during the first tour. MDCR has not provided any revision draft for review. However, DSOP 4b018, Quality and Assurance and Improvement Procedures is not completed and I have not had an opportunity to review any draft. Medical Care: Not audited. Mental Health: CHS is in the process of updating its policies and procedures in coordination with MDCR.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: MDCR reports that there is a draft DSOP, 4b018 that will address the requirements of these provisions, due to be completed on 5/2/14. Fire and Life Safety: On the second tour I was received examples of weekly Fire Safety Inspections conducted by Fire Safety Sanitation Officers (FSSOs) for each facility and monthly inspections of Fire Safety Inspections by CIAB. While MDCR inspection forms are being used, other than identifying Non-conformances, there is no process for documenting corrective actions taken to resolve the violations either for the short term or effective long-term solutions. During the second tour I did provide a one-day training program on establishing an effective internal auditing program. The program was attended by officers of MDCR and each of the facilities. Based on the training I anticipate that MDCR will review it internal inspection and audit program to create an effective program that addresses corrective actions. The MDCR monthly inspections need to include an audit of the weekly FSSO inspections. As identified in Report I there is no evidence of a consistent internal audit program or evidence of training for officers charged with conducting internal audits on inspection procedures. I have received no evidence of development or implementation of corrective actions plans within 60 days of each quarterly review. Medical Care: None. Mental Health:

	Self-audits which have occurred to date, while an excellent beginning, have been based on inaccurate data or collection methods. CHS and MDCR are aware of this and are in the process of implementing accurate systems to collect and analyze their system so that they may make sustainable, meaningful changes.
Monitors' Recommendations:	Protection from Harm: See Compliance Report #1. Fire and Life Safety: Complete the revision to DSOP 10b022. Provide a copy of DSOPs 4b0128 and 11b042 for my review before it is finalized. 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. Establish corrective actions plans for each of the quarterly reviews of fire and life safety inspections and fire drills. Medical Care: None. Mental Health: In addition to cross-training staff and updating policy, both CHS and MDCR should comprehensively review each of the inmate deaths and each adverse / serious event in a systematic, cross-discipline and organized fashion. This should include "lower level" events such as the use of the restraint chair or cell extractions. A qualitative review should include an examination of the cause of death or key event, contributing factors, and an analysis of what may have been preventable or what may be improved by an interdisciplinary team, including Dr. Gonzalez. Trends should be analyzed and systemic issues identified for improvement.

Paragraph Coordinate with Drs. Ruiz and Stern, and Grenawitzke	D. Self-Audits 2. Bi-annual Reports i. 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: 3/28/14, Not Yet Due (10/27/13)
Fire and Life Safety: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/28/14, Not Yet Due(10/27/13)
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance: 3/28/14	Non-Compliance: Not Yet Due(10/27/13)
Unresolved/partially resolved issues from previous tour:	See Compliance Report #1.		
Measures of Compliance:	<u>Protection from Harm:</u> 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. <u>Fire and Life Safety:</u> Same as the measures of compliance as Protection from Harm <u>Medical Care:</u> • (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: See Compliance Report #1. See also III.D.1. Fire and Life Safety: The MDCR staffing plan draft did not include any analysis of staffing needs for support staff including sanitation, plumbing, electricians, electrical technicians, carpenters, locksmiths or mechanical engineers. Medical Care: A medical staffing plan is pending. Mental Health: Bi-annual reports related to medical, mental health and suicide prevention started in October 2013; communication since that time has greatly improved with both MDCR and CHS. A medical and mental health staffing grid was submitted.
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 Compliance Report #1. See also III.D.1. Fire and Life Safety: During meeting with staff at each facility, there were several staffing needs identified for support services. MDCR Facility Manager requested 1 more plumber and one more general repairman . The electrician there has been pulled to do work at TTC. TGK staff suggested 4b5 more sanitation workers, one full time plumber and an electrician to be shared with TTC. TTC staff suggested 1 plumber, one sanitation supervisor, and five additional sanitation officers PTDC staff suggested 2 plumbers, 2 electricians, 1 HVAC technician Boot Camp staff suggested ½-time plumber and ½-time general maintenance person. Based on the discussions, MDCR needs to include a staffing analysis for all support services including food service, laundry, plumbing, electricians, mechanical engineers and technicians. Medical Care: None. Mental Health: Psychiatry

	• Staffing currently consists of seven FTEs and 109 total hours of per diem or 'pool' psychiatry time. • Per diem psychiatry time has been unpredictable and unreliable • Current plans include recruitment of staff to full-time positions. Other incentives and creative staffing options are also being explored. Social work • Staffing at TGK includes coverage on day and evening shifts. However, the night, 11 to 7 am shift is currently covered by a nurse. • Recruitment for a QMHP to cover this shift will be imperative. • In addition, interviews with current SW and mental health staff indicated that they were interested in development of policy and training (directed to the policy, once developed) to ensure consistency and standardization of practice between the providers
Monitor's Recommendations:	Protection from Harm: See Compliance Report #1. See also III.D.1. Fire and Life Safety: Provide a staffing analysis and implement its recommendations 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: 3/28/14, 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	Compliance:	Partial Compliance:	Non-Compliance: Not audited.

this tour:			
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance: 3/18/14	Non-Compliance: Not yet due (10/27/13)
Unresolved/partially resolved issues from previous tour:	See Compliance Report #1.		
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 posttests). 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 Compliance Report # 1. See above, III.D.1. Fire and Life Safety: There is no change from the previous report. Please follow the Measure of Compliance for this section. Medical Care: The Monitor provided feedback to MDCR on a number of policies related to operations which are undergoing change. Mental Health: CHS has implemented the Quantros system to assist with tracking reportable events. In addition, Dr. Gonzalez, its new Associate Director of Mental Health, reported she planned to 'cross-walk' the Consent Agreement with the policies from CHS.
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 Compliance Report # 1. See above, III.D.1. Fire and Life Safety: Same as above Medical Care: None 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: 3/28/14, 7/19/13
Fire and Life Safety: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/13
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance ;	Non-Compliance: Not audited.
Mental Health: Compliance Status	Compliance:	Partial Compliance: 3/28/14	Non-Compliance: 7/19/13

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. 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: See Compliance Report #1. Fire and Life Safety: No information provided to document evidence of compliance. Medical Care: Not audited. Mental Health: Meeting minutes from the Mental Health Review Committee and the Quality and Safety Committee were reviewed, as		

	well as the MAC meetings.
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 Compliance Report #1. Fire and Life Safety: No information provided to document evidence of compliance. Medical Care: None. Mental Health: The Agreement requires the implementation of a Mental Health Review Committee and a Risk Management & Quality Improvement Committee. CHS Policy JbAb04b addendum states: (Mental Health Review) Committee members will include the CHS Director, CHS Medical Director, CHS Lead Psychiatrist, Mental Health Program Director, Quality Risk Management Representative, and MDCR Medical Liaison. MDCR has provided no companion policies for Mental Health Review Committee or Quality Improvement / Risk Management. DSOP 14b007 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: See Compliance Report #1. And III.D.1. Fire and Life Safety: Development and implementation of policies as identified in the Measures of Compliance for this provision. Medical Care: None. Mental Health: MDCR and CHS implemented MAC meetings, which have improved communication between custody medical and mental health. The Quantros Incident Reporting System has also been implemented by CHS, just as the QMS tracking system has been implemented by MDCR. Sharing of this information by the two organizations has been vital. In addition, during our site visit, MDCR and CHS agreed to re-organize the organizational charts of the two organizations to ensure communication. Specific to emergencies and problem solving, this will be vital moving forward.

Paragraph	IV. COMPLIANCE AND QUALITY IMPROVEMENT
Coordinate with Drs. Ruiz and Stern,	C. On an annual basis, the County shall review all policies and procedures for any changes needed to fully

and Grenawitzke	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: 3/28/14, Not yet due 7/19/13
Fire and Life Safety: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due 3/28/14, 7/19/13
Medical Care: Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: Not yet due 7/19/13
Mental Health: Compliance Status this tour:	Compliance:	Partial Compliance: 3/28/14	Non-Compliance: Not yet due 7/19/13
Unresolved/partially resolved issues from previous tour:	Not reported.		
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: Not reported. Fire and Life Safety: No information provided to document compliance Medical Care:		

	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: Need a policy and procedure that defines these requirements. A spreadsheet was produced dated 3/25/14 which included the timelines for submission and completion of the written directives related to the Settlement Agreement. Fire and Life Safety: No information provided to document compliance Medical Care: 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 14b007 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: Mental Health: As indicated above, communication between MDCR and CHS has improved as a function of re-organization of the organizations chart, implementation of MAC meetings, and improved coordination. MDCR and CHS should continue to 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 Status this tour:	Compliance:	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:
Fire and Life Safety: Compliance Status this tour:	Compliance:	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Production of policies and procedure for review. 2. Production of lesson plans, training schedules, tests <u>Fire and Life Safety:</u> i. Providing drafts of revised/new policies for all provisions of Fire and Life Safety ii. 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. iii. Training Schedule and a training matrix that identifies specifically what training is required for each position within MDCR iv. Evidence of how training effectiveness will be measured and process for addressing staff that can or do not demonstrate MDCR specified effectiveness. v.		
Steps taken by the County to Implement this paragraph:	<u>Protection from Harm:</u> No policies have been provided for review, to date. <u>Fire and Life Safety:</u> MDCR has provided copies of 10b006, 10b010, 10b022, 10b023, and13b001 for initial review. Written comments were provided during the first tour. However, since then, I have received no revisions to review.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	<u>Protection from Harm</u> See Compliance Report #1. <u>Fire and Life Safety:</u> 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:	<u>Protection from Harm:</u> See Compliance Report #1. <u>Fire and Life Safety:</u>		

	Development of policies and review process, along with a training component to assure training to changed policies is completed before making the policies effective. As recommended in the Fire and Life Safety provisions, provide me with drafts of the revised policies identified above. Provide a copy of DSOP 4b018 for review.

Inmate Classification System
Technical Assistance Report

Miami8Dade Corrections and Rehabilitation Department
Miami, Florida

Technical Assistance Report Amended
#14 – J1038

Prepared by
Randy Demory and Dr. Patricia Hardyman

National Institute of Corrections
Jails Division

May 15, 2014

Summary of Recommendations:

Recommendation # 1 – Review the present data dictionary that can be found in the classification section of the computer system. It is a user's guide of sorts that directs the classification officers through the steps of the classification process. This document needs to be specific and complete so that it leaves little or no possibility of differing approaches by one of the twenty-nine different classification staff. The present document is a bit vague in some key points.
Recommendation # 2 – Determine the impact of the small changes that have been made to the wording of the questions. The questions dealing with institutional behavior is one of the places where subtle changes have been made to the primary instrument. The Northpointe® instrument includes a question asking if the inmate has a known SERIOUS institutional behavior problem, and then later in the tree there are two questions asking if the inmate has a known NONGSERIOUS institutional behavior problem.
Recommendation # 3 – Reevaluate the severity of offense scale.
Recommendation # 4 – Reconsider the practice of classifying all inmates placed in safety cells as level 2. While this practice is closely adhered to by the classification officers, it is not found in the jurisdiction's policy manual.
Recommendation # 5 – Proceed with plans to run complete NCIC criminal histories. Presently classification officers only check the criminal history within Miami-Dade County, and do not check for criminal histories in the State of Florida or nationally.
Recommendation # 6 – Provide regularly planned in-service or refresher training in addition to the "on-the-job" training provided at the onset of assuming classification duties. All of the training should include some mechanism for testing comprehension and competency.
Recommendation # 7 – Look for opportunities to enroll classification line staff and supervisors in classification workshops conducted by the NIC or other experienced outside professionals.
Recommendation # 8 – Continue to conduct a face-to-face classification interview with each inmate who remains in custody. Some thought should be given to investing the interview process with more meaningful responsibilities, such as a needs screening, orientation of expected inmate behavior, probing for suicidal thoughts or PREA concerns, or answering inmate's questions.
Recommendation # 9 – Provide training for the classification staff regarding conducting overrides, and then monitor the rate of discretionary overrides of each officer.
Recommendation #10 – Develop management reports to track both types of overrides over time. Daily snapshots are informative, but only the ability to establish trends over time will permit accurate conclusions to be drawn concerning the override activities of individual classification officers.
Recommendation # 11 – Require security staff to consistently record descriptions of inmate behavior in a manner that make those records easily available for retrieval in the future by classification officers doing the work of reclassification.
Recommendation # 12 – MDCR uses the Northpointe® instrument for reclassifications, but some changes were made to the reclassification instruments. Acting Captain Key has been provided with a copy of the published instrument to this report for ease of comparison. It is possible that these changes were made with the permission of the publisher, but none of the MDCR staff with which we spoke were familiar with the process that resulted in modification of the Northpointe® instrument. We'd recommend reverting to the original form of the instrument, or confirming with the instrument's publisher that the changes have not been significant enough to skew the instrument's validity.
Recommendation # 13 – Consider reformatting the housing plan to take advantage of the classification instrument's ability to identify violent inmates.
Recommendation #14 – Expand the new "Incident Self Audit System" to include tracking all of the inmate incidents and infractions that are reported, not just events related to CRIPA compliance.
Recommendation #15 – Continue, and if possible accelerate, plans to procure and implement a new jail management system (JMS).
Recommendation # 16 – Implement a system of formal evaluations of key parts of the classification system.
Recommendation # 17 – Develop incident based management reports that would assist tracking inmate misbehavior.
Recommendation # 18 – Conduct a formal statistical validation of the classification system.

[i] 14G15121

Report B
Compliance Report # 2
Fire and Life Safety
Report of Tour Week of March 24 – 27, 2014

Summary

Compliance Report No. 2 is submitted in accordance with the Settlement 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. During March 24-28, 2014 I conducted a tour of the Miami-Dade County Corrections and Rehabilitation Department (MDCR) facilities including Boot Camp, Turner Guilford Knight Correctional Center, Pretrial Detention Center (PTDC), Training & Treatment Center (TTC) and Metro West Detention Center (MWDC). I was also onsite February 17-18, 2014 to assess ongoing compliance, provide technical assistance, and meet with MDCR officials.

The purpose of the second tour was to continue assessing compliance with the Miami Dade Settlement Agreement Part B Fire and Life Safety Provisions. The report below summarizes the findings and provides recommendations for improvement to meet the Settlement Agreement.

My findings include that there are limited improvements in conditions compared to the previous tour in July 2013, for the six-fire safety and chemical control provisions. Most notably was improvement in the training of Fire Safety/Sanitation Officers (FSSOs), and in the safe and effective dilution of chemicals used for cleaning and disinfection. However, the training was not based on the DSOP policy that is being revised. Glow sticks have been added to all the emergency key rings throughout all of the facilities, improving the ability to identify keys during an emergency. All fire extinguishers and other fire and life safety equipment are now inventoried by location to establish a method to assure that all are inspected internally or by contract as required.

Although the focus of this report is the Fire and Life Safety provisions, I did complete limited tours of TTC, TGK, MWDC, Boot Camp, and PTDC. Generally the housing units that I visited along with the common areas were maintained in a clean and I did not observe any significant fire hazards in the cells. Inmates were storing commissary and personal belongings in their personal property bags. Weekly inspections by FSSOs and monthly inspections by the Compliance, Accreditation and Inspections Bureau (CIAB) are being completed. I was provided samples of those inspections.

The Training and Treatment Center (TTC) continues to be overcrowded with inadequate unobstructed space along with inadequate supervision (30-minute checks) as described in Compliance Report #1. A-Block 7 did not have hot water available in the lavatory hand sinks. Inmates stated that they did not have hot water for three weeks. However, hot water was available for the showers. Maintenance officials stated that they were working

on new hot water piping for A and B Blocks. Two of the four sinks there did not even have hot water faucets. In A-6, a large plastic bag used to store partial soap bars was hanging on the wall of the shower creating a safety issue for inmates. Housing Unit C was not being used as it is being completely renovated including the installation of cameras.

In TGK I observed in 6-2 that several of the mattresses were torn and in need of replacement or recovering. The detergent used for inmate's personal clothing did not contain any disinfecting bleach. Bleach is needed to destroy pathogens including strains that are responsible for Methicillin Resistant Staphylococcus aureus (MRSA). Units 2-1 and 2-2 were closed to inmates as they were under renovation to house mental health inmates from PTDC.

Boot camp dormitories were clean. However, the gate securing the hot water heater for the kitchen was unlocked and open. There was damage to insulation wrapping the heater.

At Metro West shower curtains were being replaced by "saloon" type doors which provide some privacy, while providing officers working in the housing areas the ability to visually monitor inmates in the showers. In unit 3-1 one shower was not functioning, and although a work order had been submitted on 3/10/14, it had not been repaired as of 3/12/14. The plumber assigned to Metro West had been reassigned for the renovation work at TTC resulting in approximately a 50 plumbing work order backlog. There were also approximately 75 pending electrical work orders according to the facility's maintenance manager.

Officers working in the housing units enter work order requests in the maintenance management system (Facilligence.) However, officers assigned to specific housing areas stated they have no way to monitor whether work orders are actually completed because each shift maintains its own unit log book and the logbooks are not available to officers on other shifts. The option for reviewing status of work orders is available to the maintenance manager. Subsequent to the tour I learned that Facilligence in fact does contain two modules (Check Service Request Status and Duplication Mode) that do allow staff to check on the status of work order requests and monitor duplicate work order requests. MDCR needs to provide training or issue written procedures instructing them on effectively utilize these modules.

At PTDC, I did not tour housing tiers but the staff that I interviewed indicated there was significant improvement since the July, 2013 tour in rodent control with fewer complaints from both detainees and staff. Miami-Dade does have a contract for pest control that includes all facilities within MDCR.

Prior to the March 2014 tour I reviewed several MDCR policies related to fire safety, evacuation, chemical control, and key control. I also reviewed the companion policies for each of the facilities covering the same procedures. Most policies have effective dates of less than one year ago, and while quite thorough and well written in some cases need further editing to eliminate inconsistencies, and duplication. The directives also need to identify responsible persons/posts accountable 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.

Recommendation: I strongly urge MDCR to eliminate redundant facility specific policies where the MDCR policy that is authorized addresses the same procedure and/or process. The facility chemical control and key control policies are examples that should be eliminated. By doing so, only MDCR policy needs to be revised and not four more policies.

The recently provided chemical control training for Fire Safety/Sanitation Officers (FSSOs) used a Power Point presentation based on the previous version of the policy. As a result, training will either have to be repeated once the revised policy is authorized in accordance with the new provisions or the training staff will need to issue a specific directive advising FSSOs of the changes.

Recommendation: I urge MDCR training staff not to develop or offer training to any new policy until the revised policy is authorized.

When the revised policies are implemented, I will monitor and review written evidence of their implementation, including effectiveness of training. The focus of future tours will be specifically to identify whether long-term corrective action resolutions were taken to reduce repetitive nonconformities/violations from reoccurring based on self-audits.

One issue that needs to be addressed is the staffing for Support Services. While there is a draft staffing analysis for corrections, it does not include Support Services functions including, but not limited to plumbers, electricians, mechanical engineers and technicians, maintenance, food service, laundry, etc.

Recommendation: I strongly urge MDCR to analyze its current staffing for Support Services and provide recommendations to the Director. Maintenance staff is currently being reassigned from their assigned facilities for special projects, such as the TTC renovation project. This use of staff significantly reduces the number of key trades able to fix ongoing issues that occur daily in each of the facilities. I look forward to reviewing that report.

I appreciate the work to prepare for the second tour 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 and expect to see significant improvement in all the fire and life safety provisions at the next tour.

Report B: Summary of Fire and Life Safety Compliance
Tour March 24 – 27, 2014

Subsection of Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments:
III. B. Fire and Life Safety					
III.B.1.	79		3/14, 7/13		
III.B.2.	81	3/14, 7/13			
III.B.3.	81		7/13		
III.B.4.	83		3/14, 7/13		
III.B. 5.	84		3/14	7/13	
III.B.6	85			3/14, 7/13	
D. Audits and Continuous Improvement					
III. D.1.	57				See Report A
III.D. 2.	60				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

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: 3/20/14; 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. 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 10P022, 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 MDCR Safety Officer position 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 Certifications, Inspections and Accreditation Bureau (CIAB) of MDCR. It establishes quarterly fire drills on each shift in each area of each facility, an inspection and cleaning every six months of the food service ventilation fire suppression systems, and filters, monthly inspections of all fire and emergency equipment for all facilities, and monthly inspections of all SCBA equipment, Fie Safety inspections are completed by designated and trained fire safety/sanitation officers. MDCR has established Policy 10P006 which provides for Emergency Procedures and Evacuation. Correspondingly, each facility also has developed a facility specific policy/plan for fire response. Many provisions restate much of the MDCR polices 10P006 and 10P022. Other than for the unique evacuation routes and plans, the duplicate provisions could be removed to assure consistency with 10P006 and 10P022. The facility policy and plans would then only address		

	emergency and evacuation procedures that are unique to a specific facility. MDCR would then have one policy in place for fire prevention and safety. Many of the divisional plans need to be revised for consistency. The Policy and Planning Chief indicated that by year-end, the facility specific plans will be consistent with DSOP 10P022.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Prior to this visit, MDCR provided a facility specific inventory identifying the location of all fire extinguishers, automatic external defibrillators (AEDs), for the following facilities: Boot Camp, MWDC, PTDC, TGK, TTC, and WDC. A complete inventory of sprinkler heads, smoke detectors, strobe lights, fire alarm pull stations, heat sensors, and shut off valves is complete and documented for the following facilities: TGK, TTC, MWDC, WDC, and PTDC. An inspection of the fire and life safety equipment is conducted weekly by each facility's Facility Safety/Sanitation Officers (FSSO). MDCR has provided copies of recent inspections. Non-conformities identified are provided to the Facility Manager for review and corrective action. Fire and Life Safety inspections are also completed monthly by MDCR's Compliance, Inspection and Accreditation Bureau (CIAB). However, it is not clear if the inspections conducted by CIAB include a review of the weekly facility fire safety/sanitation officers. Self-Contained Breathing Apparatus (SCBA) inventory is complete for Boot Camp, MWDC, PTDC, TGK, TTC, and WDC. SCBAs are inspected daily by the unit officer with findings documented in the applicable housing unit logbook. CIAB includes an inspection of SCBAs during their monthly fire safety inspections. Flow tests are conducted annually by a private contractor. Fire extinguishers are inspected every three years under contract and the extinguishers are inspected monthly by each facility's FSSO as noted on each fire extinguisher tag. However, at this tour, I did not receive a copy of the schedule or evidence that the three-year inspection was completed since the last visit. In the MDCR status update that was provided prior to this tour, it stated that a copy of maintenance responses to internal and external reports would be submitted prior to the visit. Those reports were not provided.
Monitor's Recommendations:	1. Eliminate the redundancy of facility specific provisions for fire prevention and safety in the facility specific SOPs to assure consistency with 10P006 and 10P022. There should be one fire response and prevention plan policy for all of MDCR. As stated above, there needs to be facility specific emergency evacuation plans. The plans should be written in language that is easy to understand and easy to follow. 2. Once the policies and facility plans are redrafted please provide a copy for review before implementing. 3. Provide copies of the completed monthly CIAB fire safety inspections at the end of June, September, and December for the previous three months, along with a corrective action report for each facility. 4. Provide a copy of the annual schedule for all fire safety equipment and evidence of the most recent three-year fire extinguisher inspection checks for all facilities. 5. Clarify language in Policy 10P0022 as to the responsibility of the reviewer of the weekly and monthly reports. 6. Clarify language in Policy 10P022 as to who has the responsibility and accountability for assuring Non-conformities identified in the weekly FSSO and monthly CIAB inspection are tracked to assure timely corrective action resolutions are completed and the issues formally closed. 7. Assure that Policy 10P022 establishes a verifiable procedure as to how Non-conformities/violations are investigated

	and resolved that includes a formal close out with assigned responsibility and accountability. 8. Please provide the maintenance responses that would hopefully include formal closure to all internal and external reports quarterly for the previous three months.

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: 3/20/14; 7/20/13	Partial Compliance:	Non-Compliance:
Unresolved/partially resolved issues from previous tour(s):	*N/A*		
Measures of Compliance:	Fire and Life Safety: 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 12/1/11P5/31/14. 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)	There is no change from the previous report which found this provision in substantial compliance.		
Monitor's Recommendations:	1. Please provide copies of the 2014 fire suppression systems for 2014 once they are completed, along with the Miami Dade Fire Rescue Department annual inspection for 2014 of all facilities.		

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: 3/28/14, 7/20/13	Non-Compliance:
Unresolved/partially resolved issues	*N/A First Tour*		

from previous tour(s):	
Measures of Compliance:	Fire and Life Safety: 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:	As of this report, DSOP policy 10P023 for Key Control in is the final stages of a revision that should eliminate the need for a separate policy for each building as recommended in the previous report. The emergency keys for all facilities are notched, and equipped with glow sticks. During the visits to each facility, officers in the room where emergency keys were maintained generally understood and could demonstrate accessing the emergency keys after obtaining the key that opens the emergency key storage box in each facility. However, the location of the glass front "Red Box" is different in some facilities. For example, in TTC the "red box" is located in the Shift Commander's office, along with the emergency keys. At PTDC the "red box" is located in a separate room approximately 150 feet and around three corners from the control room where the emergency key box is located. At MWDC and TGK, the "red box" is located in the control room where the emergency keys are located. However, the emergency keys at TGK are located in one drawer of an unlabeled six-drawer cabinet. Prior to finalizing DSOP 10P023, MDCR should examine each facility to determine whether a consistent location for all facilities could or should be established that would be consistent for all facilities. TTC maintains a complete set of alternate emergency keys for TGK, MWDC and PTDC. Boot Camp should be included.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	With one exception employees working in the control rooms demonstrated and understood how to access red box key that opens the emergency key box and could easily identify he emergency keys by touch. MWDC has at least three different styles of emergency keys on each ring and numerous keys on each ring that could be confusing during an emergency. The north side key ring has nine keys and the south side of the building has five keys. Staff is in the process of minimizing the different type of keys needed by installing consistent locks on several locks. Once completed, there will be seven keys for the north side and three keys for the south side. MDCR needs to review the location of all "red boxes" and emergency key boxes to determine the feasibility of using one central consistent location in all MDCR facilities. This would simplify training especially considering officers can and do change facilities in which they work through the bidding process. I observed the installation of glow sticks on each emergency key ring at each building. On future tours, I will continue to ask officers to demonstrate the use of emergency keys.
Monitor's Recommendations:	1. Complete the revision of MDCR Policy 10P023 once the emergency key location feasibility review described above is completed. Once completed, revise the training curriculum to reflect the revised policy and expectations. 2. Assess the feasibility of a consistent location for the emergency "red box" and emergency keys with the goal of reducing facility differences. 3. Provide evidence of training to the revised policy and procedure. 4. Include a requirement for the CIAB fire safety inspections to include a requirement for an unannounced

	demonstration by officers in the control room and those officers that would be accessing the key on emergency key access and key identification by touch.

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: 3/28/14; 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 10P022 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 the procedure 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)	DSOP Policy 10P022 is currently being revised and will be provided to the monitor once drafted. MDCR has formally appointed Fire Safety/Sanitation Officer for each facility. MDCR has established an annual fire drill schedule for each facility. One fire drill was completed on each of two shifts for February for TGK, TTC, MWDC, and Boot Camp. At PTDC there was one drill and report provided. Through reviewing the reports, I observed that when Non-conformities were		

	identified, there was no evidence provided that documented corrective action was implemented and that it resolved the Non-conformity. The reports were reviewed and accepted by supervisors. However it is not clear what the significance supervisor's signature represented. This should be documented in the revision to Policy 10P022. As stated in the previous report, 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 not clear who maintains the inspection reports or how corrective actions including but not limited to remedial training for any Non-conformities resulting from the drills are documented to assure that the corrective action was completed and that it was effective. The existing policy states that there needs to be a Level IV fire drill 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. As a result, I would like to review copies of all fire drill reports quarterly for adherence to the schedule, review of Non-conformities, and documentation of corrective actions taken including remedial training, policy review, etc. I continue to believe the MDCR objective should be that all officers understand the fire response and evacuation plan for the facility in which they are currently working 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 completed 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. Provide me a copy of the draft revision of 10P022 prior to establishing an effective date. You will want to assure that all training to the revised document is completed prior to its 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 2014 at the end of each quarter 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. Provide a copy of the 2014 fire drill schedule for MDCR. 5. Provide the list of the fire safety/sanitation officers (FSSO) for each shift for each facility.

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: 3/14	Non-Compliance: 7/13
Unresolved/partially resolved issues from previous tour(s):	*N/A*		
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 10P010 entitled "Chemical Control". That policy is in the process of being revised and reissued. I provided comments on the draft at the Technical Assistance visit in February, and it is not yet completed. Sanitation Officers for each division have received training on chemical safety and appropriate dilution of chemicals. However, the training was not conducted from the revised policy, as it is not yet completed. Further the training PowerPoint slides address chemical safety and dilutions, but do not include effective use of cleaning and disinfecting chemicals that are monitored by the fire safety/sanitation officer (FSSOs).		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	In reviewing the chemical control inventories process in each facility, I found them to be implemented correctly. Only in TTC was the sanitation officer not able to correctly explain the dilution process. This is a significant improvement from the previous tour. The chemical storage rooms in TTC, TGK, PTDC, and Metro West were secure, well organized, and equipped with appropriate Material Safety Data Sheets for each chemical included in the inventory. At a meeting with the training staff, I reviewed and provided written comments and suggestions to improve the chemical sanitation curriculum. It is key that the training curriculum be developed directly from the wording in Policy DSOP 10P010 and provided by a qualified trainer who is well versed in the policy. MDCR should consider the trainer to be one of the current FSSO who continues to demonstrate exceptional subject knowledge and has training skills. I noted that the laundry detergent used by detainees to wash personal clothing did not contain any type of bleach/disinfectant. I recommended that the detergent be replaced with one that can effectively disinfect personal clothing to prevent the spread of bacterial infections such as MRSA through cross-contamination.		
Monitor's Recommendations:	1. Complete and issue the revised Chemical Control Policy 10P010. 2. Revise the chemical safety, dilution, and use training program for sanitation officers, who can, then correctly train correction officers that supervise inmate workers. Assure the training Power Point slides and curriculum follows the finalized written policy. Consider using an existing FSSO as discussed in the previous section. 3. Investigate and provide a detergent containing bleach for inmates to effectively clean and disinfect personal clothing. 4. Provide evidence of training of all sanitation officers for each shift 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: 3/14, 7/13

Unresolved/partially resolved issues from previous tour(s):	*N/A*
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:	As a result of the previous tour assessment, MDCR intends to create a new DSOP to specifically address the safe and effective use of fire and emergency equipment. The lesson plan for training will be completed and submitted to the monitor within 30 days of completion of the new DSOP. The new policy will include the process they will use to identify all officers and civilian staff that will need to receive training, the qualifications of the trainer and how competency will be measured, and the process for remedial training when either testing or practice identifies lack of skills or understanding. However, the process to meet this provision has not started.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As of this tour, MDCR indicated that this provision states that implementation is not due for two years after the effective date of the consent agreement. That interpretation of provision is inaccurate. The "biennial training" refers to the time frame between trainings. The policy clearly states that training for correctional staff shall be completed at least once every two years (i.e. biennially). The training curriculum should be based on the MDCR policies, once completed, existing state or federal fire safety law, regulations and standards. If management expects officers and other staff to consistently and competently administer the written policies, the training plan and curriculum need to consistent with those policies and include detail to assure management that all provisions of the policies are taught and measured. This objective must be clearly met during the review of the Orientation Video Manual as well as the Fire Fighting Principles /Procedures outline. In Monitor Report #1 I provided an example of a training plan format. I suggest that you review it and assure that the training plan meet the minimum requirements specified in that report.
Recommendations	The recommendations from Monitor Report #1 for this provision remain unchanged. 1. Establish a MDCR training DSOP identified in Monitor Report #1. 2. Create a training plan for the organization for initial fire safety training, remedial training, and biennial refresher training with a competency exam that is based on DSOPs 10P006, 10P022, and 10P023. 3. Develop a training matrix for each position. 4. Establish a method to document that all fire safety and emergency equipment training for a position is completed. 5. Establish and follow a process for a minimum annual review of the training DSOPs, training plan, and training curriculum to assure that is meets current regulations and policies.

APPENDIX BP1

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 Status of Measures of Compliance 3/7/2014
4. TTC Housing Criteria
5. PTDC classification Housing Criteria
6. Florida Model Jail Standards 7/01/2013
7. DSOP 10D006,"Emergency Procedures Re: Evacuation;" Effective 6/6/2012
8. DSOP 10D022 and DSOP 10D022 Fire Response and Prevention Plan Lesson Plan draft 2014
9. MDCR DSOP 10D010, "Chemical Control Effective;" 2014 draft
10. MDCR DSOP 11D023, "Key Control;" Effective 6/11/2012
11. MWDC SOP M13D016; "Key Control;" Effective 7/1/2013
12. TGKCC SOP 036, "Key "Control;" Effective 7/1/2013
13. TTCSOP T13D030,"Key Control Procedures;" Effective 6/20/2013
14. PTDC SOP P13D026, "Key Control;" Effective 6/14/2013
15. Boot Camp Program SOP B12D004, "Key Control;" Effective 9/30/2012
16. Key Control Training Sign off for Boot Camp, MWDC, PTDEC, TGK, TTC,
17. MDCR Dire Drill Procedure Training 10/17/13
18. Fire Drill Reports: Boot Camp 2/6/14, 2/25/14
19. Fire Drill Reports: MWDC 2/22/14, 2/26/14
20. Fire Drill Reports PTDC 2/23/14
21. Fire Drill Reports, TGK 2/20/14, 2/21/14
22. Fire Drill Reports: TTC 2/23/14, 2/25/14
23. MDCR Fire Extinguisher Inventory Boot Camp, MWDC, WDC, PTDC, TGK, TTC
24. SCBA Inventory: Boot Camp, MWDC, WDC, PTDC, TGK, TTC
25. PTDC Facility Weekly Fire Safety Report 3/7/14 and 3/31/14
26. MDCR Fire Extinguisher/Hoses and SCBA Posicheck Inspection Schedule for March, 2014
27. MDCR Organizational Chart 1/20/2014

APPENDIX B*2

List of Persons Interviewed During the Tour

Deputy Mayor Genaro "Chip" Iglesias MDCR
Marydell Guevara, Interim 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 Ed Denson, PTDC
Captain Enrique Rodriguez, Metro West
Mike Galvin, Facility Maintenance Manager Metro West

Reports C and D: Summary of Consent Agreement (Medical and Mental Health) Compliance/Partial Compliance/Non-Compliance for Tour March 24 – 27, 2014

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.	99		7/13=med; 3/14= mh		Medical – Not audited 3/14; MH not audited 7/13
III. A. 1. b.	159		3/14, 7/13 =mh		
III. A. 1. c.	160		7/13	3/14	
III.A.1.d.	101	7/13=med	7/13= mh		Medical/MH – Not audited 3/14
III.A.1.e.	102				Medical/MH = Not audited 3/14; 7/13
III.A.1.f.	103		7/13=med ; 3/14, 7/13=mh		Medical = Not audited 3/14
III.A.1.g.	104				Medical/MH = Not audited 3/14; 7/13
2. Health Assessments					
III.A.2.a.	105				Medical = Not audited 3/14; 7/13
III. A. 1. b.	161		3/14, 7/13		
III. A. 1. c.	161		3/14, 7/13		
III. A. 1. d.	162		3/14, 7/13		
III.A.2.e.	104				Medical = Not audited 3/14; 7/13
III.A.2.f. (Covered in (IIIA1a) and C (IIIA2e))	107		7/13=med; 7/13= mh	3/14 = mh	Medical = Not audited 3/14
III.A.2.g.	109		3/14 = mh	7/13=mh, med	Medical = Not audited 3/14
3. Access to Medical and Mental Health Care					
III.A.3.a.	110			3/14, 7/13= mh	Medical = Not audited 3/14; 7/13

Subsection of Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments:
III.A.3.a.(1)	111	7/13 – med; 3/14 = mh	7/13=mh		Medical = Not audited 3/14
III.A.3.a.(2)	112		7/13= mh		Medical/MH = Not audited 3/14
III.A.3.a.(3)	112		7/13=med; 7/13= mh		Medical/MH = Not audited 3/14; med not audited 7/13
III.A.3.a.(4)	114			3/14, 7/13= mh	Medical = Not audited 3/14; 7/13
III.A.3.b.	115		7/13 – med; 7/13= mh		Medical/MH = Not audited 3/14
4. Medication Administration and Management					
III.A.4.a.	116		7/13 – med; 3/14, 7/13= mh		Medical = Not audited 3/14
III.A.4.b(1)	117, 163			3/14=mh	Medical = Not audited 3/14
III.A.4.b(2)	120, 168		7/13 – med		Medical = Not audited 3/14; 7/13
III. A. 4. c.	164		7/13=mh		Not audited 3/14
III. A. 4. d.	175		7/13=mh		Not audited 3/14
IIIA.4.e.	119			3/14, 7/13=mh	Medical = Not audited 3/14; 7/13
III.A.4.f. (Covered in (III.A.4.a.)	120				Medical/MH = Not audited 3/14; 7/13
5. Record Keeping					
III.A.5.a.	121		7/13=med; 3/14=mh	7/13= mh	Medical = Not audited 3/14
III.A.5 b.	166		3/14	7/13=mh	Medical = Not audited 3/14
III.A.5.c.(Covered in III.A.5.a.)	122		7/13= med; 3/14, 7/13mh		Medical = Not audited 3/14
III.A.5.d.	123		3/14, 7/13=mh		Medical = Not audited 3/14
6. Discharge Planning					
III.A.6.a.(1)	125		7/13=mh	3/14=mh	Medical = Not audited 3/14; 7/13
III.A.6.a.(2)	126		7/13=mh	3/14=mh	Medical = Not audited 3/14; 7/13
III.A.6.a.(3)	127		7/13=mh	3/14=mh	Medical = Not audited 3/14;7/13
7. Mortality and Morbidity Reviews					
III.A.7.a.	128		7/13 –med; 3/14=mh	7/13=mh	Medical = Not audited 3/14
III.A.7.b.	130		3/14=mh	7/13=mh	Medical = Not audited 3/14;

Subsection of Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments:
					7/13
III.A.7.c.	131			3/14, 7/13=mh	Medical = Not audited 3/14; 7/13
B. MEDICAL CARE					
1. Acute Care and Detoxification					
III.B.1.a.	132			7/13	Medical = Not audited 3/14
III.B.1.b. (Covered in (III.B.1.a.)	133			7/13	Medical = Not audited 3/14
III.B.1.c.	134				Medical = Not audited 3/14; 7/13
2. Chronic Care					
III.B.2.a.	135				Medical = Not audited 3/14; 7/13
III.B.2.b. (Covered in (III.B.2.a.)	135				Medical = Not audited 3/14; 7/13
3. Use of Force Care					
III.B.3.a.	136				Medical = Not audited 3/14; 7/13
III.B.3.b.	136				Medical = Not audited 3/14; 7/13
III.B.3.c. (1) (2) (3)	137				Medical = Not audited 3/14; 7/13
C. MENTAL HEALTH CARE AND SUICIDE PREVENTION					
1. Referral Process and Access to Care					
III. C. 1. a. (1) (2) (3)	166		7/13	3/14	
III. C. 1. b.	168		7/13	3/14	
2. Mental health treatment					
III. C. 2. a.	169		7/13	3/14	
III. C. 2. b.	170		7/13		Not audited 3/14
III. C. 2. c.	170		7/13		Not audited 3/14
III. C. 2. d.	171		7/13		Not audited 3/14
III. C. 2. e. (1) (2)	172			3/14, 7/13	
III. C. 2. f.	174		7/13		Not audited 3/14
III. C. 2. g.	175			7/13	Not audited 3/14
III. C. 2. g. (1)	176			7/13	Not audited 3/14
III. C. 2. g. (2)	176			7/13	Not audited 3/14

III. C. 2. g. (3)	177		7/13		Not audited 3/14
III. C. 2. g. (4)	178		7/13		Not audited 3/14
III. C. 2. h.	179		7/13		Not audited 3/14
III. C. 2. i.	179		7/13		Not audited 3/14
III. C. 2. j.	180			3/14, 7/13	
III. C. 2. k.	181				Not audited 3/14
3. Suicide Assessment and Prevention					
III. C. 3. a. (1) (2) (3) (4) (5)	181		3/14, 7/13		
III. C. 3. b.	183		3/14, 7/13		
III. C. 3. c.	184		3/14, 7/13		
III. C. 3. d.	185		3/14, 7/13		
III C. 3. e.	186		3/14, 7/13		
III. D. 3. f.	186		3/14, 7/13		Medical/MH = Not audited 3/14
III.C.3.g.	138, 187			3/14, 7/13=mh	Medical not audited 3/14, 7/13
III. C. 3. h.	187			3/14	
4. Review of Disciplinary Measures					
III. 4. a. (1) (2) and b.	188		7/13	3/14	
5. Mental Health Care Housing					
III. 5. a.	189			3/14, 7/13	
III. 5. b.	190			3/14, 7/13	
III. 5. c.	191			3/14, 7/13	
III. 5. d.	192		3/14		
III. 5. e.	193		7/13	3/14	
6. Custodial Segregation					
III. 6. a. (1)	193		7/13		Not audited 3/14
III. 6. a. (2)	195		7/13		Not audited 3/14
III. 6. a. (3)	196		7/13		Not audited 3/14
III. 6. a. (4) i	196		7/13		Not audited 3/14
III. 6. a. (4) ii	197		7/13		Not audited 3/14
III. 6. a. (5)	198		7/13		Not audited 3/14
III. 6. a. (6)	199			7/13	Not audited 3/14
III. 6. a. (7)	199		7/13		Not audited 3/14
III. 6. a. (8)	201			7/13	Not audited 3/14
III. 6. a. (9)	201	7/13			Not audited 3/14
III.C.6.a.(10)	139, 202		7/13 – mh		Medical not audited 3/14; 7/13; MH not audited 3/14

III. 6. a. (11)	203		7/13		Not audited 3/14
7. Staffing and Training					
III. C. 7. a.	203		3/14	7/13	
III. C. 7. b.	205		3/14		
III. C. 7. c.	206		3/14	7/13	
III. C. 7. d.	206		3/14		
III. C. 7. e.	207		3/14, 7/13		
III. C. 7. f.	207			7/13	Not audited 3/14
III. C. 7. g. (1)(2)(3)	208			7/13	Not audited 3/14
III. C. 7. h.	209		3/14, 7/13		
8. Suicide prevention training					
III. C. 8. a. (1 – 9)	210			3/14, 7/13	
III. C. 8. b.	212			3/14, 7/13	
III. C. 8. c.	213			3/14, 7/13	
III. C. 8. d.	213		3/14, 7/13		
9. Risk Management					
III. C. 9. a.	214		3/14		
III. C. 9. b. (1)(2)(3)(4)	214		3/14		
III. C. 9. a. (1)(2)(3)(4)(5)	215		3/14		
III. C. 9. d. (1)(2)(3)(4)(5)(6)	216		3/14		
D. AUDITS AND CONTINUOUS IMPROVEMENT					
1. Self-Audits					
III.D.1.a.	57				To be Determined
III.D.1.b.	141		3/14, 7/13=mh		Medical = Not audited 3/14; 7/13
III.D.1.c.	142				Medical/MH = Not audited 3/14; 7/13

2. Bi=annual Reports					
III.D.2.a. (1)					To be Determined
III.D.2.a. (2)	142				Medical/MH = Not audited 3/14; 7/13
III.D.2.a. (3)					To be Determined
III.D.2.a. (4)					To be Determined
III.D.2.a. (5)					To be Determined
III.D.2.a.(6)	144				Medical/MH = Not audited 3/14; 7/13
III.D.2.b.(Covered in (IIID1c)	145		3/14=mh		Medical= Not audited 3/14; 7/13; MH not audited 7/13
IV. COMPLIANCE AND QUALITY IMPROVEMENT					
IV.A	146		3/14=mh		Medical= Not audited 3/14; 7/13; MH not audited 7/13
IV.B	147		7/13 – med; 3/14, 7/13 = mh		Medical= Not audited 3/14
IV.C	148		3/14 = mh		Medical= Not audited 3/14; 7/13; MH not audited 7/13
IV. D.					To be Determined
JOINT REPORTING – Settlement Agreement					
III.A.1.a. Ruiz	11				See Report A
III.A.2.b.	21				See Report A
III.A.3.	24				See Report A
III.A.4.d.	28				See Report A
III.A.4.f.	31				See Report A
III.A. 5. b. Ruiz	33				See Report A
III.A. 5.e. Ruiz	50				See Report A
III.A.5.c.2.vii.	36				See Report A
III.A.5.c.5.	39				See Report A
III.A.5.c.6.	44				See Report A
III.A.5.c.10.	44				See Report A
III.A.5.c.11.	45				See Report A
III.A.5.c.12.	46				See Report A
III.C.1=6	54		7/13 – med		
III.D.2.a.4v .(Covered in (III.D.2.a.(6))	57				See Report A

V.A. (Covered in (IV.A)	63				Not yet due
IV.B. (Covered in (IV.B)	65		7/13= med		
IV.C. (Covered in (IV.C)	67				Not yet due

Attachment C=1, page 160
Attachment C=2, page 160
Attachment C=3, page 161

Attachment D=1, page 232
Attachment D=2, page 232
Attachment D= 3, page 233

Report C
Compliance Report # 2
Medical Care
Report of Tour Week of March 24:27, 2014

Executive Summary

Shortly after the Medical Monitor's arrival on site, by agreement of the Parties and Medical Monitor, it was decided to conduct this visit as a Technical Assistance. Thus, with one exception, compliance measures are marked as "Not audited" That this visit was not conducted as a formal audit should not be interpreted as a sign that MDCR[1] has not made progress. Indeed, MDCR has made significant strides in some areas, as described below. However, many of these areas of improvement are infrastructural; they are necessary for compliance with the Agreements, but are not, themselves, measured in the compliance indicators.

Leadership

There is an accelerated dedicated involvement of top level CHS leadership in management of jail health, including but not limited to the corporate Chief Operating Officer and Associate Medical Director. CHS has hired a new Chief Medical Officer for CHS who is knowledgeable, energetic, and involved in positive change. There is evidence of increased collaboration between leaders of MDCR and JMH. This collaboration is currently mostly of a "fire-fighting" nature. However, both organizations have accepted our suggestions for creating an organizational structure to support collaboration for regular operations and strategic planning. A major impediment to progress in compliance with the medical issues in the Settlement Agreement and the Consent Agreement – and therefore an issue of great concern – has been turnover of the CHS Director position, which is currently vacant. CHS' leadership has been in a state of flux since the conclusion of the monitors' last tour in July 2013. The role of CHS Director is being filled by an agglomeration of individuals who have other primary jobs. However, MDCR is actively recruiting for a new director, informed, in part by input provided by the Medical Monitor.

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[1] In comments to the draft report, the use of the term MDCR (as opposed to CHS) in certain parts of the Medical Monitor's report was questioned. The Medical Monitor understands those comments, but specifically chose to use MDCR in parts of the report that concern health care. While we recognize that MDCR has delegated certain responsibilities to JMH, at the end of the day, there is a single jail – MDCR – with responsibility for safe conditions of confinement, including safe health care. The Medical Monitor's use of the term MDCR is meant to underscore that singular purpose and encourage MDCR and its delegates, in this case JMH, to think and work like a single entity. The submission of two separate sets of comments to the draft of this report, one by MDCR and one by JMH, shows that thinking and working like a single entity has not yet been woven into the fabric of MDCR's health care operation.

Electronics

The county has implemented four electronic systems. The Cerner EHR is fully functional. This is a key step to organizing and monitoring clinical data. A system was created for keeping track of open clinic appointments (CARL). Informed by the Jail Management System (JMS) database, the system is a tremendous aid to staff by ensuring that staff know when patients are moved and are less likely to lose track of open appointments. A specially created module of the Cerner system keeps track of patients in the booking area. When used in conjunction with QMS (Queue Management System), this pair of tools is being used to monitor and improve timely access to care, especially for the most ill patients. Finally, an electronic medication administration software (Sapphire) is fully functional. Also informed by the JMS system, it is a powerful tool for documenting and tracking medication administration. With its help, the county has markedly decreased the number of missed doses of medications from a number causes, including patient movement/bed reassignment. Staff are using the audit function of this system to monitor staff compliance. The effort required to implement these electronic tools in a short amount of time cannot be overstated. JMH is making arrangements for the Medical Monitor to have off-site access to the Cerner EHR.

Intake

MDCR has made significant improvements in the safety and confidentiality of the pre-booking screening process. They have developed stricter and clearer clinical criteria for acceptance of new detainees and have provided for more auditory privacy through construction of screening booth. Pink wristbands now identify patients who required expedited evaluation and care. MDCR is in the process on converting the nursing staff who conduct Intake Screening from LPNs and RNs to all RNs. A new Booking Provider Clinic is under construction; this new set up should result in faster, more confidential care.

Mortality Reviews

MDCR has made significant improvements to the process since the last tour. It is a work-in-progress and additional improvements were suggested during this tour.

The Medical Monitor provided Technical Assistance feedback on the following areas:

Policies

Policies are a key instrument of leadership. In its efforts to satisfy the requirements of this Consent Agreement, MDCR is developing new policies. While most policies are ostensibly "custody" or "health care" policies, in a correctional environment, there are scant few policies which may not have some potential impact on the other discipline. In parallel to its need to develop an organizational structure that reflects the interdependent leadership of MDCR and JMH, the two organizations have also not yet developed a culture that recognizes and incorporates this interdependence in policy development and review. The policy arena is – understandably – further complicated by the fact that some policies

governing health care operations are general to JMH (i.e. not specific to CHS). MDCR has not yet developed an organizational system for its policies that maximizes integration, minimizes duplication, and, most importantly, optimizes the likelihood of an employee finding the right policy at the right time.

Continuity and Coordination of Care

Nurses conducting Booking Screening do not necessarily recollect data collected by nurses in Pre-Booking Screening, though that data may be relevant to Booking Screening. The Medical Monitor recommended adding a step (e.g. checkoff box) to Booking Screening as a reminder to the nurse to review the previously collected data. Unscheduled visits are still largely managed by nurse staff. The Medical Monitor recommended an approach more rooted in primary care and involvement of practitioners. When nurses care for patients with episodic problems, they sometimes defer entering documentation in the electronic medical record until all patients are seen. If they are maintaining paper notes, this process is not dangerous (but it is inefficient); if they are not maintaining paper notes, this non-contemporaneous documentation practice is dangerous. In either case, the electronic note, which is time stamped later can be misleading in the absence of a free-text notation indicating the actual time the patient was seen. There is close monitoring of patients in the Medical Housing and Detox units at TGK. However, continuity of care across practitioners (i.e. from day to day) could be improved; MDCR is already working on changing practitioners' schedules to achieve such continuity. Coordination of care between medical and mental health practitioners for patients in Medical Housing can also be heightened; this should improve when acute mental health patients are moved to TGK (thus bringing the acute medical and mental health staffs in closer proximity).

After discussion with MDCR, the Medical and Mental Health Monitors, are in the process of proposing to DOJ clarifying wording to terms of the Consent Agreement pertaining to assessment of newly admitted detainees. Specifically, the wording would set the time limit for examination of patients with significant health findings to not greater than 48 hours, and would allow MDCR to defer in depth examination of detainees who, upon Intake Screening, are healthy. These changes would affect CONSENT012/III.A.2.e, CONSENT013/III.A.2.f, CONSENT022/III.A.4.b(2), and CONSENT008/III.A.2.a.

Appendices

List of Documents Reviewed by Medical Monitor (Appendix C-1)
List of Staff Interviews by Medical Monitor (Appendix C-2)
Names of Patients Reviewed by Medical Monitor (Appendix C-3) (Names 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: 7/13	Non-Compliance: 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13 (Not audited)
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 of nurses who conduct intake screenings 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 2. Results of internal audits		

	have developed stricter and clearer clinical criteria for acceptance of new detainees and have provided for more auditory privacy through construction of screening booth. Pink wristbands now identify patients who required expedited evaluation and care. MDCR is in the process on converting the nursing staff who conduct Intake Screening from LPNs and RNs to all RNs. A new Booking Provider Clinic is under construction; this new set up should result in faster, more confidential 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):	<u>Medical Care:</u> None <u>Mental Health:</u> 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 soundproof. The lack of confidentiality and issues with sound were confirmed both by interviews with staff as well as by an independent consultant [5] who commented on the issue in preliminary findings. The CHS policy is being updated; it is not currently consistent with anchors of the Consent Agreement. For example, it does not state that inmates must be screened within 24 hours of arrival dependent on acuity.
Monitors' Recommendations:	<u>Medical Care:</u> 1. If not already done, MDCR should complete its conversion of Intake Screeners from LPNs and RNs to an all RN team. 2. MDCR should add a step (e.g. checkoff box) to Booking Screening as a reminder to the nurse (and documentation of same) to review the clinical data collected by the Pre-Booking nurse. <u>Mental Health:</u> 1. CHS Intake screening policies and suicide screening policies should be updated to concur with the requirement of the Consent Agreement. 2. CHS mental health policies should be updated to be consistent with each other and with MDCR policies. 3. Once policies, procedures, and definitions are updated, a glossary should be placed at the beginning of the CHS policy and procedure manual. 4. Training should be tailored to the policy, as discussed in Section III C 7 of this report. 5. Better auditory privacy should be provided during health screening in the Lobby of TGK. 6. The Associate Director of Mental Health should periodically sample the intake screenings to ensure adequacy of referral and quality of care.

[5] Judith Cox, March 2014

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: 7/13	Partial Compliance:	Non-Compliance: 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited)
Measures of Compliance:	<u>Medical Care:</u> • 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. <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. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	<u>Medical:</u> MDCR has implemented application of a pink band to the wrist of medical patients who require expedited assessment. <u>Mental Health:</u> 1. CHS is in the process of updating its suicide prevention policies. Current policy states, "It is CHS policy to promptly identify inmates at risk for suicide and to intervene appropriately through a series of screening, assessment, and evaluation tools." The policy does not define or identify procedures for an 'emergency referral.' 2. MDCR 12Q003 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):	<u>Medical Care:</u> None <u>Mental Health:</u> The CHS booking screening does not differentiate between urgent and emergency referrals.		
Monitors' Recommendations:	<u>Medical Care:</u> None <u>Mental Health:</u> 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 offsite 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: 7/13 (Not audited), 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited)
Measures of Compliance:	<u>Medical Care:</u> • 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. <u>Mental Health:</u> 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:	<u>Medical Care:</u> Not audited <u>Mental Health:</u> CHS Policy JQEQ12 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):	<u>Medical Care:</u> None <u>Mental Health:</u> Insufficient information was reviewed to provide an opinion on compliance with this provision.		
Monitors' Recommendations:	<u>Medical Care:</u> None <u>Mental Health:</u> 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, the Mental Health Monitor 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: 7/13	Non-Compliance: 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14	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 of intake assessment for drug or alcohol use and withdrawal 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: None Mental Health: The CHS Initial Psychiatric Examination form asks detailed questions regarding prior alcohol and drug use. In interviewing staff regarding the intake form and its implementation, further training was requested regarding assignment of levels and risk assessment.		
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 [SSIQSA]," 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: Adequate and appropriate training is recommended for all intake and mental health staff, including social workers, on the screening of substance use disorders, including alcohol, amphetamines, bath salts, opiates, and possible drug side effects.

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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (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:	Medical Care: Not audited Mental Health: Not audited		
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: None Mental Health: Not audited Current policies are pending revision.		
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 JQEQ04 (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: 7/13 (Not audited); 3/14 (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:	Not audited		
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):	None		
Monitor's Recommendations:	After discussion with MDCR, the Medical and Mental Health Monitors are in the process of proposing to DOJ clarifying wording to terms of the Consent Agreement pertaining to assessment of newly admitted detainees. Specifically, the wording would set the time limit for examination of patients with significant health findings to not greater than 48 hours, and would allow MDCR to defer in depth examination of detainees who, upon Intake Screening, are healthy. The Medical Monitor did not evaluate the rest of this measure during this visit. These changes would affect CONSENT012/IIIA2e, CONSENT013/IIIA2f, CONSENT022/IIIA4(2), and CONSENT008/IIIA2a.		

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 24Qhours 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: 7/13 (Not audited); 3/14 (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:	Not audited		
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):	None		
Monitor's Recommendations:	After discussion with MDCR, the Medical and Mental Health Monitors are in the process of proposing to DOJ clarifying wording to terms of the Consent Agreement pertaining to assessment of newly admitted detainees. Specifically, the wording would set the time limit for examination of patients with significant health findings to not greater than 48 hours, and would allow MDCR to defer in depth examination of detainees who, upon Intake Screening, are healthy. The Medical Monitor did not evaluate the rest of this measure during this visit. These changes would affect CONSENT012/IIIA2e, CONSENT013/IIIA2f, CONSENT022/IIIA4b(2), and CONSENT008/IIIA2a.		

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 24Qhours, to be seen by a practitioner as a part of the Initial Health Assessment. At that time, medication and appropriate labs as determined by the practitioner are ordered.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14
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 QMHP 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:	Medical Care: Not Audited Mental Health Care: 1. CHS has written policy, JQEQ02, 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: None Mental Health: CHS is currently updating its policies. It needs to update its policies so that they are consistent and that they reflect timelines that concur with the Consent Agreement. CHS acknowledged that not all mental health inmates are screened by a QMHP and not all access to care to a psychiatric provider with 24 hours.
Monitor's Recommendations:	Medical Care: After discussion with MDCR, the Medical and Mental Health Monitors are in the process of proposing to DOJ clarifying wording to terms of the Consent Agreement pertaining to assessment of newly admitted detainees. Specifically, the wording would set the time limit for examination of patients with significant health findings to not greater than 48 hours, and would allow MDCR to defer in depth examination of detainees who, upon Intake Screening, are healthy. The Medical Monitor did not evaluate the rest of this measure during this visit. These changes would affect CONSENT012/IIIA2e, CONSENT013/IIIA2f, CONSENT022/IIIA4b(2), and CONSENT008/IIIA2a. Mental Health: Intake screening policy should be updated to reflect the timeline of screening within 24 hours. For example, JQEQ02 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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13
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:	Medical Care: Not audited		
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: None Mental Health: The Response to Consent Agreement reflects plans to train medical, mental health and custodial staff on relevant mental health policies and procedures. As noted above, CHS provided a report indicating that on March 19, 2014, greater than 90% of TGK and PTDC staff were trained on suicide policy and the suicide-warning card. This training was completed by Dr. Gonzalez and Dr. Razdan. The training was completed before updating of mental health and suicide prevention policy and procedure. CHS agreed that partial compliance was "pending tool revisions as it is requiring further enhancements."		
Monitor's Recommendations:	Medical Care: None Mental Health: Please implement adequate training protocols for all staff. This should include training on use of force and restraint in persons with mental illness as well as identification and management of suicide risk.		

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: 7/13; 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14
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:	Medical Care: Not Audited Mental Health:		
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: Lack of visual and auditory privacy from custody staff and other inmates during sick call at MWDC observed during the last tour was also observed during this tour. Mental Health: There was a backlog of patients waiting to be seen. A new system for sick call triage will be implemented.		
Monitors' Recommendations:	Medical Care: 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 passerby) may be used. Mental Health: 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: 1. Adequate signage for how to access mental health care; 2. Access to a counselor or provider to assist with writing or expressing requests, if clinically necessary; 3. Access to grievance slips, if requested.		

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: 7/13	Partial Compliance:	Non-Compliance: 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance: 3/14	Partial Compliance: 7/13	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:	Medical Care: Not audited 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: None 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 (II.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: 7/13 (Not audited); 3/14 (Not Audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited)
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:	Medical Care: Not audited Mental Health:		
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: None Mental Health: 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: 7/13	Non-Compliance: 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited)
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:	Medical Care: Not audited Mental Health:		
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: None 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 who 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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14
Measures of Compliance:	Medical Care: • Audit Step a: (Chart Review) Health care request slips are reviewed appropriately, including: 1) within 24 hours or submission 2) by, or under the direct supervision of RNs or practitioners 3) 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:	Medical Care: Not audited Mental Health:		
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: None 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. In addition, as noted above, zero mental health grievances were reported as submitted. This is an abnormally low number for the size of this facility.		
Monitors' Recommendations:	Medical Care: None Mental Health: Please update policy and provide adequate procedures and definitions for urgent vs. emergent referrals and criteria for emergent grievances. The fact that there are no mental health grievances in a system that has 30% of its grievances stemming from medical complaints should be questioned and investigated.		

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: 7/13	Non-Compliance: 3/14 (Not audited)
Mental Health : Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited)
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:	Medical Care: Not audited Mental Health:		
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: In its efforts to satisfy the requirements of this Consent Agreement, MDCR is developing new policies. While most policies are ostensibly "custody" or "health care" policies, in a correctional environment, there are scant few policies which may not have some potential impact on the other discipline. MDCR and JMH have not yet developed a culture that recognizes and incorporates this interdependence in policy development and review. The policy arena is – understandably – further complicated by the fact that some policies governing health care operations are general to JMH (i.e. not specific to CHS). MDCR has not yet developed an organizational system for its policies that maximizes integration, minimizes duplication, and, most importantly, optimizes the likelihood of an employee finding the right policy at the right time. 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. MCDR and JMH should develop an over-arching policy structure/map that maximizes integration, minimizes duplication, and, most importantly, optimizes the likelihood of an employee finding the right policy at the right time. The Medical Monitor explored some possible structures with JMH leadership staff during the tour. 2. MDCR and JMH should implement a policy development and review process that involves both organizations, regardless of the policy (i.e. even for policies that appear to be strictly custody or health related). In its simplest form, such as system might require that each policy bear the approving signature (or at least review signature) of the Chief of MDCR and a senior executive of JMH. 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 and with dual diagnoses. 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: 7/13	Non-Compliance: 3/14 (Not Audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14	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 JQDQ01 and JQDQ02. • 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 of staff involved in medication management 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:	Medical Care: Not audited Mental Health: CHS policy JQDQ01 outlines medication administration and the maintenance of medication records.		
Monitors' analysis of conditions to	Medical Care:		

assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	An electronic medication administration software (Sapphire) is fully functional. Also informed by the JMS system, it is a powerful tool for documenting ad tracking medication administration. With its help, the county has markedly decreased the number of missed doses of medications from a number causes, including patient movement/bed reassignment. Staff are using the audit function of this system to monitor staff compliance. Mental Health: CHS implemented Sapphire, an Electronic Medication Administration system, in Fall 2013. It does not yet have a computerized physician order entry (CPOE), but anticipated that this system will be implemented in the next six to twelve months. Sapphire has made it much easier for the physicians to check what medications the patients are taking and what medications they have previously been prescribed. Based on data submitted, approximately 26.7% of the population of MDCR is being treated with psychotropic medication. This number is consistent with national averages.
Monitors' Recommendations:	Medical Care: None Mental Health: Sapphire has allowed tracking and analysis of missed medications, medication errors, numbers of inmates on psychotropic medication and analysis of patterns related to psychotropic medication use. Continued management of this information will be necessary to for the provision of adequate mental health care.

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: 7/13 (Not yet due)	Non-Compliance: 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not yet due – Not audited); 3/14
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 dose 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 audited 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: None Mental Health: Review of several court orders in 2013 and early 2014 indicated that CHS had not been able to see all of its mental health caseload in a timely manner in order to justify continuing care or not. A CHS submission received during the on-site entitled Response to Consent Agreement (dated 2/23/14) indicated that this provision and that III C 1, Referral and Access to Care for mental health inmates was in Non-compliance.
Monitor's Recommendations:	Medical Care: None Mental Health: As discussed with CHS on site, referral and access to care is partially a function of staff and it is partially a function of the system it has in place to provide adequate care. CHS is aware of this and reported it is updating policy, systems and increasing mental health staff to meet its needs.

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: 7/13 (Not yet due)	Non-Compliance: 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not yet due – Not audited); 3/14 (Not audited)
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: Not audited (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: After discussion with MDCR, the Medical and Mental Health Monitors, are in the process of proposing to DOJ clarifying wording to terms of the Consent Agreement pertaining to assessment of newly admitted detainees. Specifically, the wording would set the time limit for examination of patients with significant health findings to not greater than 48 hours, and would allow MDCR to defer in depth examination of detainees who, upon Intake Screening, are healthy. The Medical Monitor did not evaluate the rest of this measure during this visit. These changes would affect CONSENT012/IIIA2e, CONSENT013/IIIA2f, CONSENT022/IIIA4b(2), and CONSENT008/IIIA2a. 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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14
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 medications immediately. • Audit Step c: (Chart Review) Laboratory tests not marked as urgent will be drawn within 3 days. [NB: Lab tests in this measure are only those related to medications.] • Audit Step d: (Chart Review) Laboratory tests marked as urgent will be drawn immediately. [NB: Lab tests in this measure are only those related to medications.] 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:	Medical Care: Not audited 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 Mental Health: No CHS policy was identified which addressed the availability of laboratory tests and timeline for review of results. CHS acknowledged that it is Non-compliant with this provision.
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 antipsychotics and mood stabilizers, etc.). Urine pregnancy tests should be available for all women of childbearing age. If phlebotomy and laboratory testing are not available onsite, 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: 7/13 (Not yet due – Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not yet due – Not audited); 3/14
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:	Medical Care: Not audited		

	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: None Mental Health: See section III A4a. In addition, a case was identified in which a patient was hoarding medication. Policy and procedure specific to medication dispensing to prevent hoarding have not been delineated.
Monitor's Recommendations:	Medical Care: None Mental Health: Policy and procedure to prevent hoarding should be updated and implemented by both CHS and MDCR.

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: 7/13	Non-Compliance: 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13
Measures of Compliance:	Medical Care: • Audit Step a: (Chart Review) Paper medical records are adequate. This would include, among others, the provisions of NCCHC JQHQ01 and JQHQ04. (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 JQHQ01 and JQHQ04. 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 implemented an electronic medical record, CERNER, in December 2013. This system has improved legibility, access to prior patient records, and communication between providers. 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: When nurses care for patients with episodic problems, they sometimes defer entering documentation in the electronic medical record until all patients are seen. If they are maintaining paper notes, this process is not dangerous (but it is inefficient); if they are not maintaining paper notes, this Non-contemporaneous documentation practice is dangerous. In either case, the electronic note, which is time stamped later can be misleading in the absence of a free-text notation indicating the actual time the patient was seen. Mental Health: CHS implemented an electronic medical record, CERNER, in December 2013. This system has improved legibility, access to prior patient records, and communication between providers.
Monitors' Recommendations:	Medical Care: None Mental Health: CHS is pending computerized order entry. Order entry remains in a paper format that is scanned into the computerized record, causing delays and possible communication gaps.

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.		
Medical Care Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited)
Mental Health Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14	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 JQHQ01 and JQHQ04. (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 JQHQ01 and JQHQ04. Mental Health: 1. Review of policy and procedure related to documentation 2. Review of medical record 3. Review of EHR, once implemented		
Steps taken by the County to Implement this paragraph:	Medical Care: Not audited (See CONSENT027 (IIIA5a)) Mental Health: CHS Policy JQHQ04 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: None Mental Health: The medical record should document **all** medical and 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. Verbal orders should be cosigned 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 or time of death, as clinically appropriate. Patients 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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14 2014	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:	Medical Care: Not audited Mental Health: CHS Policy #035QA Transfers of Behavioral Inmates from Mental Health Facilities (Purple Bands): a policy and procedure to identify, evaluate and track patients returning from State mental health hospitals into the Jail. This new system ensures that the patient's record is received, his medications are ordered and administered, and if the patient refuses, his attorney is notified. CHS Policy #050 Hand Off: a standardized handoff procedure in the event that an inmate requires medical or psychiatric hospitalization.
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: None Mental Health: The updated policies and procedures identify and track patients as they enter and leave MDCR for medical / mental health reasons are an improvement.
Monitors' Recommendations:	Medical Care: None Mental Health: Clinical progress notes should reflect conversations with outside providers as handoffs occur and should reflect the review of the record when receiving outside records or reviewing information from the emergency department, etc.

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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14
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:	Medical Care: Not audited Mental Health: CHS Policy JQEQ13states: Whenever possible, arrangements are made for access to community-based organizations for serious medical, mental health and dental needs. All referrals for follow-up 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: None Mental Health: CHS policy state 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 , "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. ” 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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance 3/14
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: Not audited Mental Health: 1. In 2013, CHS Policy JQEQ13 stated: Whenever possible, arrangements are made for access to community-based organizations for serious medical, mental health and dental needs. 2. A 7Qday bridge supply of medication will be provided to inmates upon release. All inmates will be provided with a 24Q7 local phone # to request medications upon release. 3. CHS acknowledged that it is not in compliance with this provision.		
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: None 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[2], , "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. " 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.

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 24Qhours 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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14
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 audited Mental Health: CHS reported plans to implement adequate mental health discharge planning. This has not been completed to date.		
Monitor's analysis of conditions to	Medical Care:		

[2] Standards for Health Services in Jails, 2008, JQEQ13, Discharge Planning, p.81

assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	None Mental Health: CHS reported they it is not in compliance with this provision of the agreement.
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: 7/13	Non-Compliance: 3/14 (Not audited)
Mental Health Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13
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	Medical Care:		

Implement this paragraph:	MDCR's has made marked improvements to the Mortality Review process. <u>Mental Health:</u> CHS Policy JQAQ10Qa states: In the event of an inmate death, the following will be carried out: 1. The responsible health authority audits the incident to determine the appropriateness of clinical care. 2. The medical examiner or coroner is notified as required by law. 3. A postmortem examination is requested. 4. 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):	<u>Medical Care:</u> MDCR provided a list of the 11 in-custody deaths for 2013 and 2014 (YTD), including the place and cause of death, along with CHS's mortality review of each. We (CHS, the Mental Health Monitor, and I) reviewed one of those deaths reviews together in depth. <u>Mental Health:</u> I reviewed the CHS Mortality Log and several of the patient deaths. The Mortality Log identified nine patients who died in 2013 and two patients who have died thus far in 2014. The analysis of the Mortality Log demonstrated that there are further opportunities for improvement. For example, in the case of a suicide, Quantros does not categorize or define preventable or possible errors related to the patient's death. The current suicide prevention policy and procedure does not state who performs the mortality or sentinel event review. The self-harm and mortality reports reviewed by the Mental Health Monitor during the March on site were improved over prior reports; they included an interdisciplinary team and they are now being conducted in a timely manner. Medical examiner reports and mortality reports have been provided upon request.
Monitors' Recommendations:	<u>Medical Care:</u> The Monitors made some recommendations for further improvement of the review process, including those cited by the Mental Health Monitor in this Indicator. <u>Mental Health:</u> 1. Policy for both CHS and MDCR should be updated to reflect the makeup of the interdisciplinary team for the review of sentinel events. 2. Mortality review for CHS and MDCR should require a quorum. 3. Notification to the Monitor should include prompt notification of all serious suicide attempts, adverse events involving inmates with mental health issues (regardless of whether he or she was on the mental health caseload) and inmate deaths. It should also include a qualitative corrective action plan that incorporates thoughtful input into the root cause of the adverse event. 4. The Associate Director of Mental Health / Psychiatry should be present for all sentinel events that involve patients with a history of mental illness, even if the patients was not originally on the mental health caseload.

Paragraph Stern and Ruiz	CONSENT035 (III.A.7.b.) Defendants shall address any problems identified during mortality reviews through training, policy revision, and any other developed measures within 90 days of each death or serious suicide attempt.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13
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:	Medical Care: Not audited Mental Health: CHS hired Ms. Judith Cox as an independent consultant to review and provide input to the facility and staff in terms of suicide screening and risk assessment. She visited Miami Dade March 19Q21, 2014 and is anticipated to return for record review and further analysis in several weeks		
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: None Mental Health: In February 2014, MDCR had one suicide.[i] As reported by CHS in the 'Attempted Suicide / Self Harm Log,' six of nine, or 67% of the inmates that were documented to have expressed suicidal ideation / intent in February 2014 were not formally considered to be on the mental health caseload; this indicated that mental health screening and / or suicide risk assessment was broken. It was also noted that the qualitative analysis of the self-harm attempts included several errors. For example, in one case, an inmate swallowed several razors and required medical intervention, including an endoscopy. This event was categorized as a 'D,' "increased the need for monitoring but caused no harm." It should have been categorized an 'F,' "an event that that resulted in temporary harm and required initial hospitalization."		
Monitors' Recommendations:	Medical Care: None Mental Health: 1. Mental health training should have a cross-discipline, practical approach 2. Corrective action plans should include sufficient detail and accountability such that failure to implement can be tracked. 3. Information input into the Quantros and other quality management system should be reviewed, as the data and		

	analysis will only be as good as the information that it relies upon and the persons interpreting it.

Paragraph Stern and Ruiz	CONSENT036 (III.A.7.c.) Defendants will review mortality and morbidity reports and corrective action plans biannually. 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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Records reflect that biannually 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:	Medical Care Not audited Mental Health: • CHS did not provide policy does not that required review of mortality and morbidity reports, their risk management system and / or corrective action plans biannually. • DCOP 14Q007 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 biannual 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 See comments under CONSENT034 (III.A.7.a.) Mental Health: CHS is in the process of updating its policies and procedures; as such the policies and procedures have yet to be fully implemented. CHS has been through two transitions in the preceding year. It did not provide written analysis on its Quantros Incident Reporting System or other current data collection modalities; it is in the process of updating several policies and systems.		
Monitors' Recommendations:	Medical Care: None Mental Health: As alluded to previously, the Mental Health Monitor 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: 7/13; 3/14 (Not audited)
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 1) timely, 2) performed by or under the direct supervision of an RN or practitioner, and 3) 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: 1) they can get attract the attention of a CO immediately, 2) their request is accepted by the CO without further screening (beyond "Do you feel this cannot be handled through a health request slip?"), 3) 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:	Not audited		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the	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.		

County's representations, and the factual basis for finding(s):	Unscheduled visits are still largely managed by nursing staff. The Medical Monitor recommended an approach more rooted in primary care and involvement of practitioners.
Monitor's Recommendations:	MDCR will need to develop a health care system for unscheduled/episodic care in which nurses and practitioners are used in a more effective and efficient way. Compared to the current system, this would mean more of these patients going, initially to practitioners, and all cases being handled using a team approach, rather than separate operation by nurses and practitioners.

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: 7/13; 3/14 (Not audited)
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 care is clinically appropriate. • (duplicate) CONSENT037 (IIIB1a) Audit Step g: (Inspection) The number of upheld grievances for poor quality		

Steps taken by the County to Implement this paragraph:	Not audited
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):	None. See CONSENT037 (IIIB1a)
Monitor's Recommendations:	None. 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: 7/13 (Not audited); 3/14 (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 JQGQ06 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:	Not audited		
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):	None		
Monitor's Recommendations:	None		

2. Chronic Care

Paragraph	CONSENT040 (III.B.2.a.) CHS shall sustain implementation of the Corrections Health Service ("CHS") Policy JQGQ01 (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: 7/13 (Not audited); 3/14 (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:	Not audited		
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):	None		
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: 7/13 (Not audited); 3/14 (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:	Not audited		
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):	None		
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 15Qminute in-person visual observation by trained custody. Qualified Medical Staff shall perform 15Qminute 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: 7/13 (Not audited); 3/14 (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:	Not audited		
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):	None		
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: 7/13 (Not audited); 3/14 (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:	Not audited
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):	None
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: 7/13 (Not audited); 3/14 (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:	Not audited		
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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14 (Not audited)
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. Onsite 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:	Medical Care: Not audited 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	Medical Care: None		

documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Mental Health: 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: 1. Suicide prevention and emergency response drills should be conducted on all units, particularly PTDC given its physical plant issues. 2. Medical emergency response bags should be put together and available on all housing units.3. Adverse events should be reviewed for evidence of timely response, use of appropriate lifesaving tools, evidence of routine and timely checks, 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: 7/13 (Not completely audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14
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. Onsite tour of facility 3. Review of grievances 4. Inspection that mechanism for placement of sick call and access to care is timely
Steps taken by the County to Implement this paragraph:	Medical Care: Not audited 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 interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: None Mental Health: CHS reports that they are in non-compliance with this provision.
Monitors' Recommendations:	Medical Care: None Mental Health: 1. Medical staff should round on all inmates within disciplinary segregation daily. The Mental Health Monitor recommends developing and implementing a policy to ensure this. 2. Audits should track and assess the adequacy of treatment of all inmates with severe mental illness in custodial segregation. 3. 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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14	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:	Medical Care: Not audited 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: None Mental Health: CHS implemented the Mental Health Review Committee and Quality and Safety Committees. The minutes for these meetings were reviewed for June 2013 through December 2013		
Monitor's Recommendations:	Medical Care: None Mental Health: The primary focus of the Quality and Safety Committee has been preparation for the Biannual report. Systematic review and analysis of serious incident reports, use of force reports, and inmate grievances for allegations of staff misconduct, particularly as they relate to inmates with mental illness, development delay and cognitive disorder secondary to profound substance misuse has not occurred to date.		

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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (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 audited Mental Health: Not audited		
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 Mental Health: Not audited		
Monitor's Recommendations:	Medical Care: None Mental Health: Not audited		

2. Biannual 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 biannual reports regarding the following: All health care delivered by the Jail to inmates to address serious medical concerns. The report will include: if. 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: 7/13 (Not yet due – Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not yet due – Not audited); 3/14 (Not audited)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) The Medical Monitor receives biannual 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 biannual reports, to be submitted in a timely manner and to include accurate data.		
Steps taken by the County to Implement this paragraph:	Medical Care: CHS provided the first annual report responsive to this paragraph on 11/18/13. The report notes that the Emergency Transfer Tracking Tool was revised on 10/1/13 to more completely capture the reason for ER transfers. Mental Health: Not audited		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: CHS's report of 11/18/13 responsive to this paragraph included a scanned spreadsheet with ER admission data from 2011 through to the end of October, 2013 and hospital admission data from 2013. Use of the revised Emergency Transfer Tracking Tool, which was to have increased recording of the reason for ER transfer, does not yet appear to have taken hold, thus most ER transfers are still missing reasons. The EHR was still in the process of implementation, so there was not yet any record of infirmary admissions. Chronic care visits were reported for the 6Qweek period from 8/13/13 to 10/31/13 in one format, and for the period from 6/1/13 to 10/31/13 in a second format. Mental Health: Not audited		
Monitor's Recommendations:	Medical Care: 1. To improve legibility of the data, as well as to allow the Monitors to better analyze the data provided (including, for example, to focus on data for the current year or half year), the Medical Monitor requests that for the next round of reports, this information be provided electronically, i.e. as a spreadsheet, embedded as an icon in the report or as a single spreadsheet appendix to the report, with each tab corresponding to the respective report paragraph. Additionally, CHS should chose a reasonable (i.e. something that is useful to CHS and satisfies the Agreement)		

	convention for the time intervals it will cover in these regular reports, and apply that time interval uniformly to each part of the report. 2. Non-obvious abbreviations should be explained (e.g. Admission Codes ER1 and ER2). 3. The system to ensure recording of the reason for transfers to the ER should be fully implemented. 4. The report of patients admitted to the hospital should report clinical outcomes. While "outcome" is not defined in the Agreement, it would make more sense to report the reason for admission viewed in retrospect, than the "complaint" leading to admission. For example, CHS will find it easier to analyze these data if it knows that Patient X was admitted for "loss of consciousness due to atenolol overdose" than "blackout." Of course, recording both reasons would be optimal. <u>Mental Health:</u> Not audited

Paragraph <u>Stern and Ruiz</u>	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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited)
Measures of Compliance:	<u>Medical Care:</u> • 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. <u>Mental Health:</u> 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: CHS reported the required medical elements in its report dated 11/18/31 <u>Mental Health:</u>		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the	<u>Medical Care:</u> The 11/18/13 report was acceptable as is. <u>Mental Health:</u>		

County's representations, and the factual basis for finding(s):	The quality of the dashboard and its analysis will depend on the quality of the data that goes into it.
Monitors' Recommendations:	Medical Care: None Mental Health: It is imperative that the County track and analyze systemic problems in order to 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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13 (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 Mental Health: Not audited		
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: None. See CONSENT111 (IIID1c) Mental Health: 1. CHS policies are in the process of being updated. 2. Corrective action plans are unsigned. 3. Some corrective action plans assign responsibility to corrections staff without representation by Corrections at the table.		
Monitors' Recommendations:	Medical Care: None Mental Health: The Mental Health Monitor strongly recommends that both CHS and MDCR collaborate to comprehensively review each		

	adverse event and each of the inmate death 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 without pointing fingers. Trends should be analyzed and systemic issues should be identified for improvement. Corrective action plans should include sufficient specificity such that accountability may be assigned for failure in implementation.

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: 7/13 (Not audited); 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13 (Not audited)
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 posttests) 6. Observation 7. Staff interviews.		
Steps taken by the County to Implement this paragraph:	Medical Care: CHS is in the process of updating its current policies. Mental Health: CHS is in the process of updating its current policies.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals	Medical Care: Not audited		

interviewed, verification of the County's representations, and the factual basis for finding(s):	Mental Health Please see above
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: 7/13	Non-Compliance: 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14	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: Not audited 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 JQAQ04Q 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 14Q007 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 documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care:</u> None <u>Mental Health:</u> The Quality and Safety Committee and the Mental Health Review Committee and provided minutes for 2013, prior to the hire of the new Associate Director.
Monitors' Recommendations:	<u>Medical Care:</u> None <u>Mental Health:</u> MDCR and CHS should revise policy and continue to implement plans to ensure adequate analysis of mental health data by both custody and mental health on at least a monthly basis, at the individual and system levels. It should also analyze and aggregate mental health data to identify trends that present a risk of harm. Specific analyses should be run on the following: 1. Incident reports involving the mentally ill, including criteria for screening for critical incidents and suicide attempts (see also III.A.3); 2. Documentation of referrals of mental health grievances for investigations; outcomes. 3. Corrective actions for incidents not referred as required. 4. Referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc.

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.		
Medical Care Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited)
Mental Health Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13 (Not audited)
Measures of Compliance:	<u>Medical Care:</u> • 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 audited Mental Health: CHS is currently reviewing and updating its policies
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: None Mental Health: Not audited
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 CE3)

1. CHS Policies
2. Mortality Review Mr. Wilmer
3. Mini MAC meeting minutes, current cycle, MWDC
4. CHS summary data/dashboard items regarding: Missed Medications; Crude Mortality; Quantros Events; Mortality Log; Detox Data; Booking and Intake Data; Intake Denials; Grievances

Appendix C*2
List of Staff Interviews by Medical Monitor

1. Carlos Migoya, President CEO, JMH
2. Don Steigman, EVP COO, JMH
3. Eddie Borrego, Director Corporate Initiatives
4. Rachel Rodriguez, Associate Director of Quality CHS
5. Kevin Andrews, VP of Quality & Safety JMH
6. Dr. Andrew Ta, Assoc. Chief Medical Officer
7. Dr. Shashi Razdan, CHS Medical Director
8. Maura Davis, Consultant CHS
9. Eli Medina, CHS Associate Administrator
10. Ginger Adler, JMH Clinical Informatics Program Director
11. Bridgette Johnson, JMH Director of Professional Nursing Education
12. Mercy YeroEaguayo, Nurse Educator
13. Practitioners, nurses, officers, custody supervisors, HSAs at TGK and MWDC

Appendix C – 3 List of Patients Reviewed by Medical Monitor (Name key available to authorized parties)

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 AA
Patient 2 BB
Patient 3 CC
Patient 4 DD
Patient 5 EE
Patient 6 FF
Patient 7 GG
Patient 8 HH
Patient 9 II
Patient 10 JJ
Patient 11 KK
Patient 12 LL
Patient 13 MM
Patient 14 NN
Patient 15 OO
Patient 16 PP
Patient 17 QQ
Patient 18 RR
Patient 19 SS
Patient 20 TT
Patient 21 UU
Patient 22 VV
Patient 23 XX

Report D
Report # 2 of Compliance
Report of Tour March 24827, 2014

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 1:13dCVd 21570dWJZ. From March 24dMarch 27 I conducted a tour of the Miami Dade Corrections and Rehabilitation Department (MDCR) facilities including Pretrial Detention Center (PTDC) and the Ted Guilford Knight Detention Center (TGK). I also conducted a tour and provided technical assistance on February 17 and 18, 2014.

The purpose of the March tour was to assess compliance with the Miami Dade Settlement Agreement Section III. C. Mental Health Care and Suicide Prevention. This second report outlines the actions taken by Miami Dade Correction and Rehabilitation Department (MDCR) and Corrections Health Services (CHS), its medical and mental health provider, 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.

Both prior to the tour 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. In addition, I reviewed a document submitted by Correctional Health Services entitled, "Department of Justice Response to Consent Agreement November 2013" dated February 23, 2014.

CHS has been through significant transitions since the last on site July 15d19, 2013. Specifically, it is currently searching for a permanent Director and it is being managed by Mr. Donald Steigman, the Chief Operating Officer of Jackson Health System. It also recently rehired Dr. Mercy Gonzalez as its Associate Director of Mental Health. She, together with other Jackson staff I met, demonstrated commitment, focus, and skill. I am hopeful that mental health will be able to begin to turn a corner.

Most policies for Correctional Health Services are currently in the process of being updated. While significant work has been completed in implementing systems of care such as an electronic health record (CERNER), an electronic pharmacy management system (Sapphire) and an electronic scheduling system (CARL), several inconsistencies were noted between the data that was initially submitted in November 2013, the care that was observed in February 2014 during a brief visit, and actual day-to-day operations. For

example, mental health staffing gaps caused backlogs in access to care and contributed to longer lengths of stay. Recommendations include ongoing data analysis and collaboration between medical and custody as policy and procedure is further refined.

While on site in March, I visited the PTDC, where inmates that are designated Level I and II are housed. Overcrowding remains an issue that should be addressed urgently. Because the physical plant of 9C and the overcrowding issues present concerns of imminent harm to floridly psychotic patients, I recommend that the inmates with severe mental illness (SMI) on the 9th, 10th, and overflow floors be moved to a safe and humane environment as soon as possible.

I also spoke to inmates and reviewed medical records at TGK related to booking and screening. These sources confirmed that patients with mental illness are still not routinely able to access a therapeutic environment or timely and adequate care. Several sourced demonstrated that a nurse is providing mental health screening at night; this is not a qualified mental health provider. In one recent case an agitated patient was transferred to Metro West where he subsequently began having auditory hallucinations and "attempted to hang himself with a sheet." Another chart demonstrated that although a qualified mental health professional screened a patient at booking, subsequent gaps in supervision permitted a self-injurious act to take place. As a result, I recommended an independent consultant to assist the development of Correctional Health Services' suicide prevention and training program. A consultant was hired and is working with CHS and MDCR.

I reserve the right to change my opinions at any time based on independent analysis and whether the facility utilizes accurate data, information and suggestions in a reasonable manner and / or a manner consistent with generally accepted standards of care.

Correctional Health System and MDCR have demonstrated improvement in the preceding months. Thank you for the hard work and responsiveness that has gone into improving the provision of medical and mental health care. I look forward to continued growth and sustainable progress.

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 JSES 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: 3/14; 7/13	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 JSES05 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, JSES05, 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 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, verification of the County's representations, and	CHS has implemented use of a form entitled, "CHS Initial Psychiatric Evaluation." This form includes all compliance indicators of National Commission on Correctional Health Care JSES05. This form is considered the initial QMHP screening and it is administered by a social worker the majority of the time at booking screening upon referral by a		

the factual basis for finding(s)	nurse (LPN or RN). However, on the night shift from 11 pm to 7 am, an LPN or RN without mental health certification or training administers the QMHP screening and evaluation.
Monitor's Recommendations:	I recommend: 1. CHS update its policies and procedures so that they are consistent with the Consent Agreement 2. CHS update its policies so that they are consistent with one another. 3. CHS update its policies so that they are consistent with MDCR policies. 4. Once this is completed, CHS should place a glossary in the beginning of its policy and procedure manual to define and outline terms for both its providers and for custody. 5. Train all medical staff on intake procedure and process would be helpful.

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:7/17	Non-Compliance: 3/14
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, CHSS059, Suicide Prevention Program states, "The facility identifies suicidal inmates and intervenes appropriately." 2. MDCR policy (DSOP 12S003) 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)	As stated above, CHS is in the process of updating its policies. CHS policy requires "appropriate intervention" for inmates at risk of suicide. It does not differentiate between urgent and emergent mental health referrals.		
Monitor's Recommendations:	I recommend CHS differentiate urgent referrals from emergent referrals and assign / triage care as needed. 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: 3/14; 7/13	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 CHSS059. It is in the process of being updated.		
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. As indicated above, CHS has hired a consultant to assist them in this arena; her input is pending.		
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: 3/14; 7/13	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 JSGS05. CHS is currently updating this policy.		

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As stated above, CHS is in the process of updating their suicide policy and procedure.
Monitor's Recommendations:	It is recommended that CHS develop and implement a policy for suicide risk assessment by QMHPs. As noted by the NCCHC[8], 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, risk factors, or previous confinement behavior indicates the presence of elevated risk.

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: 3/14; 7/13	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, JSGS04 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 JSGS04 states, "2. Inmates arriving to the jail and who are assessed as Level I or II and who remain in the jail for 30Sdays 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. Staff at booking told me they were forced to fill them out but they had no idea why.		
Monitor's Recommendations:	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.		

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

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: Not audited 3/14
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. 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; III.A.4.b. (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: 3/14
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 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 recent court orders in late fall 2013 and early 2014 indicated lapses in the provision of psychiatric care and medication. I was informed that by March 2014, CHS had implemented a system to track missed consecutively missed psychotropic medication doses; missed attestations by the nurses led to counseling by the Health Services Administrator. Further time will be required to assess whether this system will be sustainable.
Monitor's Recommendations:	A medical doctor, preferably a psychiatrist, should evaluate, in person, inmates with serious mental health needs within 24 hours of entry to the 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. Sapphire and training in the utilization of the Sapphire system, as well as implementation of computerized physician order entry should assist in continuity of care. This may require assigning one specific individual at each facility to track inmates with mental health disorders, their medications and accuracy of medication dispensation, as CHS is beginning to do.

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: 7/13	Non-Compliance: Not audited 3/14
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 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 JSGS04 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 7/13	Non-Compliance: Not audited 3/14
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 JSDS02Se 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 assess compliance, verification of the County's representations, and the factual basis for finding(s)	Although CHS policy requires that the psychiatrist be notified if a patient misses a psychotropic medication for two consecutive intervals, there is no policy that prescribed that the patient must be seen by a QMHP within twenty four to seventy-two 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: 3/14	Non-Compliance: 7/13
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 has implemented the CARL, an appointment scheduler. I was unable to verify what appointments had been made for the patients and how often it was being utilized. Modifications and enhancements are pending to this system.		
Monitor's Recommendations:	None at this time.		

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	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:	Non-Compliance: 3/14
Unresolved/partially resolved issues from Previous tour			
Measures of Compliance:	Mental Health:		

	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.
Measures of Compliance:	(1) Review of medical records for implementation of policy. (2) Review of internal audits. (3) Review of emergency, urgent and routine referral logs.
Steps taken by the County to Implement this paragraph:	1. Booking and screening was moved to Ted Guildford Knight Correctional Center (TGK) in the LEO Lobby on June 18, 2013. 2. 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) 17S005 "Limited English Proficiency," MDCR shall provide assistance to an inmate whose primary language is not English and requires an interpreter/translator." 3. 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	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

representations, and the factual basis for finding(s)	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 14Sday assessment; or 3. At any time by inmate self-referral or by staff referral.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13	Non-Compliance - Not audited 3/14
Unresolved/partially resolve issues from Previous tour			
Measures of Compliance:	<u>Mental Health Care:</u> 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:	In 2013, CHS had written policy, JSES02, Receiving Screening and policy, JSES07, 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." Current CHS policies are in the process of being updated.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As indicated above, access to care is limited in administrative segregation. In addition, enhancements are pending to the electronic scheduling system.		
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. MentalHealth 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: 7/13	Non-Compliance: 3/14
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. 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 internalaudits 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 acknowledges that it is not in compliance with this provision. CHS policy for basic mental health care was outlined in JSGS04. This policy stated 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. Insufficient information was available to assess group therapy and discharge planning. Internal audits were not available for review.		
Monitor's Recommendations:	CHS and MDCR are in the process of analyzing data to further assess staffing needs relative to the level of mental health care of the inmate population, turnover, and supervision needs.		

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: 7/13	Non-Compliance – Not audited 3/14
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 JSGS04. During this onsite 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: 7/13	Non-Compliance:Notaudited3/14
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 JSES12, 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 JSGS04, Addendum 2 Section 2 states, "Psychiatrist will document each follow-up encounter on the *Psychiatric Progress Note* (CS 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 cosigned by the psychiatrist.
Monitor's Recommendations:	1. Progress notes and medical records of patients with severe mental illness (SMI) should reflect individualized treatment plans. 2. Audits will be conducted to look for signs of inter-disciplinary treatment teams.

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: 7/13	Non-Compliance:Notaudited3/14
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, JSGS04 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)	3. Section 2 of JSGS04 states, "2. Inmates arriving to the jail and who are assessed as Level I or II and who remain in the jail for 30Sdays 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 45Sdays of the first IDT in order to have a minimum of two (2) IDT's within the first 90Sdays of admission."		

	4. 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 interdisciplinary plans of care for inmates on Level I who are housed seven continuous days or longer. 5. 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 30S35 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:	Non-Compliance: 3/14; 7/13
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:	CHS reported they are not in compliance with this provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for	As indicated above, the current policy as written is unclear as to the specific timelines for treatment plans and IDT.		

finding(s)	
Monitor's Recommendations:	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. 3. Mental Health Care and Suicide Prevention: c. 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: 7/13. Not audited 3/14
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 onsite 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. 2. Mental Health Care and Suicide Prevention: c. The interdisciplinary team will: (1) Include the treating psychiatrist, a custody representative, and medical and nursing staff. Whenever clinically appropriate, the inmate should participate in the treatment plan. (2) Meet to discuss and review the inmate's treatment no less than once every 45 days for the first 90 days of care, and once every 90 days thereafter, or more frequently if clinically indicated; with the exception being inmates housed on 9C (or equivalent housing) who will have an interdisciplinary plan of care at least every 30 days.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14
Unresolved/partially resolved issues from Previous tour			
Measures of Compliance:	<u>Mental Health Care:</u> 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:	CHS reported that they are non-compliant with this provision. Treatment plans and their implementation are outlined in CHS policy, JSGS04 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.		

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: 7/13	Non-Compliance: Not audited 3/14
Unresolved/partially resolved issues from Previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 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 JSGS04 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, groups 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: 7/13; Not audited 3/14.
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 JSGS04 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 JSGS04 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 IVS i. Inmates classified as requiring Level IV level of care will receive: ii. Managed care in the general population; iii. Psychotropic medication, as clinically appropriate; iv. Individual counseling and group counseling, as deemed clinically appropriate, by the treating psychiatrist; and v. 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: 7/13; Not audited 3/14
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 JSGS04 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 onsite 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	III. C. 2. G. (2) Mental Health Care and Suicide Prevention: Mental Health Treatment Level III: Inmates classified as requiring Level III level of care will receive: i. Evaluation and stabilizing in the appropriate setting; ii. Psychotropic medication, as clinically appropriate; iii. Evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; iv. Individual counseling and group counseling, as deemed clinically appropriate by the treating psychiatrist;

	and v. Access to at least one group counseling session per month or more, as clinically indicated.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; Not audited 3/14
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 III, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement This paragraph:	CHS policy JSGS04 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 onsite 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.		

Paragraph	III. C. g. (3) Mental Health Care and Suicide Prevention: Level II: Inmates classified as requiring Level II level of care will receive: i. evaluation and stabilizing in the appropriate setting; ii. psychotropic medication, as clinically appropriate; **iii.** **private** assessment with a Qualified Mental Health Professional on a daily basis for the **first five days** and then once every seven days for two weeks; iv. evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; and v. access to individual counseling and group counseling as deemed clinically appropriate by the treating psychiatrist.		
Compliance Status this tour:	Compliance: <date>	Partial Compliance: 7/13	Non-Compliance – Not audited 3/14
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	CHS policy JSGS04 Addendum 2 and Addendum 4 describe frequency of follow-up, individual and group		

This paragraph:	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 onsite 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: 7/13	Non-Compliance: Not audited 3/14
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 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 JSGS04 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 onsite 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 yet due
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 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: 7/13	Non-Compliance:Notaudited3/14
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 JSGS04 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: 3/14; 7/13
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. Insufficient group therapy and individual counseling was documented. Review of unit census numbers reflected overcrowding.		

Monitor's Recommendations:	It is recommended that patients with severe mental illness be moved to a therapeutic environment as soon as possible. This environment should include access to the following: • Showers, • Recreation, • Mental health treatment in a confidential setting • Adequate supervision

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 audited 3/14
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Review of representative sample dashboards and internal audits. 2. Review of medical records for concordance of data		
Steps taken by the County to Implement This paragraph:	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 upon submission of key performance indicators and dashboards.		
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. This information will be cross-referenced with a representative sample of patient records.		

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: 3/14; 7/13	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 Program is covered in policy #CHSS059, JSGS05. It is currently being reviewed and updated with input from an outside consultant, Ms. Judith Cox. MDCR specific to suicide prevention is outlined in DSOP 12S03, 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 suicides resistant mattresses or blankets.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The current policy does not specify the following provisions of the Consent Agreement: S Property granted to inmates upon clinical determination of QMHS - Inmates have suicide resistant mattresses - Inmates have proper suicide resistant clothing - Staff do not retaliate against inmates by sending them to suicide watch cells The CHS policy currently states that "the mental health assessment includes an assessment for suicide risk." A suicide risk screen is not a suicide risk assessment. It is recommended that each policy and its terminology be clarified to avoid this confusion. Adequate retraining of correctional and medical staff in suicide prevention remains pending.		
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 and procedures by CHS and MDCR for all inmates on Level I restricting reading materials, access to recreation and showers are not appropriate. 2. Implement mental health and suicide prevention training for all staff that work directly with inmates, including custody, medical and mental health. As indicated above, this training should be practical		

	and should cross disciplines. 3. 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: b.1. 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. b.2. 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: 7/13	Non-Compliance: 3/14
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 Program is covered in policy #CHSS059, JSGS05. It is currently being reviewed and updated.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS hired a consultant to assist with its suicide prevention program. Ms. Cox's input and formal recommendations are forthcoming. These include: 1. Suicide training needs to have a more functional approach that crosses all disciplines 2. Mental Health training should be integrated and cross both corrections and medical i.e.; general training as well as are specific training by functional area 3. Training Leadership		

	4. Role playing (set up suicide scenarios) 5. Advisory form to be converted to electronic (define symptoms and behavior checklist) 6. Increase the privacy in pre-booking 7. Need for signage as how to access medical or mental health services 8. RN's need to be placed in pre-booking 9. Booking needs to have access to prior housing location data 10. Need to create consistency in suicide terminology 11. Hardwire a consistent system to ensure the identification and tracking of individuals at risk as there is a lot of movement ofinmates
Monitor's Recommendations:	I agree with the consultant recommendations as outlined above. Once the suicide-screening instrument and the suicide risk assessment have been in place for a period of six months, the Director of Quality and the Director of Mental Health should collaborate to assess the strengths and weaknesses of the instruments being utilized for possible improvements, if needed.

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: 3/14; 7/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 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 Policy is in the process of an update.		

	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 15Sminute 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)	Review of the attempted suicide / self-harm cases indicated that patients were not placed on constant observation. This finding is confirmed by the fact that several patients succeeded in injuring themselves despite being on Level I. For example, in one case, a patient swallowed razor blades (that reportedly had the plastic casing) while on Level I.[iii]
Monitor's Recommendations:	Monitoring and auditing this provision of the agreement is a shared responsibility. Although MDCR may provide the supervision or checks, CHS and its clinicians function as advocates for the patients. Thus, adverse events and random audits should be reviewed to assess the adequacy of monitoring and staggered checks. This information may be discussed during Mental Health Review Committee, interdisciplinary treatment teams, and MAC meetings.

Paragraph	III. C. 3 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: 3/14; 7/13	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, including screening and suicide risk assessments.		
Steps taken by the County to Implement this paragraph:	CHS policy 059, is in the process of an update.		
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 and mental health pre-screening are completed by nurses. If the screen is positive, the patient is referred to a social worker during the day. Due to a current staffing gap, if the screen is positive, the patient is referred to a nurse for further mental health assessment on the night shift (from 11pm to 7 am).		
Monitor's Recommendations:	1. Hiring plans must include a QMHP for the night shift as soon as possible. 2. The Associate Director of Mental Health should review:		

	• Number of patients referred to psychiatrist by QMHP per day • Number of patients referred to psychiatrist by QMHP per day by Level • Accuracy of'Leveling' • Accuracy of suicide screen and mental health screen

Paragraph	III. C. 3 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: 7/13	Non-Compliance: 3/14
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 acknowledges noncompliance with this provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)			
Monitor's Recommendations:	None.		

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: 3/14; 7/13	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 onsite inspections, if any 4. Incident reports documenting use of cut-down tool		
Steps taken by the County to Implement this paragraph:	MDCR policy 12S003 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)	Due to physical plant issues, cut down tools and other emergency rescue items are placed at long distances from first responders at PTDC.
Monitor's Recommendations:	The Mental Health Monitor plans to maintain, track and audit training records for suicide prevention and emergency response in collaboration with the Fire and Safety Monitor. This should include whether cut down tools and emergency response bags are adequately stocked, available, and utilized on all units. In addition to this, all adverse events including deaths should be reviewed for evidence of timely response, use of appropriate lifesaving tools, and identification of at-risk individuals.

	medical staff shall know the location of this emergency response bag and the Jail will train staff how to use its		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/14
Unresolved/partially resolved issues from previous tour:			
	_____		
Steps taken by the County to Implement this paragraph:	Insufficient training and documentation was provided in reference to this provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	I did not review training materials and records of current CPR certification. Review of adverse events demonstrated inadequate and problematic documentation of response times and treatment in urgent and emergent cases.		
Monitor's Recommendations:	1. Maintain and update CPR records for all staff. 2. Maintain training records for all disaster, emergency and suicide response drills. 3. Audit and review adverse events for opportunities to identify at-risk individuals and training		

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: Unresolved/partially resolved issues	Compliance: Partial Compliance: Non-Compliance: 3/14
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	3. Representative sample of inmate records. CHS is in the planning phases to comply with this provision.
This paragraph: Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for	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-
finding(s) Monitor's Recommendations:	harming behaviors and other suicidal ideation. This report is pending. In addition to adequate screening, suicide risk assessment for patients that have screened positive is recommended.

4. Review of Disciplinary Measures

	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		
Compliance Status this tour:	inmate is not able to understand Compliance:	d or meaningfully participate in the process Partial Compliance: 7/13	s without assistance. Non-Compliance: 3/14
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: *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. They acknowledge they are not in compliance with this provision. 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 factual basis for finding(s)	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.
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.

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: 3/14; 7/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health Care:</u> 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:	In 2013, CHS Policy JSGS02 stated, "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 12S005 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 onsite 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 overcrowding, and lack of private or semiprivate 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 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 II, and I 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: 3/14; 7/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health Care:</u> 1. Onsite 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 12S003, 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 onsite 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 reevaluation of this decision on a daily basis when the clinical duration is not specified.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/14; 7/13
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:	CHS acknowledges that they are noncompliant with this provision. MDCR policy 12S005 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	In 2013, CHS policy JSGS05 Addendum A specifically stated 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		

representations, and the factual basis for finding(s)	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: 3/14	Non-Compliance:
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)	Current plans include retrofitting units of TGK so that mental health inmates may be transferred to that space. This is anticipated to occur in December 2014. However, no transition team has been created to implement this move.		

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: 7/13	Non-Compliance: 3/14
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health Care:</u> 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 interdisciplinary plans of care within seven days of placement on 9C or overflow unit		
Steps taken by the County to Implement this paragraph:	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)	I reviewed approximately five charts on 9C; none had an IDT.		
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 biweekly 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: 7/13	Non-Compliance:Notaudited3/14
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 an 3. Review of medical records for implementation of policies, including results of disciplinary proceedings of persons on the mental health caseload and evidence of consultation with Qualified Mental Health Staff. 4. Review of logs of compliance with initial evaluation of inmate by Medical and QMHS.		
Steps taken by the County to Implement this paragraph:	CHS reported it is non-compliant with this provision. DSOP 12S002 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)	DSOP 12S002 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 highs 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: 7/13	Non-Compliance – Not audited 31/4
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health Care: *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 internalaudits		

Steps taken by the County to Implement this paragraph:	CHS reported that it is not compliant with this provision. DSOP 12S002 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)	
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: 7/13	Non-Compliance – Not audited 3/14
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:	CHS reported that it is not compliant with this provision. DSOP 12S002 states that inmates placed in disciplinary segregation will have a psychosocial evaluation 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 concurred 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: 7/13	Non-Compliance – Not audited 3/14
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:	CHS reported that it is not compliant with this provision. As indicated above, DSOP 12S002 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 JSES09 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: 7/13	Non-Compliance: Not audited 3/14
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 reported that it is not compliant with this provision.		

	DSOP 12S002 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: 7/13	Non-Compliance: Not audited 3/14
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 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 stated that it is not compliant with this provision. DSOP 12S002 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, JSES09 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: 7/13	Non-Compliance: July 2013. Not audited 3/14
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 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 12S002 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: 7/13; Not audited 3/14
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:	CHS stated they are noncompliant with this provision. 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: 7/13	Non-Compliance: Not audited 3/14
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 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:	CHS reported that they noncompliant with this provision. DSOP 12S002 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 Pretrial 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.		

Paragraph	III. C. 6. Mental Health Care and Suicide Prevention: 8. If an inmate with SMI in custodial segregation suffers deterioration in his or her mental health, decompensates, engages in self-harm, or develops a heightened risk of suicide, that inmate shall immediately be referred for appropriate assessment and treatment and removed if the custodial segregation is causing the deterioration.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; Not audited 3/14
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:			
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. CHS reported that they are Non-compliant with this provision.		
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: 7/13	Partial Compliance:	Non-Compliance – Not audited 3/14
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health Care:</u>		

	1. Manual of MDCR and mental health policies and procedures *2.* Review of log of patients in custodial segregation with SMI *3.* Review of custodial segregation log checks
Steps taken by the County to Implement this paragraph:	DSOPS12S002 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: 7/13	Non-Compliance – Not audited 3/14
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of MDCR and mental health policies and procedures 2. Onsite 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:	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.		
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 Compliance7/13	Non-Compliance –Not audited 3/14
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 JSES07 and JSES08 describe the procedures for nonemergency and emergency referrals in general. However, these policies do not give examples of what might an 'urgent' referral be 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: 3/14	Non-Compliance: 7/13

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)	Psychiatry • MDCR/CHS has rehired an Associate Director of Mental Health, Dr. Gonzalez; she is both capable and interested. This is a good step. • Staffing currently consists of seven FTEs and 109 total hours of per diem or 'pool' psychiatry time. • Per diem psychiatry time has been unpredictable and unreliable • Current plans include recruitment of staff to fulltime positions. Other incentives and creative staffing options are also being explored. Social work • Staffing at TGK includes coverage on day and evening shifts. However, the night, 11 to 7 am shift is currently covered by a nurse. • Recruitment for a QMHP to cover this shift will be imperative • In addition, interviews with current SW and mental health staff indicated that they were interested in development of policy and training (directed to the policy, once developed) to ensure consistency and
Monitor's Recommendations:	A comprehensive staffing plan remains pending. The staffing plan previously submitted was not completed in an interdisciplinary manner. As such, it is not complete and will lead to gaps in care. For example, it did not include input by medicine and also did not factor in custody needs for transferring patients to medical appointments or supervising 1:1s. This will need to be taken into consideration. In addition: • Hiring plans should include a relief factor for mental health as needed and a QMHP for the night shift at TGK as soon as possible. • Hiring plans should include a deadline for hiring plans and a back-up plan should adequate hiring not occur. • **Inadequate provision of mental health care and lowering of the mental health care caseload should not be the backup plan for in/adequate staffing.** • Staffing and hiring plans for CHS will depend partially on data that remained outstanding at the time of this report: total mental health caseload numbers per level were not available.

Paragraph	III. C. 7. Mental Health Care and Suicide Prevention: b. Within 180 days of the Effective Date, and annually thereafter, CHS shall submit to the Monitor and DOJ for review and comment its detailed mental health staffing analysis and plan for all its facilities.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			

Measures of Compliance:	Mental Health: *1.* Review of staffing plan and matrix as it relates to current and projected average census and mental health population. *2.* Review mental health policies and procedures
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:	Please see III. C. 8.
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: Unresolved/partially resolved issues from previous tour:	Compliance: Partial Compliance: 3/14 Non-Compliance: 7/13
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)	
Monitor's Recommendations:	Please see page 199. Specific to mental health, CHS is still processing data to assess its staffing needs.
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 reevaluate and agree upon the timetable for the hiring of any additional staff.
Compliance Status this tour: Unresolved/partially resolved issues from previous tour:	Compliance: Partial Compliance: 3/14 Non-Compliance:

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)	
Monitor's Recommendations:	Please see page 199. Please see above.
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: 3/14; 7/13 Non-Compliance:
Unresolved/partially resolved issues from previous tour:	
Measures of Compliance:	Mental Health: *1.* Review of staffing plan *2.* Review of meeting minutes *3.* Interview of staff *4.* MDCR and mental health policies and procedures *5.* Review of timetable for hiring, as needed
Steps taken by the County to Implement this paragraph:	CHS has an Associate Director, Dr. Gonzalez.
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 an Associate Director, Dr. Gonzalez. She performs both administrative and clinical functions.
Monitor's Recommendations:	None at this time.
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: 7/13; Not audited 3/14
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Mental Health: 1. Review of organizational chart and staffing matrix 2. Review of in-service training signs 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. 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 1S3) 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: 7/13 - Not audited 3/14
Unresolved/partially resolved issues from previous tour			
Measures of Compliance:	Mental Health:		

	1. Review of organizational chart and staffing matrix 2. Review of in-service training signs 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 12S005 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: 3/14; 7/13	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 factual basis for finding(s)	MDCR policy on medical compliance inspections is covered in DSOP 14S007. 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 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:	During the onsite in March 2014, a provisional organizational change in chart was initiated to ensure regular and effective communication between custody, medical and mental health staff.

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) highs 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: 3/14; 7/13
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) Highs 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 begun but is not adequate, as has been outlined above. No lesson plans were submitted prior to initiation of the training. As indicated above, DSOP 12S005 refers to adequately training assigned staff in the forensic units in the identification of mental illness and suicide prevention. 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 retraining 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 1S3), and custodial segregation units and biannually for all other officers.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/14;7/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> *1.* Review of training logs and signs in sheets for correctional custodial who work in intake, forensic (Levels 1S3), 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 that has occurred to date did not reflect the above stated measures of compliance. An outline of the CIT lesson plan was previously reviewed; no update has been submitted. 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 1S3), and custodial segregation units and biannually for all other officers.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/14;7/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> a. Review of training logs and signs in sheets for correctional custodial who work in intake, forensic (Levels 1S3), 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. The information I have received to date is inadequate to assess compliance with this provision.		
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: 7/13	Non-Compliance: Not audited 3/14.
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: 3/14	Non-Compliance:
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)	The Quantros incident reporting system has been implemented. Several adverse events were reviewed. The analysis of the recent events has improved and reflected implementation of changes to prevent recurrence. Future reviews will focus on sustainability of recent gains.		
Monitor's Recommendations:	In addition to the Quantros system, I recommend continued interdisciplinary 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: 3/14	Non-Compliance:
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:			
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, Mental Health Review Committee and Quality and Safety Committee have been implemented.		
Monitor's Recommendations:	Psychiatry should implement JHS risk management criteria and / or qualitative analysis of adverse events on a regular monthly basis in order to assess root causes; I recommend both qualitative individual 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: 3/14	Non-Compliance:
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:	
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Mental Health Review Committee has been implemented. Individuals have not been referred to the committee.
Monitor's Recommendations:	Once individual cases are referred to the MHRC, difficult cases may be analyzed in the context of trends for Possible solutions.

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: 3/14	Non-Compliance:
Unresolved/partially resolved 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 Quality and Safety Committee has started meeting monthly. Its focus has been on the Department of Justice report, approval of policies and procedures, and improving safety, typically in response to an adverse event or outcome.
Monitor's Recommendations:	Once staffing and backlog issues in terms of access to care have been addressed, Quality and Safety may be better suited to be able to proactively address and analyze projective trends based on the data.

Appendix D*1
List of items reviewed:

1. United States of America vs. Miami Dade County Consent Agreement Case 1:13DcvD21570DWJZ, May 2013
2. Corrections Health Services Policies and Procedures
3. MDCR Policy 12D002, Inmate Administrative and Disciplinary Confinement, 6/12
4. MDCR Policy 12D003, Suicide Prevention and Response Plan, 5/12
5. MDCR Policy 12D005, Recognizing and Supervising Mentally Ill Inmates, 2/13
6. MDCR Policy 12D007, Inmates with Disabilities Act, 6/11/12
7. MDCR Policy 14D001, Inmate Injury Request for Services, 6/07
8. MDCR Policy 14D007, Medical Compliance Inspections, 12/12
9. MDCR Policy 14D008, 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

Don Steigman, COO, Jackson Health System and CHS Director
Andrew Ta, M.D.CHS Medical Director
Mercy Gonzalez M.D., Associate Medical Director Rachel
Rodriquez CHS Assoc Director Quality Assurance Kevin
Andrew, Vice President Quality and Patient Safety
Paulette Johnson, R.N., HAS
Denise Haye, LCSW
Wayne Wilbright, MD, CMIO Jackson
Naomi Auerbach, LCSW
Odalis Periera, RN, HSA
Eli Medina, CHS Financial Officer
Judge Steven Leifman
Carlos Migoya, CEO Jackson Health System
Genaro "Chip" Iglesias, Chief of Staff / Deputy Mayor
Practitioners, nurses, and officers at TGK, Intake, PTDC

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

[ii] 14D06836
[iii] 12D81861