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. 3

November 28, 2014

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Compliance Report # 3

USA v. Miami-Dade County
Consent Agreement
Settlement Agreement
November 28, 2014

Introduction

This is Compliance Report #3 regarding the Consent Agreement and Settlement Agreement referenced above. The monitors conducted a joint tour the week of October 20, 2014.

The monitors 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 is an overview of findings and recommendations shared by all the monitors. There are additionally four individual reports, each of which includes a summary.

> Report A – Protection from Harm, Inmate Grievances, Audits and Continuous Improvement, authored by Susan W. McCampbell, page 1 (Summary of compliance, p. 6).
> Report B – Fire and Life Safety, authored by Harry Grenawitzke, page 65 (Summary of compliance, page 69).
> Report C – Medical Care, authored by Marc F. Stern, MD, Mental Health Care, authored by Amanda Ruiz, MD page 81 (Summary of compliance pp. 87).

The draft of this report was provided to all parties on November 11, 2014; comments were received from the parties on November 24, 2014. The monitors considered all comments in preparing this final report.

Monitors' Shared Concerns

The shared concerns discussed in this introduction are similar to those in Compliance Report #2 – and, importantly include positive updates in several areas:

- Leadership
- Organization and Collaboration – Commitment, Human and Infrastructure Resources
- Move of inmates with mental illness to TGK
- Long-Term Improvements in Conditions of confinement, TTC and PTDC
- Initiative, Problem Solving and the Data Driven Jail
- Inmate Safety – Classification System Reform
- Inmate Safety – Prison Rape Elimination Act of 2003

- Inmate Safety – Inmate/Inmate Violence
- Uses of Force
- Court Notice
- Achieving Compliance and additional monitoring resources
- Policies, Procedures and Employee Training

Leadership

During the March 2014 tour there were interim and/or acting leaders in both MDCR and CHS. There were also individuals at in critical management positions in these organizations also in "interim" and "acting" status. The monitors were very concerned that the County had not made timely decisions about the individuals to lead these two large organizations in the midst of significant transition. We believed that this situation was to the detriment of the organizations and to achieving compliance with both the Settlement Agreement (SA) and the Consent Agreement (CA).

In May of 2014, Marydell Guevara was appointed Director of MDCR, and in July 2014, Jesus "Manny" Estrada was appointed Director of CHS. The monitors see these appointments as significant positives. As will be noted elsewhere in this report, we see the impact of the initiatives and commitment of both Directors Guevara and Estrada.

Organization and Collaboration – Commitment, Human and Infrastructure Resources

In March 2014 the monitors expressed concerns about the level of collaboration between CHS and MDCR. While all parties articulated how critical it was to work together to achieve compliance with both the SA and CA, both agencies needed to overcome inertia, history, and resources to achieve this necessary outcome.

The monitors are generally pleased with the improvements not only in the language about collaboration, but also in outcomes. We are concerned that sufficient *resources* be allocated to allow the collaboration and coordination to be successful and sustainable. These resources include appropriate administrative staff and specialty support functions. For example, we believe that the CHS Director needs to have staff resources to manage compliance initiatives with the CA; and the MDCR Director needs staff to collect and analyze data, and importantly to engage in the action planning required in the SA. Both organizations need improvements in infrastructure/computer support. MDCR also needs long-term capital planning to replace facilities that do not meet Constitutional conditions of confinement (e.g., TTC).

Throughout this report there are references to written directives/policies/procedures/ and training that are needed to be developed, or modified, to achieve compliance with various paragraphs. The monitors are not identifying if those policies are MDCR policies, CHS policies, or collaborative memoranda. We will be looking for the *outcomes and results* of the required collaboration. The organizations can determine how best to manage and document collaboration.

We commend both organizations on their commitment to collaboration, but caution is this will only be sustainable with allocation of appropriate resources.

Move of inmates with mental illness to TGK

Inmates with acute mental illness (along with the corrections and medical/mental health staff) will be relocated in December from the 9th floor at the Pre-Trial Detention Center (PTDC) to Turner-Guilford-Knight (TGK) and housed in areas specifically designed to accommodate inmates' needs. This new environment will also enhance staff effectiveness in addressing the needs of this inmate population.

We acknowledge the County's efforts to move this significant initiative forward in a very short time period. We have been reviewing the transition planning, training, and physical plant work associated with this move. We believe this move will make a significant difference in the treatment and outcomes for inmates on the mental health caseload, as well as improve their safety and that of the staff.

Long-Term Improvements in Conditions of Confinement, TTC and PTDC[1]

We understand from the Deputy Mayor Russell Benford that the County will again start examining potential solutions to the need to replace existing inadequate inmate housing. We look forward to learning about these initiatives.

Initiative, Problem Solving, and the Data Driven Jail

The SA requires MDCR to develop systems to collect and analyze data, as well as develop, implement and evaluate action plans to improve conditions of confinement. MDCR will implement a new jail management information system in, perhaps, 18 months. But impressively, MDCR did not allow the current cumbersome systems to delay collecting and analyzing data. A new system was put in place in February 2014 to review data; and impressively, the talent and resources of the department were leveraged to develop an inmate grievance tracking system (by November 1, 2014) and a system to track inmate discipline (by January 1, 2015).

The written directives that guide the sections of the SA relative to data collection, analysis and action planning await finalization. The monitors are encouraged based on the work accomplished since the March 2014 tour that MDCR's direction is well conceived, and we look forward to the improvements that will result from these processes.

Inmate Safety – Prison Rape Elimination Act of 2003

The SA requires the County to reach compliance with the Prison Rape Elimination Act of 2003. This is a substantial requirement. In July 2014, the County was audited for and

[1] See also Compliance Report #1.

achieved compliance with the PREA standards. The monitors acknowledge this monumental accomplishment. There are more than 3,200 local jails in the United States and only a few (possibly fewer than 20) have been audited and achieved compliance. Compliance with PREA standards contributes directly to inmate safety. The collaboration with the Miami-Dade Police Department is also recognized.

Inmate Safety – Inmate/Inmate Violence

The monitors are concerned about the level of inmate/inmate violence in the County's jails. This is an issue with many aspects – including but not limited to: correctional staffing adequacy, level of appropriate mental health care resources, the inmate classification system, staff training, and staff supervision. The data-driven jail, as described above, will contribute to better understanding the issues, along with the work of the Trend Analysis and Action Planning unit (TAAP).

Uses of Force – MDCR Responds

As reported in Compliance Report #2, the monitors remain concerned about the numbers of uses of force in the jails. While the data analysis mandated by the SA will refine the uses of force, MDCR is in need of a more robust system of examining use of force reports. This was evidenced by the monitors' review of use of force reports for June 2014, shared with the Director. MDCR did not wait until the monitors' current tour to act. The Director reorganized the Compliance Division to include a Trend Analysis and Action Planning (TAAP) Unit. While not specifically funded in the budget, MDCR reallocated resources to this unit – including four sergeants. The operational directives and post orders governing TAAP are under development, the goal of this unit is to address issues raised by the monitors as well as to incorporate best practices from other large jails that are also grappling with uses of force.

To continue this significant reform, funding is needed for this unit. The data generated will allow MDCR to examine more fully uses of force and initiate any necessary reforms in practice, supervision and/or training.

Court Notice

On October 21, 2014, the parties appeared before The Honorable William J. Zloch, U. S. District Court for the Southern District of Florida. The purpose of this status conference was to advise the Court regarding the County's compliance with the Consent Agreement. The outcomes of that status conference are a request for an action plan to achieve compliance, and the scheduling of another status conference for November 17, 2014. This conference was held, and the parties agreed to continue preparation of the plans, targeting for another status conference in mid-January 2015. The monitors look forward to assisting the Court in any way possible in this matter, as well as assisting the County in working toward compliance.

Achieving Compliance and Additional Monitoring Resources

For this tour, three additional medical/mental health professionals were added to the monitoring team. The purpose of adding these professionals was to conduct the in-depth review of inmate medical and mental health records to verify compliance, and to conduct interviews with both inmates and staff. The requirements of the CA are substantial, and the monitoring team, while conscious of fiscal issues in the County, understands that this work is needed to support any conclusions, as well as make recommendations for change. The monitoring team will judiciously assign these additional resources. There may be an additional person added to the team for the next tour to conduct the inspections and interviews required to verify compliance with the SA.

Policies, Procedures and Employee Training

The monitors will continue to assist in reviewing policies and procedures as these directives are updated. These documents provide the bases for the employee training lesson plans that also require revision. We urge the County to devote the resources to these critical initiatives.

Conclusions

All parties, and the monitors, recognize that there was and is substantial work to be done to comply with the both the Settlement Agreement and the Consent Agreement. The monitors urge the County and the Public Health Trust to devote the resources required to a not only achieve compliance, but sustain the level of care required. We see the interest and involvement of the Court in the review of the County's compliance with the Consent Agreement as appropriately highlighting the urgency of the issues needing a remedy. We look forward to working with the parties to assist where we can in achieving sustainable compliance.

Report A
Compliance Report # 3
Protection from Harm
Inmate Grievances
Audits and Continuous Improvement
Report of Tour October 20 – 24, 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. See the chart, below, for a depiction of the progress made since the first tour of July 2013.

Findings/Overview:

Report #	Compliance	Partial Compliance	Non; Compliance	Not Applicable/Not Due/Other	Total
1	0	23	21	6	50
2	6	23	21	0	50
3	12	27	9	2	50

The areas that require the attention of County's attention:

1. Inmate Safety – Classification Reform

   The inmate classification system is inextricably linked to inmate and staff safety. MDCR is implementing an action plan to meet the recommendations of the National Institute of Correction (NIC) analysis of the current inmate classification system. As noted above in the data collection initiative regarding the inmate disciplinary process, progress is being made awaiting the new jail management information system.

   The monitors remain concerned about the human resources needed to fully implement a classification system for this size jail. Additionally, funding for a new classification system (different than the new jail management system's module) is needed.

   Recommendations:
   a. MDCR needs to acquire a new inmate classification system.
   b. MDCR needs to assure that there is an appropriate level of staffing for classification.
   c. MDCR needs to complete the action plan based on the NIC technical assistance event.

1. 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 continue to provide Corrections Intervention Training (CIT) for the staff assigned to work with inmates with mental illness, and extend the training over the next few years to as many employees as possible.[2]

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

2. 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.

3. Response to Resistance (Use of Force)

   MDCR should continually evaluate uses of force to assure they are within the directives

[2] For more information see http://community.nicic.gov/blogs/mentalhealth/archive/2011/08/04/crisisOinterventionOteamOcitOtrainingOforOcorrectionalOofficersOanOevaluationOofOnamiOmaineOs02005O2007Oexpansion0program.aspx

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 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, 2013 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 2013O2014 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.

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[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.

[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.

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.

4. Inmate/Inmate Violence

Analysis of information from incidents of inmate/inmate violence/assaults also 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: Report of Compliance for Tour the week of October 20, 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)	8		x		
III.A.1.a. (2)	9		x		
III.A.1.a. (3)	10	x			
III.A.1.a. (4)	10		x		
III.A.1.a. (5)	11	x			
III.A.1.a. (6)	12	x			
III.A.1.a. (7)	13	x			
III.A.1.a. (8)	13		x		
III.A.1.a. (9)	14		x		
III.A.1.a. (10)	15		x		
III.A.1.a. (11)	16		x		
2. Security Staffing					
III.A.2. a.	17		x		
III.A.2. b.	18			x	Med/MH non-compliance
III.A.2.c.	19		x		
III.A.2.d.	20			x	
3. Sexual Misconduct					
III. A.3.	21	x			
4. Incidents and Referrals					
III. A.4 a.	22	x			
III.A.4. b.	23	x			
III.A.4.c.	24		x		
III.A.4.d.	24		x		Med/MH Not audited
III.A.4.e.	26		x		
III.A.4.f.	27		x		Med/MH Not audited
5. Use of Force by Staff					
III.A. 5 a.(1) (2) (3)	28		x		
III.A.5. b.(1), (2) i, ii, iii, iv, v, vi	29			x	MH non-compliance
III.A. 5. c. (1)	31	x			
III.A. 5. c. (2)	31			x	MH non-compliance; Med not audited
III.A. 5. C. (3)	33		x		

Subsection of Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments:
III.A. 5. C. (4)	34	x			
III.A. 5. C. (5)	34			x	MH non-compliance
III.A. 5. c. (6)	36		x		Med not audited
III.A. 5. c. (7)	38	x			
III.A. 5. c. (8)	38	x			
III.A. 5. c. (9)	39		x		
III.A. 5. c. (10)	40			x	MH non-compliance
III.A. 5. c. (11)	41			x	
III.A. 5. c. (12)	42			x	
III.A. 5. c. (13)	43	x			
III.A. 5. c. (14)	44			x	
III.A.5. d. (1) (2) (3) (4)	44		x		
III.A.5. e. (1) (2)	45		x		
III.A.6. a. (1) (2) (3) (4) (5)	47		x		
III.A.6.b.	48				Not yet due
III.A.6.c.	49				Not yet due
III. C. Inmate Grievances					
III.C. 1.,2.,3.,4.,5.,6.	50		x		
D. Audits and Continuous Improvement					
III.D.1. a. b.	52		x		
III.D. 2.a. b.	55		x		Med not audited
IV. Compliance and Quality Improvement					
IV. A.	58		x		MH/Med not audited
IV. B.	60		x		Med not audited
IV. C.	62		x		Med not audited
IV. D.	63		x		

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:	Compliance:	Partial Compliance: 3/28/14, 7/19/13, 10/24/14	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	MDCR is completing/updating the elements of their written directive system.		
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 completing/updating the elements of their written directive system.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR is revising the last set of written directives that will bring the agency into compliance with this paragraph. The monitors and DOJ have been reviewing the drafts as they are completed. I anticipate this paragraph will be in compliance at the time of the next tour in 2015.		
Monitor's Recommendations:	Complete the required work.		

Paragraph	III. A. 1. Safety and Supervision: a. MDCR will take all reasonable measures to ensure that inmates are not subjected to harm or the risk of harm. While some danger is inherent in a jail setting, MDCR shall implement appropriate measures to minimize these risks, including: (2) Within 90 days of the Effective Date, conduct an inmate bed and classification analysis to ensure the Jail has adequate beds for maximum security and disciplinary segregation inmates. Within 90 days thereafter, MDCR will implement a plan to address the results of the analysis. The Monitor will conduct an annual review to determine whether MDCR's objective classification system continues to accomplish the goal of housing inmates based on level of risk and supervision needs.		
Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See Recommendations:		
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:	MDCR requested and received technical assistance from the National Institute of Corrections (April 2014) to assess the inmate classification system. The eighteen (18) recommendations from that analysis resulted in an Action Plan that remains in the process of completion. When DOJ clarifies if this report, the Action Plan, and the data that MDCR provides regarding allocation of beds by inmate classification, the work will be clarified and completed.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR needs to develop and/or purchase from a vendor a validated (for MDCR) classification system. MDCR is evaluating options. The agency has developed, using internal resources and talent, a system to enter, identify, manage, and track inmate grievances as of 11/1/4. This system will inform the classification process. Importantly, MDCR has developed a similar system to track the inmate disciplinary process and outcomes, an important data set currently not automated in the inmate classification and reclassification process. This system is anticipated to be "live" on 1/1/15. MDCR is commended for their ingenuity and resource management to move the process of improving inmate classification forward, without waiting for either the new jail management system (18 months into the future), or purchase of a system. I also recognize MDCR's work in devoting the resources to this effort and security training for staff involved.		
Monitor's Recommendations:	1. Complete Plan of Action from NIC Technical Assistance 2. Determine whether to purchase from a vendor a new classification system; secure funds, and move forward as soon as possible. 3. Assess the staffing needed to develop and sustain a classification process and system for this size agency; assure		

	staffing is secured as soon as possible. 4. Identify the data that will be needed to validate the classification system and assure that this data is captured in the jail management system currently under development. 5. Identify the data that will inform MDCR leadership about the impact of an updated classification system on decreasing inmate/inmate violence, uses of force, and staff injuries. 6. Request clarification from DOJ as soon as possible regarding the language in this paragraph.

Paragraph	III. A. 1. Safety and Supervision: a. MDCR will take all reasonable measures to ensure that inmates are not subjected to harm or the risk of harm. While some danger is inherent in a jail setting, MDCR shall implement appropriate measures to minimize these risks, including: (3) Develop and implement a policy requiring correctional officers to conduct documented rounds, at irregular intervals, inside each housing unit, to ensure periodic supervision and safety. In the alternative, MDCR may provide direct supervision of inmates by posting a correctional officer inside the day room area of a housing unit to conduct surveillance.		
Compliance Status:	Compliance: 10/24/14	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	None		
Measures of Compliance:	<u>Protection from Harm:</u> 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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	I examined logs at Metro West.		
Monitor's Recommendations:	Continue self-audits of compliance. Will review additional logs for all facilities during first tour of 2015.		

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:	Compliance:	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	See previous report; pending updating of written directives		
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)	The governing written directives need to be finalized; staff training.		
Monitor's Recommendations:	Complete directives; develop lesson plans; train staff; complete self-audits.		

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 0 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:	Compliance: 10/24/14	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			

Measures of Compliance:	Protection from Harm: 1. Re-classification screening documentation for inmates moved to maximum-security housing that does not have direct supervision or video monitoring. 2. Plan to increase video surveillance and recording capacity; implementation dates; contracts; evidence of completion on required dates; plan of action if dates specified in the Settlement Agreement for completion not met.
Steps taken by the County to Implement this paragraph:	MDCR reports that 24 cameras have been installed at PTDC in the safety cells; 16 cameras in PTDC in 3 C-wing); 94 cameras in the TTC; 40 cameras in TGK kitchen and intake; and 103 cameras installed throughout Metro West. Overall MDCR reports that 1,415 surveillance cameras have been installed.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	I observed camera installations at PTDC, TGK and Metro West. I believe that MDCR has exceeded the requirements of the Settlement Agreement in terms of camera installations.
Monitor's Recommendations:	Continue to assure that cameras are working as planned; monitor work orders.

Paragraph	III. A. 1. Safety and Supervision: a. MDCR will take all reasonable measures to ensure that inmates are not subjected to harm or the risk of harm. While some danger is inherent in a jail setting, MDCR shall implement appropriate measures to minimize these risks, including: (6) In addition to continuing to implement documented half-hour welfare checks pursuant to the "Inmate Administrative and Disciplinary Confinement" policy (DSOP 12.002), for the PTDC safety cells, MDCR shall implement an automated welfare check system by July 1, 2013. MDCR shall ensure that correctional supervisors periodically review system downloads and take appropriate action with officers who fail to complete required checks.		
Compliance Status:	Compliance: 10/24/14, 3/28/14	Partial Compliance: 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 1. Policies and procedures governing welfare checks. 2. Implementation of an automated welfare check system in PTDC by 7/1/13. 3. Policies and procedures regarding management of data generated from automated welfare check system, including re-training and corrective action. 4. Review of incidents from housing units in which automated welfare check system is deployed.		
Steps taken by the County to Implement this paragraph:	Nothing needed at this time.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This paragraph was not audited during this tour.		

Monitor's Recommendations:	1. Develop lesson plans 2. Provide self-audit to monitors prior to first tour of 2015.

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:	Compliance: 10/24/14	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. 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:	MDCR completed the required written directives.		
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.(3).		
Monitor's Recommendations:	1. Continue self-audits of logs. 2. Monitors will review logs during first tour of 2015.		

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:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	MDCR completed the reviewed directive, 11-045. It is pending issuance.		
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:	MDCR provided the draft directive for review; pending finalization. MDCR provided evidence of shakedowns conducted to the monitors.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR has responded to previous recommendations of the monitors. The process is being refined.		
Monitor's Recommendations:	1. Continue self-audits. 2. Provide reports, summaries, etc. of contraband seized, patterns, sources, and any required plans of action 3. Monitors will review in first tour of 2015.		

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:	Compliance:	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	This issue is being discussed with DOJ and is related to on-going labor/management negotiations.		
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding training for officers who transfer from one division to another. 2. Facility specific operational procedures/written directives. 3. Lesson plans on facility-specific safety and security. 4. Proof of attendance within 30 days of assignment. 5. Demonstration of knowledge gained (e.g. pre and post tests) 6. Examples of remedial training, if any.		
Steps taken by the County to Implement this paragraph:	MDCR is requesting clarification from DOJ to form the basis for modifying the measures of compliance.		

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Awaiting finalization of discussions between DOJ and MDCR and outcomes of labor/management negotiations. In the interim, I find that this paragraph is in partial compliance due to the written directive currently in place (DSOP 60 046).
Monitor's Recommendations:	Awaiting direction from DOJ.

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:	Compliance:	Partial Compliance: 10/24/14; 3/28/14, 7/19/13	Non-Compliance:
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 10/24/14; 3/29/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	Training lesson plans.		
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 post tests) 7. Remedial training, if any.		
Steps taken by the County to Implement this paragraph:	<u>Protection from Harm:</u> Lesson plans have not yet been updated. MDCR leadership is providing corrections-competencies' based CIT training to staff who will be assigned to the mental health unit when moved to TGK. This training is in collaboration with CHS. The Director notes that it is her intention to include sworn staff in the 40 hours of CIT training, along with civilian staff who work with inmates on the mental		

	health caseload, over the next four years, provided that staffing is adjusted, and the shift relief factor is employed to determine staffing. Mental Health: I reviewed the lesson plan and information submitted related to specialized training received by officers specific to suicide prevention training and CIT. CIT was provided to pre-service class #123 and will begin on October 27, 2014 for MDCR staff assigned to the forensic unit at Pre-Trial Detention Center and the mental health treatment center at Turner Guilford Knight Correctional Center.
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 is adequate. I did not receive the results of testing at the end of suicide prevention training demonstrating proficiency in mental health screening and suicide risk demonstrating competency.
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: Please submit matrix of staff trained and assessment of competency post training.

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:	Compliance:	Partial Compliance: 10/24/14; 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	MDCR's information system that was implemented in February 2014 is providing useful reports regarding operational issues in the agency. The first reports from this system, along with their action plans are anticipated at the beginning of 2015. Clarify with DOJ the reporting time periods for both the bi-annual reporting and the actions plans and action plan updates.		
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 is aware of the concerns of the monitoring team and DOJ regarding inmate/inmate violence. See also III.A. 1.a.(2).
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The monitors and DOJ continue to track reports of inmate/inmate violence. MDCR provided data regarding inmate/inmate violence as of 7/31/14, but the action plans from that data are not yet provided.
Monitor's Recommendations:	1. Refine the data reporting system. 2. Request clarification from DOJ regarding the discrete data reporting elements of the SA. 3. Complete the directive governing bi-annual reports and compliance/quality management, provide formats to the monitors for review. 4. Develop action plans based on the requirements of the SA.

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:	Compliance:	Partial Compliance: 10/24/14, 3/28/14	Non-Compliance: Not yet due (11/27/13)
Unresolved/partially resolved issues from previous tour:	The staffing analysis is due to monitors and DOJ on 10/31/4. The contractor's (MGT of America's) report was provided in January 2014, and MDCR requested more time to review that document as well as provide additional data for the staffing not included as part of the contract. Additionally, the budget process has diverted the completion of this product. It is the plan that after DOJ and the monitors have reviewed the document, and MDCR makes any changes, it will be presented to the County.		
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:	There has been on-going review of staffing, which will result in a document being provided for review on 10/31/14.		

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The monitors are concerned about the level of staffing in MDCR. The requirements of the SA require additional staff to accomplish, participating for support and management levels. MDCR reports that there has been a significant increase in overtime, which might also support the need for more staff. A temporary moratorium on hiring due to budget issues has the potential for a negative impact on staffing, particularly because of the difficulty of recruiting in a more robust economy, and the time it takes from initial application to hire.
Monitor's Recommendations:	1. Develop a hiring timeline. 2. Improve hiring practices with the goal of shortening the time between application and hiring (e.g. hiring contract background investigators, more polygraphists, etc.). 3. Other recommendations will await the finalization of the staffing analysis and the County's response to the recommendations.

Paragraph Coordinate with Drs. Ruiz and Stern	III. A. 2. Security Staffing: b. MDCR shall ensure that the staffing plan includes staffing an adequate number of correctional officers at all times to escort inmates to and from medical and mental health care units.		
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance: 10/24/14, 3/28/14	Non-Compliance: 7/19/13
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/24/14; 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. This is an ongoing issue.
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. For example, multiple notations were identified in the discharge planning log which indicated that services could not be provided because "Officer not available."
Monitors' Recommendations:	Protection from Harm: See III. A. 2. a. Medical Care: None. Mental Health: See III. A. 2. a and III C. 7

Paragraph	III. A. 2. Security Staffing: c. MDCR shall staff the facility based on full consideration of the staffing plan and analysis, together with any recommended revisions by the Monitor. The parties shall agree upon the timetable for the hiring of any additional staff.		
Compliance Status:	Compliance:	Partial Compliance: 10/24/14; 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:	Compliance:	Partial Compliance:	Non-Compliance: 10/24/14; 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	See III. A. 2. a.		

assess compliance, verification of the County's representations, and the factual basis for finding(s)	
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 Coordinate with Drs. Ruiz and Stern	III. A. 3. Sexual Misconduct MDCR will develop and implement policies, protocols, trainings, and audits consistent with the requirements of the Prison Rape Elimination Act of 2003, 42 U.S.C. § 15601, et seq., and its implementing regulations, including those related to the prevention, detection, reporting, investigation, data collection of sexual abuse, including inmate-on-inmate and staff-on-inmate sexual abuse, sexual harassment, and sexual touching.		
Protection from Harm: Compliance Status:	Compliance: 10/24/14	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:
Medical Care: Compliance Status:	Compliance: 10/24/14	Partial Compliance:	Non-Compliance:
Mental Health: Compliance Status:	Compliance: 10/24/14	Partial Compliance:	Non-compliance: Not audited
Unresolved/partially resolved issues from previous tour:	MDCR was audited by the PREA Resource Center's auditor July 21 – 25, 2014. There were two areas requiring further attention – camera views in PTDC and Boot Camp participants under age 17. MDCR reports both these issues have been resolved and they are awaiting the auditor's return to verify compliance.		
Measures of Compliance:	Protection from Harm: 1. PREA policies and procedures 2. Self-audit (separate action plan to be based on MDCR's self-audit) [see http://static.nicic.gov/Library/026880.pdf] 3. Implementation of plans of action, etc., including audit based on self-audit. Medical Care: • Audit Step a: (Inspection) Medical staff receive appropriate PREA training. • Audit Step b: (Chart Review) Medical care delivered pursuant to a possible sexual assault is clinically appropriate and consistent with PREA. Mental Health: 1. PREA policies and procedures 2. Self-audit (separate action plan to be based on MDCR's self-audit) [see http://static.nicic.gov/Library/026880.pdf] 3. Implementation of plans of action, etc., including audit based on self-audit.		
Steps taken by the County to Implement this paragraph:	Protection from Harm: PREA Audit completed. Medical Care:		

	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: MDCR is one of a few of the 3,200+ local jails that have had their PREA audit and passed. MDCR is to be commended and recognized for this major accomplishment. In addition to reviewing the audit of the facilities, I also met with MDPD's Special Victims Unit and reviewed the 8 investigations into PREA-related allegations since the beginning of 2014. I was impressed by MDPD's commitment to the tasks and work. Medical Care: See PREA report. Mental Health:
Monitors' Recommendations:	Protection from Harm: 1. Continue to self-audit PREA compliance. 2. Continue on-going training for staff and inmate orientation. 3. Will review on-going PREA compliance during future tours. 4. Develop a system to advise the MDPD investigators if the alleged perpetrator and/or the alleged victim in on the jail's mental health caseload. 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:	Compliance: 10/24/14	Partial Compliance: 3/28/14,7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	None at this time		
Measures of Compliance:	Protection from Harm:		

	1. Policies and procedures regarding notifications to managers regarding critical incidents; actions required. 2. Policies and procedures regarding reportable incidents. 3. Documentation of notification managers; checklists/incident reports. 4. Review of incident reports. 5. Review of critical incidents. 6. Interview with supervisory and management staff. <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 written directives completed.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR directives provides that reportable incidents are documented at the end of each 8 hour shift.
Monitor's Recommendations:	Continue to self-audit compliance.

Paragraph	4. Incidents and Referrals b. Staff shall report all suicides and other deaths immediately, but no later than one hour after the incident, to a supervisor, Internal Affairs ("IA"), and medical and mental health staff.		
Compliance Status:	Compliance: 10/24/14	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/14
Unresolved/partially resolved issues from previous tour:	See III.A.4.a.		
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:	See III.A.4.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.4.a.		
Monitor's Recommendations:	See III.A.4.a.		

Paragraph	4. Incidents and Referrals c. MDCR shall employ a system to track, analyze for trends, and take corrective action regarding all reportable incidents. The system should include at least the following information: 1. unique tracking number; 2. inmate(s) name; 3. housing classification; 4. date and time; 5. type of incident; 6. any injuries to staff or inmate; 7. any medical care; 8. primary and secondary staff involved; 9. reviewing supervisor; 10. any external reviews and results; 11. corrective action taken; and 12. administrative sign-off.		
Compliance Status:	Compliance:	Partial Compliance: 10/24/14; 3/28/14	Non-Compliance: 7/19/13
Unresolved/partially resolved issues from previous tour:	Incident Self-Audit System (ISAS) operational in February 2014. Awaiting finalization of guiding written directive.		
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, and 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)	Monitors have reviewed draft written directive. Will be finalized in the coming months.		
Monitor's Recommendations:	1. Complete directive. 2. Assure appropriate staffing to support functions required by SA. 3. Self-audit, review of action plans and supporting data.		

Paragraph Coordinate with Drs. Ruiz and Stern	4. Incidents and Referrals d. MDCR shall develop and implement a policy to screen incident reports, use of force reports, and inmate grievances for allegations of staff misconduct and refer an incident or allegation for investigation if it meets established policy criteria.		
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13 (not yet due)
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	Written directive is in place. The grievance data base is due to be operational on 11/1/14 and MDCR will consider adding the names of officers to that data base to better track officer misconduct allegations.		
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding incident reports, including criteria for screening for critical incidents (see also III.A.3); 2. Documentation of referrals of grievances for investigations; outcomes. 3. Corrective actions for incidents not referred as required. 4. Review of medical and mental health policies and procedures regarding referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc. 5. Medical and mental health policies and procedure regarding review of medical grievances to screen for critical incidents. 6. Documentation of referrals to investigators by medical and/or mental health staff, if any. Medical Care: • Audit Step a: (Inspection) Medical policies and procedures address the screening of medical grievances for allegations of staff misconduct and their referral for investigation when appropriate. • Audit Step b: (Inspection) When interviewed, CHS leaders report screening medical incident reports and grievances for allegations of staff misconduct and referring for investigation when indicated by policy. • Audit Step c: (Inspection) Medical grievances and incident reports which contain allegation so of staff misconduct are referred for investigation. Mental Health: 1. Policies and procedures regarding incident reports, including criteria for screening for critical incidents (see also III.A.3); 2. Documentation of referrals of grievances for investigations; outcomes. 3. Corrective actions for incidents not referred as required. 4. Review of medical and mental health policies and procedures regarding referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc. 5. Medical and mental health policies and procedure regarding review of medical grievances to screen for critical		

	incidents. 6. Documentation of referrals to investigators by medical and/or mental health staff, if any.
Steps taken by the County to Implement this paragraph:	Protection from Harm: See above. DSOP 11-003; DSOP 15-001; DSOP 11-041. Medical Care: Not audited. Mental Health: CHS policy JOAO11 addresses grievances.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from harm: MDCR provided documentation of referrals for investigations based on inmate grievances, correspondence, phone calls and other contacts with MDCR. This work is also linked to the Early Warning System requirements of the SA. See also III.C. Medical Care: None Mental Health: None at this time.
Monitors' Recommendations:	Protection from Harm: See above, revision of policies. Medical Care: None. Mental Health: See recommendations in last compliance report.

Paragraph	4. Incidents and Referrals e. Correctional staff shall receive formal pre-service and biennial in-service training on proper incident reporting policies and procedures.		
Compliance Status:	Compliance:	Partial Compliance: 10/24/14; 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	Training lesson plans.		
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding training on preparing incident reports; and notification criteria for critical incidents.		

	2. Lesson plans; pre-service and in-service. 3. Training schedule and attendance rosters. 4. Documentation of knowledge gained (e.g. pre and post tests) 5. Evidence of remedial training, if needed. 6. Review of incident reports.
Steps taken by the County to Implement this paragraph:	See above, lesson plan revision necessary.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Written directives completed; monitors need to review training lesson plans.
Monitor's Recommendations:	Complete training lesson plans and provide to monitors for review.

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:	Compliance:	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance: 10/14 (Not audited)
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 post tests) 4. Evidence of remedial training, if needed. 5. Review of incidents in which medical/mental health issues reported and not reported. 6. Minutes of meetings between security and medical/mental health. <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 above Protection from Harm		
Steps taken by the County to Implement this paragraph:	<u>Protection from Harm</u>: Need for updating of lesson plans		

	Medical Care: Not audited. Mental Health: 2014: Specific training as to this provision was 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: Directive completed; need to review lesson plan. Medical Care: None. Mental Health: See last compliance report.
Monitor's Recommendations:	Protection from Harm: Provide updated lesson plan to monitors. 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. (same recommendation as last two compliance reports.)

Paragraph	III. A. 5. Use of Force by Staff a. Policies and Procedures (1) MDCR shall sustain implementation of the "Response to Resistance" policy, adopted October 2009. In accordance with constitutional requirements, the policy shall delineate the use of force continuum and permissible and impermissible uses of force, as well as emphasize the importance of de-escalation and non-force responses to resistance. The Monitor shall provide ongoing assistance and annual evaluation regarding whether the amount and content of use of force training achieves the goal of reducing excessive use of force. The Monitor will review not only training curricula but also relevant data from MDCR's bi-annual reports. (2) MDCR shall revise the "Decontamination of Persons" policy section to include mandatory documentation of the actual decontamination time in the response to resistance reports. (3) The Jail shall ensure that each Facility Supervisor/Bureau Commander reviews all MDCR incidents reports relating to response to resistance incidents. The Facility Supervisor/Bureau Commander will not rely on the Facility's Executive Officer's review.

Compliance Status:	Compliance:	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	MDCR has developed the relevant policies and procedures; monitors are concerned about the quality of the review of the incidents. MDCR has acted to establish a Trend Analysis and Action Planning Unit (TAAP) to assure quality review/control of use of force reports. This unit, however, is not specifically funded as part of MDCR's budget.		
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 above, MDCR has established a Trend Analysis and Action Planning Unit (TAAP) to address, among other issues, quality of use of force reports.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR has policies that address the requirements of this paragraph; but the application of those policies requires attention. I reviewed all use of force reports for June 2014 and provided the Director with my critique. In summary the major issues are the critical review of those incidents to assure not just the correct boxes are checked on forms – but to analyze the pre-incident issues, inmate classification, staff actions, alternatives, and emergent critical matters.		
Monitor's Recommendations:	1. Gain full funding for the Trend Analysis and Action Planning Unit (TAAP). 2. Train the members of the Unit to critique use of force (and other critical areas of operations) and develop and monitor plans of action. 3. Develop measures of Unit effectiveness. 4. Monitor through self-audit.		

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 12-005) to include the following minimum requirements: i. other than restraints for transport only, mechanical or injectable restraints of inmates with mental illness may only be used after written approval order by a Qualified Health Professional, absent exigent circumstances. ii. Four-point restraints or restraint chairs may be used only as a last resort and in response to an emergency to protect the inmate or others from imminent serious harm, and only after the Jail attempts or rules out less-intrusive and non-physical interventions. iii. the form of restraint selected shall be the least restrictive level necessary to contain the emerging crisis/dangerous behavior. iv. MDCR shall protect inmates from injury during the restraint application and use. Staff shall use the least physical force necessary to control and protect the inmate.

<table>
<tr><td></td><td colspan="3">v. restraints shall never be used as punishment or for the convenience of staff. Threatening inmates with restraint or seclusion is prohibited.
vi. any standing order for an inmate's restraint is prohibited.
(2) MDCR shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15 minute in-person visual observation by trained custodial staff. For any custody-ordered restraints, Qualified Medical Staff are notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.</td></tr>
<tr><td>Protection from Harm: Compliance Status:</td><td>Compliance:</td><td>Partial Compliance: 10/24/14, 3/28/14, 7/19/14</td><td>Non-Compliance:</td></tr>
<tr><td>Mental Health: Compliance Status:</td><td>Compliance:</td><td>Partial Compliance: 3/28/14, 7/19/13</td><td>Non-Compliance: 10/14</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="3">Complete written directive; coordinate with CHS' directives. Consider the use of restraints as prevention for use of force. (See Dr. Ruiz' comments/recommendations.)</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.
5. Review of use of seclusion.
6. Maintenance of data regarding uses of force involving inmates on the mental health caseload, by facility.</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="3"><u>Protection from Harm:</u>
None since March 2014 tour.

<u>Mental Health:</u>
See recommendations in previous compliance reports.</td></tr>
</table>

Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Need to review final directive; also collaboration with CHS. Mental Health: 2014: CHS stated that it has had no episodes requiring the use of restraint. In contrast, my review of the record was notable for various inmates that were administered intramuscular medication without a corresponding psychiatric progress note describing the circumstances for the need or attempts at de-escalation / lesser intrusive care.
Monitors' Recommendations:	Protection from harm: Complete directive; evidence of collaboration with CHS. 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:	Compliance: 10/24/14, 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)	No change since March 2014 tour. In my review of use of force reports for June 2014 I found compliance with this provision.		
Monitor's Recommendations:	MDCR monitor through self-audit.		

<table>
<tr><td>Paragraph
<u>Coordinate with Drs. Ruiz and Stern</u></td><td colspan="3">III.A. 5.c.
(2) MDCR shall ensure that use of force reports:
i. are written in specific terms and in narrative form to capture the details of the incident in accordance with its policies;
ii. describe, in factual terms, the type and amount of force used and precise actions taken in a particular incident, avoiding use of vague or conclusory descriptions for describing force;
iii. contain an accurate account of the events leading to the use of force incident;
iv. include a description of any weapon or instrument(s) of restraint used, and the manner in which it was used;
v. are accompanied with any inmate disciplinary report that prompted the use of force incident;
vi. state the nature and extent of injuries sustained both by the inmate and staff member
vii. contain the date and time any medical attention was actually provided;
viii. include inmate account of the incident; and
ix. note whether a use of force was videotaped, and if not, explain why it was not videotaped.</td></tr>
<tr><td>Protection from Harm: Compliance Status:</td><td>Compliance:</td><td>Partial Compliance: 10/24/14, 3/28/14</td><td>Non-Compliance: 7/19/13</td></tr>
<tr><td>Medical Care: Compliance Status:</td><td>Compliance:</td><td>Partial Compliance:</td><td>Non-Compliance: 10/14 (Not audited)</td></tr>
<tr><td>Mental Health: Compliance Status:</td><td>Compliance:</td><td>Partial Compliance:</td><td>Non-Compliance: 3/28/14, 7/19/13, 10/24/14</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="3">Revised directive due.</td></tr>
<tr><td>Measures of Compliance:</td><td colspan="3"><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</td></tr>
<tr><td>Steps taken by the County to</td><td colspan="3"><u>Protection from harm</u>:</td></tr>
</table>

Implement this paragraph:	See III.A.5.a. Medical Care: Not audited. Mental Health: 2013: During the prior site visit, the County provided the MDCR Inmate Violence Report for 2012O2013; it did not do so for 2013O2014. I reviewed specific cases that indicated mental health patients were placed in restraint without a medical order.
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.5.a. Medical Care: None. Mental Health: In 2012-2013, 21% of custody response to violence included 4-point 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 2013-2014, 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: See III.A.5.a. Medical Care: None Mental Health: Please see above, 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:	Compliance:	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues	See III.A.5.a.		

from previous tour:	
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:	See III.A.5.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.5.a.
Monitor's Recommendations:	See III.A.5.a..

Paragraph	III. A. 5.c. (4) The Facility Supervisor/Bureau Commander or his/her designee shall submit the MDCR Incident Report (with required attachments) and a copy of the Response to Resistance Summary (memorandum) to his/her Division Chief within 14 calendar days. If the MDCR Incident Report and the Response to Resistance Summary (memorandum) are not submitted within 14 calendar days, the respective Facility Supervisor/Bureau Commander or designee shall provide a memorandum to his/her Division Chief explaining the reason(s) for the delay.		
Compliance Status:	Compliance: 10/24/14	Partial Compliance: 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 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:	See also III.A.5.a.		

Paragraph _ Coordinate with Dr. Stern and Dr. Ruiz	III. A. 5.c. (5) The Division Chief shall review use of force reports, to include a review of medical documentation of inmate injuries, indicating possible excessive or inappropriate uses of force, within seven business days of submission, excluding weekends. The Division Chief shall forward all original correspondences within seven business days of submission, excluding weekends to Security and Internal Affairs Bureau.		
Protection from Harm: Compliance Status:	Compliance: 10/24/14, 3/28/14	Partial Compliance: 7/19/13	Non-Compliance:
Medical Care: Compliance Status:	Compliance: 10/14	Partial Compliance:	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/19/14, 10/24/14
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: Mental Health:		
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and	Protection from Harm: I did not evaluate the sufficiency of the medical evaluation of inmates who had been involved in a use of force. The reports I reviewed demonstrated that the inmate had been taken for review. In some instances, the notes from the		

the factual basis for finding(s)	medical provider were very brief. Medical Care: None. Mental Health: There is no system or analysis of incidents of use of force involving patients with developmental disabilities or mental illness.
Monitors' Recommendations:	Protection from Harm: See also III.A.5.a. 1. The TAAP Unit should evaluate with CHS and SIAB if the information provided on the medical review is sufficient for the investigators to draw conclusions. 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. This has yet to occur.

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:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 7/19/13
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 10/14	Non-Compliance: Not audited
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Unresolved/partially resolved issues from previous tour:	The written directive is in place; need for monitoring of referrals based on my review of June's use of force packages. See also III.A.5.a.		
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding criteria for referrals to IAB for use of force investigations. 2. Review of reports. 3. Review of medical and mental health policies and procedures for referrals regarding injuries consistent with excessive use of force, and other related critical incidents.		

	4. Documentation of referrals from medical/mental health to IAB. 5. Minutes of meeting between security and medical/mental health in which these topics are discussed/reviewed. 6. Treatment of inmates at outside hospitals. 7. PREA policies, data. 8. Review of investigations. 9. Review of remedial or corrective action plans, if any. Medical Care: • (duplicate) CONSENT044 (IIIB3c) Audit Step b: (Inspection) When interviewed, nurses and practitioners on staff report that when they evaluate patients with any injury, they always consider whether the injury might be the result of staff-on-inmate abuse, and if so, (1) take all practical steps to preserve evidence of the injury (e.g., photograph the injury and any other physical evidence); (2) report the suspected abuse to the appropriate Jail administrator; and (3) complete a Health Services Incident Addendum describing the incident. • Audit Step a: (Chart Review) Medical records of inmates subject to use of force where the force may be excessive, show evidence of referral (with patient permission) to jail authorities. Mental Health: See Protection from Harm Use of force reports as they relate to inmate with SMI and evidence of their adequate treatment both before and after the incident will be reviewed.
Steps taken by the County to Implement this paragraph:	Protection from Harm: MDCR has established the TAAP Unit (See III.A.5.a). This unit needs to be formally funded. Medical Care: Mental Health: See Protection from Harm
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: See III.A.5.a. Medical Care: MDCR did not request the Medical Monitor to audit this provision. However, it did ask for audit of provision CONSENT044 (IIIB3c) in the Consent Agreement which includes an audit step that is identical to an audit step here (CONSENT044 (IIIB3c) Audit Step b). During that audit, the Monitor found compliance. Mental Health: See previous compliance report.

Monitor's Recommendations:	Protection from Harm: See III.A.5.a. Medical Care: None. Mental Health: Use of Force incidents involving patients on the mental health caseload should be specifically tracked. This would assist in differentiating problematic cases of possible staff misconduct from routine staff assist when necessary, such as cell extractions and medication administration.

Paragraph	III. A. 5.c. (7) Security supervisors shall continue to ensure that photographs are taken of all involved inmates promptly following a use of force incident, to show the presence of, or lack of, injuries. The photographs will become evidence and be made part of the use of force package and used for investigatory purposes.		
Compliance Status:	Compliance: 10/24/14, 3/28/14	Partial Compliance: 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	None at this time.		
Measures of Compliance:	Protection from Harm: 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:	NA		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	I reviewed more than 30 use of force investigations for June 2014. All appropriately included photos and/or video.		
Monitor's Recommendations:	Continue to self-monitor compliance via TAAP.		

Paragraph	III.A.5.c. (8) MDCR shall ensure that a supervisor is present during all planned uses of force and that the force is videotaped.		
Compliance Status:	Compliance: 10/24/14	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	Nothing at this time.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force; supervisory presence; location of recording equipment; supervision of recording equipment (batteries charged, repairs needed, etc.) 2. Policies and procedures regarding digitally recording incidents; training for users; instructions. 3. Review of incident reports; including exceptions in which digital recordings not made. 4. Review of investigations; review of digitally recorded incidents. 5. Review of remedial or corrective actions, if any. 6. Interview with IAB staff.		
Steps taken by the County to Implement this paragraph:	NA		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The files I reviewed were consistent with the provisions of this paragraph.		
Monitor's Recommendations:	Continue self-monitoring via TAAP.		

Paragraph <u>See also PREA policies/procedures</u>.	III.A.5.c. (9) Where there is evidence of staff misconduct related to inappropriate or unnecessary force against inmates, the Jail shall initiate personnel actions and systemic remedies, including an IA investigation and report. MDCR shall discipline any correctional officer with any sustained findings of the following: i. engaged in use of unnecessary or excessive force; ii. failed to report or report accurately the use of force; or iii. retaliated against an inmate or other staff member for reporting the use of excessive force; or iv. interfered with an internal investigation regarding use of force.		
Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See III.A.5.a		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Personnel policies and procedures regarding employee discipline; relevant portions of CBAs. 2. Employee disciplinary reports; investigations. 3. Employee disciplinary sanctions. 4. Records of hearings, including arbitration hearings, if any.		

	5. Documentation of terminations for cause.
Steps taken by the County to Implement this paragraph:	See III.A.5.a
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. For the most part, appropriate referrals are being made. I have concerns about the totality of the referral process given my review of the use of force reports for June 2014. These issues have been discussed and documented with the Director and the TAAP unit. When operational issues are addressed and I evaluate future use of force reports I expect compliance will be achieved. Evidence was provided of employees who had been subject to disciplinary action and/or counseling.
Monitor's Recommendations:	See III.A.5.a.

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:	Compliance: 10/24/14, 3/28/14	Partial Compliance: 7/19/13	Non-Compliance:
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/14
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	<u>Protection from Harm:</u> 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. <u>Medical Care:</u> • (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:	<u>Protection from Harm:</u> NA <u>Medical Care:</u>		
Monitors' analysis of conditions to assess compliance, verification of	<u>Protection from Harm:</u> It appears from a review of the use of force reports from June 2014 that inmates are appropriately referred to medical.		

the County's representations, and the factual basis for finding(s)	<u>Medical Care:</u> MDCR did not specifically request that the Medical Monitor audit this provision, however, since the sole audit step is identical to an audit step for a provision in the Consent Agreement (CONSENT043 (IIIB3b) Audit Step a) for which MDCR did request auditing, this provision was, de facto, audited. Please see CONSENT043 (IIIB3b) in Part C of this report for detail.
Monitors' Recommendations:	<u>Protection from Harm:</u> Continue self-monitoring. <u>Medical Care:</u> Please see CONSENT043 (IIIB3b) in Part C of this report for detail.

Paragraph <u>Coordination with Dr. Stern</u>	III. A. 5.c. (11) Every quarter, MDCR shall review for trends and implement appropriate corrective action all uses of force that required outside emergency medical treatment; a random sampling of at least 10% of uses of force where an injury to the inmate was medically treated at the Jail; and a random sampling of at least 5% of uses of force that did not require medical treatment.		
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/24/14, 3/28/14, 7/19/13
Medical Care: Compliance Status:	Compliance: 10/14	Partial Compliance:	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	Complete the written directive; fund the TAAP Unit.		
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 above; complete the appropriate directive; fully fund the TAAP unit. <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:	Protection from Harm: See above and III.A.5.a. Medical Care: None.

Paragraph Coordinate with Drs. Ruiz and Stern	III.A.5.c. (12) Every 180 days, MDCR shall evaluate use of force reviews for quality, trends and appropriate corrective action, including the quality of the reports, in accordance with MDCR's use of force policy.		
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/24/14, 3/28/14, 7/19/13
Medical Care: Compliance Status:	Compliance: 10/14	Partial Compliance:	Non-Compliance:
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/13, 10/24/14
Unresolved/partially resolved issues from previous tour:	See IV. A – C. See also III.A.5.a.		
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 IV. A – C. See also III.A.5.a. Medical Care: Not audited. 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. 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 IV. A – C. See also III.A.5.a. Medical Care: None. Mental Health: 2013: 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:	Compliance: 10/24/14, 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)	No audit this tour.
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:	Compliance:	Partial Compliance:	Non-Compliance: 10/24/14, 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See above III.A.5. (11) and IV A – C.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding unauthorized uses of force and/or allegations of excessive force. Evaluation of uses of force involving inmates on the mental health caseload. 2. MDCR annual reporting, by facility. 3. Review of incidents. 4. Review of baseline for determining increases/decreases, and subsequent data reporting. 5. Observation and interview. 6. Review of a corrective action plans, if needed		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See above III.A.5. (11) and IV A – C.		
Monitor's Recommendations:	See III.A.5.c.(11) and IV A – C.		

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:	Compliance:	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	Awaiting revised lesson plans		
Measures of Compliance:	<u>Protection from Harm:</u> 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:	Awaiting revised lesson plans		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Awaiting revised lesson plans		
Monitor's Recommendations:	Awaiting revised lesson plans		

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

	reports, input into IAB review. 11. Evidence of medical and mental health cooperation/collaboration in IAB investigations into uses of force; e.g. requests for and release of inmate medical records. 12. Interviews with medical and mental health staff. <u>Medical Care:</u> [No medical audit step unless questions/issues are referred by the Security Monitor.] <u>Mental Health:</u> 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)	<u>Protection from Harm:</u> Did not review the updated SIAB procedures (more than the DSOP); if submitted prior to next tour, compliance is achievable. <u>Mental Health:</u> No issues were referred to the Medical Monitor by the Security Monitor during this visit. <u>Medical</u>: None.
Monitor's Recommendations:	<u>Protection from Harm:</u> 1. Provide the SIAB updated operating procedures. <u>Medical</u>: None. <u>Mental Health:</u> Not audited.

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 <u>analyze the data according to the following criteria:</u> i. number of incidents for each data category by individual officer and by all officers in a housing unit; ii. average level of activity for each data category by individual officer and by all officers in a housing unit; iii. identification of patterns of activity for each data category by individual officer and by all officers in a housing unit; and iv. identification of any patterns by inmate (either involvement in incidents or filing of grievances).		
Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	When the revised policy is in effect, this paragraph will be in compliance.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures establishing and maintaining the early warning system; including criteria for thresholds and referrals. 2. Existence of a fully functioning early warning system. 3. Reports generated by the early warning system as described above. 4. Evidence of employee actions (e.g. remedial training, EAP, disciplinary actions, terminations) based on early warning system. 5. MDCR report of trends, etc. regarding use of force and employee corrective actions. 6. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.		
Steps taken by the County to Implement this paragraph:	MDCR has had a functioning Early Warning System (EWS) in effect since February 2014. DSOP 4O107. The Security Operations and Internal Affairs Bureau (SIAB) receives the notices.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The system will be fully implemented when the directive is finalized. I met with the SIAB commander and reviewed materials, and memoranda that form the basis for counseling.		
Monitor's Recommendations:	1. Finalize and issue the directive. Consider a mechanism to assure that remediation, counseling, etc. is consistent among all facilities. Assure that training is provided to those who will be in charge at the facility level. Consider addition of formats for remediation to assure consistency among facilities. Consider modifying the soon-to-be-implemented grievance software to add the name of officers as an additional early-warning regarding behaviors which are inconsistent with departmental directives (e.g. rude).		

Paragraph	III. A. 6. Early Warning System b. MDCR will provide to DOJ and the Monitor, within 180 days of the implementation date of its EWS, and on a bi-annual basis, a list of all staff members identified through the EWS, and any corrective action taken.		
Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/24/14, Not yet due, 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See III.A.6.a.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding EWS and reporting. 2. Reports on EWS (180 days and bi-annually), as specified above. 3. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.		
Steps taken by the County to Implement this paragraph:	See III.A.6.a.105		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The due date for this first review will be dependent upon the date the directive is finalized.		
Monitor's Recommendations:	1. Complete the directive 2. Establish the due date and notify DOJ and the monitors.		

Paragraph	III. A. 6. Early Warning System c. On an annual basis, MDCR shall conduct a documented review of the EWS to ensure that it has been effective in identifying concerns regarding policy, training, or the need for discipline.		
Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/24/14 not yet due; 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See III.A.6.a.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding annual report. 2. Production of a review of the EWS; recommendations for changes, if needed. 3. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.		
Steps taken by the County to Implement this paragraph:	See III.A.6.a.		
Monitor's analysis of conditions to	This report would be due one year after the effective date of the directive governing the EWS.		

assess compliance, verification of the County's representations, and the factual basis for finding(s)	
Monitor's Recommendations:	1. Complete and issue the directive. 2. Provide proposed reporting formats to the monitors for review ahead of the annual report. 3. Include in self-audit process.

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:	Compliance:	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/14 (Not audited.)
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 3/28/14, 10/14 (Not audited.)
Unresolved/partially resolved issues from previous tour:	Awaiting final directive.		
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. <u>Medical Care</u>: • Audit Step a: (Inspection) The content of medical grievance replies is responsive and meaningful. As provided for in CHS Policy JOAO11, 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. <u>Mental Health:</u> See Protection from Harm and Medical Care
Steps taken by the County to Implement this paragraph:	<u>Protection from Harm:</u> Handbook is completed; awaiting review of sample of grievances. <u>Medical Care:</u> <u>Mental Health:</u> 2014: Specific to mental health, no grievances were reviewed.
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> Next tour – review of grievance trends, and review of a sample of inmate grievances. <u>Medical Care:</u> Not audited. <u>Mental Health:</u>

	2013: 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: See also Compliance Report # 2. Medical Care: MDCR should have access to facility and MDCR ADP-adjusted grievance rates (e.g. #medical grievances/100 inmates/month) trended over time. Mental Health: 2013: 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 SMIO 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 Coordinate with Drs. Ruiz and Stern, and Grenawitzke	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:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13
Fire and Life Safety: Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13
Medical Care: Compliance Status:	Compliance: 10/14	Partial Compliance:	Non-Compliance
Mental Health Compliance Status:	Compliance:	Partial Compliance: 10/24/14	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 self-audits. 2. Self-monitoring reports. 3. Corrective action plans, if any. 4. Evidence of implementation of corrective action plans, if any. Fire and Life Safety: 1. Development and implementation of effective and consistent policies for regular audits of all facilities housing inmates. It should include audits by designated staff trained in auditing techniques and the polices within each facility and from MDCR for all fire and life safety provisions as well as cleanliness, functioning of electrical and plumbing fixtures etc. 2. Inspections should result in identifying specific non-conformities to the policies and include the assigning of persons responsible for taking and documenting corrective actions including oversight to measure the effectiveness of same. Medical Care: [No medical audit step unless questions/issues are referred by the Security Monitor.] Mental Health: See Protection from Harm Review of minutes from Mental Health Review Committee and Quality Assurance Committee, including adequate and timely analysis of the quarterly MDCR Violence Report.		
Steps taken by the County to Implement this paragraph:	Protection from Harm: The directive governing this process is in final form, having been reviewed by the monitor and DOJ. Fire and Life Safety: DSOP 10-022 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 CIAB reviews the reports of all fire drills. When		

	issues are identified, corrections are documented. However, MDCR does not track the non-conformities to determine any trends that should be included in any refresher training programs for officers. Revisions to DSOP 10-022 have been drafted, I reviewed the proposed revisions and provided comments. However, the revised DSOP has not been issued. DSOP 4-018, Quality and Assurance and Improvement Procedures is not yet completed. Once completed, I would like to review the draft before it is authorized. 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: It is anticipated that the reports pursuant to this paragraph and the soon-to-be released directive will begin to be produced. MDCR is requesting clarification from DOJ regarding some data elements that do not appear to MDCR or the monitor as particularly relevant or helpful. A sample of the format was provided for the monitors' review. Fire and Life Safety: MDCR provided copies of all weekly fire safety inspections conducted by the Fie Safety Sanitation Officers (FSSOs) from April through September 2014 for review prior to the tour along with the copies of the CIAB monthly inspections for the same period. Documentation was provided showing that corrections were made when non-conformities were identified. On a couple of reports, non-conformities that were carried over from the previous report disappeared from subsequent reports without any evidence of corrective action taken. In reviewing reports of inspections completed by the Miami Dade Fire Prevention Department, I found that those inspections identified violations that should have been observed by an effective internal auditing program. MDCR needs to work with the Miami Dade Fire Prevention Department to understand specifically their requirements and modify the internal inspection program accordingly. As reported in Report II, there is still no evidence of training for officers responsible for conducting the fire safety internal audits. Medical Care: No issues were referred to the Medical Monitor by the Security Monitor during this visit. Mental Health: No issues were referred to the Medical Monitor by the Security Monitor during this visit.
Monitors' Recommendations:	Protection from Harm: 1. Complete and issue the directive; begin to prepare reports consistent with this paragraph. Fire and Life Safety:

	• Complete the revision to DSOP 10-022. • MDCR should collaborate with the local fire prevention authority to assure that MDCR's internal inspection program is consistent with the local fire authority. • Develop and implement a plan to train MDCR officers who are responsible for conducting internal audits and reporting. • Engage in data analysis to identify trends that may require modifications to DSOP policies and/or training materials. <u>Medical Care:</u> None. <u>Mental Health:</u> 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. Possible venues for discussion include the MAC meeting or the Mental Health Review Committee. Trends should be analyzed and systemic issues identified for improvement.

Paragraph <u>Coordinate with Drs. Ruiz and Stern, and Grenawitzke</u>	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:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, Not Yet Due (10/27/13)
Fire and Life Safety: Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, Not Yet Due(10/27/13)
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/14 (Not audited.)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 10/24/14, 3/28/14	Non-Compliance: Not Yet Due(10/27/13)
Unresolved/partially resolved issues from previous tour:	The data was provided; analysis was not provided. See also III.D.1. a. b.		
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. <u>Mental Health:</u> See Protection from Harm		

Steps taken by the County to Implement this paragraph:	Protection from Harm: Document with data produced; analysis not provided (d). Fire and Life Safety: Considerable data was provided regarding fire and life safety provisions; but there was no evidence of any analysis or identification of changes needed as a result of the analysis. Medical Care: Not audited. 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. However, this grid did not include an assessment of current vacancies. Recent submissions have not included adequate analyses on inmate-violence as it related to patients with mental health issues, nor has it included adequate analysis of factors related to self-injurious behavior and suicide prevention.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Document with data produced; analysis not provided (d). Fire and Life Safety: MDCR provided data, but no analysis. Medical Care: Not audited. Mental Health: Psychiatry • Staffing currently consists of seven FTEs. • Per diem psychiatry time has been unpredictable and unreliable • There is no 'relief factor' or back-up for vacancies or sick providers • There is no psychiatry time at booking / intake • Current plans continue to 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 p.m. to 7 am shift remains uncovered by a QMHP. • Psychologists • There are two psychologists. They primarily run group therapy and individual therapy.

Monitor's Recommendations:	Protection from Harm: Complete the directive and provide the analysis and action plans (and action plan updates). Fire and Life Safety: Provide evidence of analysis of data along with action plans to improve conditions for all fire and life safety provisions. 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:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, Not yet due (10/27/13)
Fire and Life Safety: Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: Not yet due (10/27/13)
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/14 (Not audited.)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 3/18/14	Non-Compliance: 10/14 (Not audited.) 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 post tests). 8. Observation. 9. Staff interviews. <u>Fire and Life Safety:</u> 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. <u>Medical Care:</u> • (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. <u>Mental Health:</u> See Protection from Harm
Steps taken by the County to Implement this paragraph:	<u>Protection from Harm:</u> As reflected in this report, progress is being made, but the provisions of this paragraph remain in partial compliance. <u>Fire and Life Safety</u>: There have been no changes from the previous reports as the policy revisions have not yet been completed and authorized. <u>Medical Care:</u> Not audited. <u>Mental Health:</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> MDCR continues to make progress regarding the major work in the Settlement Agreement. The work is reflected in the comments throughout this report.

	Fire and Life Safety: Same as above Medical Care: Not audited. 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:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13
Fire and Life Safety: Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13
Medical Care: Compliance Status:	Compliance:	Partial Compliance ;	Non-Compliance: 10/14 (Not audited.)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 10/24/14, 3/28/14	Non-Compliance: 7/19/13
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding compliance and quality improvement. 2. QI reports. 3. Corrective action plans, if needed. 4. Evidence of implementation of corrective action plans, if any. Fire and Life Safety: 1. Development and implementation of compliance with the provision 2. A process for corrective action plans and responsibility assigned Medical Care: • (duplicate) CONSENT120 (IV.B) Audit Step a: (Inspection) CDCR has policies and procedures governing its quality improvement process (described in CONSENT110/IIID1b (Audit Step a) and CONSENT110/IIID1c (Audit Step a). • (duplicate) CONSENT110 (IIID1b) Audit Step a: (Inspection) Review of appropriate documents (e.g. meeting minutes) reveal that at least quarterly CHS staff review data regarding medical care to identify potentially harmful		

	patterns or trends. Such review will include not only the active cause of the patterns or trends, but also the underlying (or root) cause(s). • (duplicate) CONSENT111 (IIID1c) Audit Step a: (Inspection) Review of appropriate documents reveals that within 30 days of quarterly reviews, MDCR staff have developed and implemented corrective action plans addressing potentially harmful patterns or trends in medical care. The corrective action plans address the active and underlying (or root) cause(s) in a sustainable manner (e.g. changes to policy, procedures, job descriptions, training curricula.) Mental Health: See Protection from Harm
Steps taken by the County to Implement this paragraph:	Protection from Harm: The directive has been completed in draft; is awaiting final approval and implementation. Fire and Life Safety: Not audited. Medical Care: Not audited. Mental Health: Not audited.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Complete the directive and implement. Fire and Life Safety: Develop and implement policies to address the provision. Medical Care: Not audited. Mental Health: Not audited.
Monitor's Recommendations:	Protection from Harm: See above. Fire and Life Safety: Develop and implement the policies as identified in the Measures of Compliance. Medical Care:

	None. Mental Health: None.

Paragraph Coordinate with Drs. Ruiz and Stern, and Grenawitzke	IV. COMPLIANCE AND QUALITY IMPROVEMENT C. On an annual basis, the County shall review all policies and procedures for any changes needed to fully implement the terms of this Agreement and submit to the Monitor and DOJ for review any changed policies and procedures.		
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, Not yet due 7/19/13
Fire and Life Safety: Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: Not yet due 3/28/14, 7/19/13
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/14 (Not audited) Not yet due 7/19/13
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 3/28/14	Non-Compliance: Not audited 10/24/14, 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	Protection from Harm:		

Implement this paragraph:	See IV. A. and B. Fire and Life Safety: See IV.A. and IV. B. Medical Care: Mental Health: Not audited.
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 IV. A. and B. Fire and Life Safety: See IV.A. and IV. B. Medical Care: Not audited. Mental Health: Not audited.
Monitor's Recommendations:	Protection from Harm: Develop written policy and procedures to comply with this paragraph. Fire and Life Safety: Develop and implement formal policies meeting the provision. Medical Care: None. Mental Health: Not audited.

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:	Compliance: 10/24/14	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:
Fire and Life Safety: Compliance	Compliance:	Partial Compliance: 10/24/14,	Non-Compliance:

Status:		3/28/14, 7/19/13	
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	Protection from Harm: 1. Production of policies and procedure for review. 2. Production of lesson plans, training schedules, tests Fire and Life Safety: 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.		
Steps taken by the County to Implement this paragraph:	Protection from Harm: Policy drafts are provided and comments are made to MDCR. Fire and Life Safety: MDCR has provided copies of 10-006, 10-010, 10-022, 10-023, and13-001 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)	Protection from Harm In compliance. Fire and Life Safety: 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 BOD.		
Monitor's Recommendations:	Protection from Harm: Continue to provide drafts. Fire and Life Safety: Development of policies and review process, along with a training component to assure training to changed policies is completed before making the policies effective. As recommended in the Fire and Life Safety provisions, provide me with drafts of the revised policies identified above. Provide a copy of DSOP 4-018 for review.		

Report B
Compliance Report # 3
Fire and Life Safety
Report of Tour October 20>22, 2014

Summary

Compliance Report # 3 is submitted in accordance with the Settlement Agreement in the matter 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 1:13ACVA21570ACIVAZLOCH. October 20 – 22, 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).

The following notes the changes in compliance since the initial tour:

Report #	Compliance	Partial Compliance	Non> Compliance	Not Applicable/Not Due Unable to Assess	Total
1	1	3	1	0	6
2	1	4	1	0	6
3	1	4	1	0	6

The purpose of this third tour was to again assess compliance with the Miami Dade Settlement Agreement Part B Fire and Life Safety Provisions. The report summarizes the findings for each provision and provides recommendations for improvement to meet the Settlement Agreement.

First, I want to recognize the leadership of the new director and her commitment and dedication to improve the conditions of confinement. Her hard work, in not only understanding of severity of the issues, but more importantly her ability, through cooperation and demands for excellence, are just beginning to have a positive influence in resolving the provisions of this settlement agreement. I would be remiss if I did not recognize and report on the hard work and the time that the staff of MDCR invested in preparing for this tour. The number of supporting documents provided helped me to prepare for the tour and allow me to focus my visit to monitoring and suggesting ways to help assure continuous improvement. The MDCR leadership at all levels is clearly committed to assure the safety and health of the inmates housed within the MDCR system. I am confident that I will see continued significant improvements and as a result be able to move into compliance, most, if not all provisions for fire and life safety.

Since the previous tour, MDCR made several improvements in the six fire and life safety provisions.

- Monthly fire drills are now conducted on all shifts in all facilities. Training of Fire Safety/Sanitation Officers (FSSOs) has resulted in regular weekly fire safety

inspections, along with monthly fire safety inspections completed by Compliance, Inspection and Accreditation Bureau (CIAB).

- Red emergency key access boxes are now in a consistent location within each facility so that any officer working there or transferring there knows specifically where and how to the keys.
- MDCR staff at all facilities are consistently diluting chemicals based on the chemical manufacturer's specifications.
- FSSOs in all facilities have implemented an effective inventory control process to enable management to know what chemicals have been distributed, to what location, and maintain an accurate inventory of chemicals within the chemical control storage rooms.
- New five-year contracts for inspections of fire alarms and fire suppressions systems have been signed by Miami Dade County, and implemented.
- MDCR has updated the facility specific inventory for sprinklers, smoke detectors, and strobes, pull stations, heat sensors, and shut off valves.
- 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.

The major focus of this tour was to conduct assessments of housing units and medical facilities at Boot Camp, Training and Treatment Center, Turner Guilford Knight (TGK), Pretrial Detention Center (PTDC), and Metro West Detention Center (MWDC). As reported in previous tour reports, housing unit cells and dormitories were generally maintained clean with no significant fire hazards in the cells. Inmates were storing commissary and personal belongings in their personal property bags.

MWDC, TGK, and Boot camp housing dormitories, cells, showers, and toilets were clean and well organized. However TGK, PTDC, and MWDC have some showers that need significant scouring to remove the buildup of dried soap residue followed by at least daily cleaning to prevent the accumulation.

The Training and Treatment Center (TTC) continues to be overcrowded with inadequate unobstructed space in the dormitories for the number of inmates housed there. Work in Building C to replace water supply lines, fix leaks, make repairs to showers and toilets, and repainting has been completed. In spite of that work, electrical cords and television cables extending into the cells from the common hallway continue to present a potential fire and safety hazard for inmates. TTC has no direct supervision of inmates. There are 30Aminute checks of cell areas by staff. As a result, inmates could access electrical cords to injure themselves or others. In Building B, leaking water lines in the pipe chase is creating standing water and dampness and the appearance of mold in the chases and musty odors in the adjoining dormitories. The windows had an accumulation of dirt and dust and did not appear to have been cleaned for some time. This condition severely limits the amount of natural light available in the dormitories. Inmate safety and health continues to be compromised as the facility continues to age with little resources to adequately maintain it. I believe Miami Dade needs to conduct a thorough building engineering assessment of TTC that includes the cost of necessary renovation of each of the buildings, the increased costs

of staffing necessary to operate that complex efficiently and effectively and determine whether it needs to replaced or continue dedicating dollars and staff resources to staff and maintain it.

At TGK most of the torn and no longer cleanable mattresses have been replaced, following up on my recommendation from the previous tour. However, at MWDC and at PTDC, numerous mattresses were no longer cleanable and in good repair and are used for inmate bedding. It appears there is no formal process to identify mattresses and change out those that are no longer serviceable.

All laundry facilities throughout all housing units are being equipped with automatic dispensing equipment to assure safe and effective dispensing of detergent, bleach, etc.

At PTDC, I toured floors 9, 10, kitchen, and chemical supply storeroom. There I noted that on floor 9 there is no written evidence to demonstrate that mattresses had been cleaned and disinfected prior to it being assigned to another inmate. The only evidence was on a typed release report for the inmate that had previously used the mattress. There is inadequate documentation to confirm cleaning and disinfecting. On other floors and in other facilities, there was a dedicated form taped to the door of all vacant cells. That form is completed and signed by the person completing the cleaning and disinfection of, not only the mattress, but also the toilet, floor etc.

The kitchen at PTDC is being remodeled. A new temporary kitchen is under construction that will house the food service until the existing kitchen can be completely rebuilt as a cook/chill operation.

As of this tour there were several DSOPs under revision that were being held up until completion of an overall policy development DSOP. As a result, important policies are not being released or implemented and the training curriculums for those policies are not yet developed/revised. I strongly recommend that a concerted effort be made to finalize the fire safety and evacuation, chemical control and key control policies. Also facility specific SOPs or Post Orders must be finished after the DSOP policies are released for implementation.

Recommendation: I again urge MDCR to consider eliminating 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.

When the revised policies are implemented, I will monitor and review written evidence of their implementation in accordance with the procedures specified, including effectiveness of training. The focus of future tours will be specifically to identify whether MDCR continues to just correct issues on a case-by-case basis; or truly focuses on the correcting the systemic causes of noncompliance.

One issue that needs to be addressed is the staffing for Support Services. THE MGT of

America's staffing analysis did not include either a review or recommendations about support services. The Director's soon-to-be-completed staffing review contains recommendations. The monitors will each review these staffing recommendations and assist MDCR in alerting the County governing regarding critical needs.

Report B: Summary of Fire and Life Safety Compliance
Tour October 20 - 24, 2014

Subsection of Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments:
III. B. Fire and Life Safety					
III.B.1.			x		
III.B.2.		x			
III.B.3.			x		
III.B.4.			x		
III.B. 5.			x		
III.B.6				x	
D. Audits and Continuous Improvement					
III. D.1.					See Report A
III.D. 2.					See Report A
IV. Compliance and Quality Improvement					
IV. A.					See Report A
IV. B.					See Report A
IV. C.					See Report A
IV. D.					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:	Compliance:	Partial Compliance: 10/14; 3/14; 7/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour(s):	*N/A First Tour*		
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. 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 policy, DSOP 10-022, entitled Fire Response and Prevention Plan effective 7/2/12. It is in the revision process. 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 including Fire Safety Sanitation Officers (FSSOs) for each facility, 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, Weekly Fire Safety inspections are completed by the designated FSSOs. Correspondingly, each facility also has developed a facility specific policy/plan for fire response and prevention to supplement 10-022. Many provisions restate much of the MDCR policy 10-022. The draft revisions to the facility specific fire response and prevention will remove the duplications to assure consistency with the MDCR policy. MDCR		

	would then have one policy in place for fire prevention and safety. The revised policy DSOP 10-022 should be released. in the next couple of months. MDCR utilizes a contractor, Underwater Unlimited to test SCBA units; Security Fire to conduct hydro tests and recharging of all fire extinguishers, MDCR has developed and maintains a facility specific location of all sprinklers, smoke detectors, strobes, pull stations, heat sensors and shut off valves for use in internal and contracted inspections.
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. It should be noted that Boot Camp and TTC are not equipped with sprinklers. However, they are equipped with smoke detectors, strobes, pull stations, heat sensors and shut off valves. Inspection of the fire and life safety equipment is conducted weekly by each facility's Facility Safety/Sanitation Officers (FSSO). MDCR has provided copies completed inspections from April through September 2014. Non-conformities identified are provided to the Facility Manager for review. A copy is provided to CIAB. Facility maintenance provides written corrective action for any issues identified on the reports. In addition Fire and Life Safety inspections are also completed monthly by CIAB. However, it is not clear if the inspections conducted by CIAB include a review of the weekly facility fire safety/sanitation officers. The monthly CIAB inspections are redundant and could be eliminated if a review of the weekly inspection reports completed by the FSSOs demonstrates compliance with documented corrective action. While reviewing the annual inspections conducted by the Miami Dade Fire Rescue Department for 2014 identified several violations that should have been found during internal inspections. The question that MDCR needs to resolve is why that is happening. During discussions on the tour with FSSOs, there seems to be no consistency with respect to what they are checking. For example, at MWDC the FSSO does not monitor the fire pump for pressure. This needs to be included. I suggest that CIAB work in cooperation with Miami Dade Fire Rescue and the City of Miami Fire Rescue to jointly develop a robust checklist that when implemented would be consistent with inspection criteria utilized by the fire departments. 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. The SCBA annual testing is being completed by Underwater Unlimited. However, the receipts provided are not facility specific. As a result, it is not possible to assure that all SCBA's have been checked. . Fire extinguishers are inspected every three years under contract and the extinguishers are inspected weekly by each facility's FSSO as noted on each fire extinguisher tag. However, at this tour. MDCR provided documentation demonstrating that he fire extinguisher testing by Security Fire is completed for all fire extinguishers for Boot Camp,

	TTC, TGK, PTDC, and MWDC.
Monitor's Recommendations:	1. Consider amending the written directive system to eliminate the redundancy of facility specific provisions for fire prevention and safety in the facility specific SOPs to assure consistency with 10-022. There should be one fire response and prevention plan policy for all of MDCR with facility fire response and prevention limited to each facility's fire and life safety equipment. 2. Assure the facility inspection forms used by the FSSOs for their weekly inspections are consistent with inspection parameters utilized by the respective Fire and Rescue Departments. Provide a copy of the revised inspection form. 3. Continue to provide copies of the completed weekly FSSO fire safety inspections at the end of each quarter, along with a corrective action report for each facility. 4. Clarify language in Policy 10-022 as to the responsibility of the reviewer of the weekly and monthly reports. 5. Clarify language in Policy 10-022 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. 6. Assure that Policy 10-022 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.

Paragraph(s):	**III. B. 2. Fire and Life Safety** 2. MDCR shall ensure that fire alarms and sprinkler systems are properly installed, maintained and inspected. MDCR shall document these inspections.		
Compliance Status:	Compliance: 10/24/14; 3/20/14; 7/20/13	Partial Compliance:	Non-Compliance:
Unresolved/partially resolved issues from previous tour(s):	*N/A First Tour*		
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. Development of either a MDCR or facility specific policy mandating at least an annual inspection of all fire alarms and sprinkler systems. The policy needs to include assurance of installation in accordance with all applicable fire codes and require effective repairs for any deficiency found. All policies and procedure are to be reviewed and updated as necessary at least annually on a schedule. 2. Establishment and implementation of a written contract with a company licensed to conduct the inspection, and make repairs. 3. Copies of the annual inspection reports and corrective actions taken for all non-conformances.		
Steps taken by the County to Implement this paragraph:	Miami-Dade County renewed its five year contract with Fred McGilvray Inc. of Miami, FL to inspect all fire sprinkler systems and provide maintenance for all facilities. The new contract period is 11/1/13O10/31/18. MDCR renewed a five year contract with Florida Fire Alarm of Miami FL to annually inspect, test, and certify the fire alarm systems for all MDCR facilities. The new contract period is 4/1/14O3/31/19 Miami-Dade Fire Rescue Department annually completes its independent annual fire safety inspection of each facility.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and	The only change from the previous report is that the contracts were renewed for the next five years as indicated above. Miami Dade Fire Rescue or the City of Miami Fire Rescue Department (dependent upon which agency has responsibility) also completed their annual inspections for all facilities. MDCR provided copies of the inspections for all		

the factual basis for finding(s)	facilities and included evidence of corrective actions taken for all notices of violations, along with a copy of the re-inspections completed. This provision continues to be in compliance.
Monitor's Recommendations:	1. Continue to provide evidence of inspection completions for 2015

Paragraph(s):	**III. B. 3. Fire and Life Safety**: 3. Within 120 days of the Effective Date, emergency keys shall be appropriately marked and identifiable by sight and touch and consistently stored in a quickly accessible location; MDCR shall ensure that staff are adequately trained in the location and use of these emergency keys.		
Compliance Status:	Compliance:	Partial Compliance: 10/14; 3/14; 7/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour(s):	*N/A First Tour*		
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. Establishment of a MDCR or facility specific policy outlining the policy and procedure and staff responsibility and accountability for the systematic marking of emergency keys. It must include sight and touch identification and designated locations for quick access for all keys. All policies and procedure are to be reviewed and updated as necessary at least annually on a schedule. 2. Implementation of the policy and procedure. 3. Documented evidence of officer and staff training on the policy and procedure.		
Steps taken by the County to Implement this paragraph:	DSOP policy 11-023 for Key Control in is the final stages of a revision that should eliminate the need for a separate policy for each facility as recommended in the previous report. The emergency keys for all facilities are notched, and equipped with glow sticks. Each facility has a "Red Box" containing the key that accesses the emergency key box. It is located in the Shift Commander's office. The "Red Box" is accessible by breaking the glass front. Using an attached hammer. The revision to DSOP 10-023, needs to reflect the established common location for the "Red Box". TTC maintains a complete set of alternate emergency keys for TGK, MWDC and PTDC. Boot Camp should be included. The policy requires that emergency keys be tested monthly. However, the policy does not specify the testing procedures to be followed by each facility's key control officer.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	All employees asked were able to describe correctly the accessing of emergency keys. During tours of all facilities, the key control officer used the emergency keys to access all locks and doors as evidence that the keys provided access as necessary. However, there was no consistency as to how those keys are tested. Some key control officers only tested their ability to open the emergency key box. The key control officer at MWC alternately tested the north side and the south side of the building, as each side has a separate emergency key ring located in a common emergency key box. DSOP 10-023 needs to specify the testing process and frequency for consistent practice. 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. MWDC 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. I		

	again observed that glow sticks were on all emergency key rings at all facilities. On future tours, I will continue to ask officers to demonstrate the use of emergency keys. Once DSPOP Policy 11-023 is effective, this provision will be in compliance.
Monitor's Recommendations:	1. Complete the revision of MDCR Policy 11-023 to reflect the common location of emergency key access box and the location of the emergency keys. Once completed, revise the training curriculum to reflect the revised policy and expectations. 2. Provide evidence of training to the revised policy and procedure. 3. 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:	Compliance:	Partial Compliance: 10/14; 3/14; 7/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour(s):	*N/A*		
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. Establishment of a MDCR or facility specific policy outlining the policy and procedures including staff responsibility and accountability for conducting fire drills within each facility at least once every three months on each shift. The policy shall include applicable drill reports that outline at a minimum start and stop times of the drills and the number of inmates who were moved as part of the drills, a formal review process for each drill that identifies the root cause of any identified non-conformities, along with documented verified corrective actions taken as a result of the analysis. 2. Appointment of facility specific fire safety officers that assures at least one trained designated officer on duty on all shifts to oversee fire drills and verify corrective actions as necessary for non-conformities. 3. Development of a confidential annual drill schedule that meets the minimum requirements of the "Settlement Agreement." 4. Documented evidence that the fire drills are conducted that meet the minimum requirements specified.		
Steps taken by the County to Implement this paragraph:	DSOP 10-022 entitled "Fire Response and Prevention Plan" requires that the AIB commander or Departmental Safety Officer (DSO) conduct fire drills. It further states that there be a quarterly fire drill on each shift, in each area of the facility" as outlined in the "MDCR Fire Drill Procedures." It establishes four levels of drills: They include 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 Compliance Accreditation and Inspections Bureau Fire Drill Report form is required to be completed and forwarded to the Shift Supervisor/Commander and the Facility/Bureau Supervisor for review and signature before forwarding to CIAB. The drills are scored using a numerical score for acceptability. MDCR has established Policy 10-006 that establishes emergency procedures and evacuation. Correspondingly, each facility also has developed a facility specific policy/plan for fire response that supplements the DSOP 10-006. Many provisions restate much of the MDCR policy.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	DSOP Policy 10-022 and 10-006 are currently being revised. MDCR has formally appointed one Fire Safety/Sanitation Officer for each facility. MDCR has established an annual fire drill schedule for each facility. MDCR provided copies of fire drill reports for seven consecutive months beginning with from March 2014 as evidence that a minimum of one fire drill per month for each facility was completed. Drill reports reviewed showed that only Level II drills were conducted. There were no Level 4 drills conducted. DSOP 10-22 requires one Level IV drill every six months. The scoring process is subjective and not based on any type of weighting system for critical and non-critical elements. MDCR should consider eliminating the scoring mechanism, As an alternative focus management attention to addressing non-conformities and inconsistencies. I found no evidence of documented corrective actions taken as a result of the drills. The reports were reviewed and accepted by supervisors. However it is not clear what the significance supervisor's signature represented. This should be specified in the revision to Policy 10-022. MDCR's CIAB maintains copies of all drills, but has not used the information to determine any need for changes to either policy or training curriculum. It appears that the drill reports only serve to demonstrate that required drills are conducted as required in the provision, but lacks evidence of how the information learned during the drills is utilized. Further there is no evidence that any Facility Captain uses the information to make improvements. It is also not clear as to how many Level 1 or Level 3 drills are required. I suggest that MDCR consider revising the drill policy to establish two types of drills, one with movement of inmates and one with simulated movement. The local fire department should be provided a copy of the annual schedule and invited to participate in any drill for their training purposes and to address interagency coordination issues. At a minimum the policy continues to need clarification. I would like to continue receiving the drill reports monthly, along with a summary documenting any non-conformity identified and how it was addressed. By reviewing monthly, I will have adequate time to prepare for future visits. The MDCR objective should be that all officers understand the fire response and evacuation plan for the facility in which they are assigned and should be able to demonstrate that understanding. This is important considering the six month bidding process that officers can use to move to different facilities. All officers should be part of drills at least once every three years. That goal is more important than the quarterly frequency. This provision continues in partial compliance.

Monitor's Recommendations:	1. Provide me a copy of the draft revision of 10-022 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. It should also be included in the "biennial training" specified in III BO6. 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 each month for my review. The reports need to include a summary of 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. Consider establish only two types of drills a suggested in the Monitor's analysis. 4. Provide a copy of the 2015 fire drill schedule for MDCR by January 2015. 5. Provide the list of the designated fire safety/sanitation officers (FSSO). MDCR should consider a fire safety officer for each shift at 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:	Compliance:	Partial Compliance: 10/14; 3/14	Non-Compliance: 7/13
Unresolved/partially resolved issues from previous tour(s):	*N/A First Tour*		
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. Establishment of either a MDCR or facility specific documented policy outlining the procedures including staff responsibility and accountability for the control of all chemicals in the jail including cleaning, maintenance, pest control, food service and flammables. This includes procedures for chemical spill response and cleanup and personal protective equipment including but not limited to gloves, eye, and skin protection. 2. Establishment of either a MDCR or facility documented specific policy outlining the safe and effective use of chemicals including training requirements and supervision of inmates who have access to them. 3. Evidence of effective implementation of the policies and procedures. 4. Each facility shall maintain spill kits in their designated chemical supply areas that are replaced as necessary. 5. Observations by the monitor.		
Steps taken by the County to Implement this paragraph:	MDCR developed DSOP 10-010 entitled "Chemical Control". However, that policy continues to be in a revision by Policy Development and has not been reissued. I provided comments on the draft in February 2014. Sanitation Officers for each division have received training on chemical safety and appropriate dilution of chemicals. However, the training was based on the current edition of DSOP 10-010 and not policy as being revised. Further, the training PowerPoint slides addressed chemical safety and dilutions, but did not include the process of how officers will assure that inmate workers are appropriately supervised. Staff supervising the inmates must also be trained on the control and safe use of all chemicals.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and	In reviewing the chemical control inventory and distribution process with designated Firs Safety Sanitation Officers (FSSOs) at Boot Camp, TTC, TGK, PTDC, and Metro West, I found them to be implemented correctly. The chemical storage rooms at all facilities were well organized, and secure. Safety Data Sheets (SDSs) were available for all		

the factual basis for finding(s)	chemicals stored in the respective chemical control rooms. Following my recommendation from the precious report MDCR has begun installing mechanical dilution systems for chemicals at all facilities. All laundry washers in each facility will also have electronic systems to dispense detergent and bleach directly into the washers, eliminating the risk of inmate workers misusing laundry chemicals for personal laundry. 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 provisions in the revised DSOP 10-010. I understand that the training will be provided by a designated trained FSSO. This provision will move to "partial compliance" once the revised policy has been reissued, and most likely to substantial compliance once evidence of the training to the revised policy has been completed.
Monitor's Recommendations:	1. Complete and issue the revised Chemical Control Policy 10-010. 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 revised written policy. 3. Provide evidence of training of all sanitation officers for each shift and inmate workers who have responsibility to use or supervise inmates using chemicals in housing areas, kitchens, classrooms, etc. for all facilities.

Paragraph(s):	**III. B. 6. Fire and Life Safety** 6. MDCR shall provide competency-based training to correctional staff on proper use of fire and emergency equipment, at least biennially.		
Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/14; 3/14; 7/13
Unresolved/partially resolved issues from previous tour(s):	*N/A First Tour*		
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. Establishment of either 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 45 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)	On this tour MDCR staff again stated that this provision is not required to be met for two years from the effective date of the settlement agreement. I again clarified that compliance with the provision should have started immediately. The provision is clear that it is the biennial training on the "safe and effective use of all fire and emergency equipment" is measured when the "biennial training" process is implemented. As of this tour no documentation has been provided that demonstrates any compliance with this provision. Refresher training has not started and there is no training syllabus or outline developed or provided. As outlined in the previous report the refresher training curriculum should be developed based on identified shortcomings from internal fire drills, both internal and external fire safety inspections and existing fire safety laws, regulations, and standards. The provision further requires that the training be "competency based". That means there needs to be a validation process such as a written exam that documents the training was effective. This provision continues to be non-compliant.
Recommendations	The recommendations from Monitor Report #1 for this provision remain unchanged. 1. Develop a MDCR DSOP that establishes the requirement for competency based biennial training for all correctional staff on safe and effective use of fire and emergency equipment. Include in the policy a list of the fire and emergency equipment for which training will be provided. 2. Create a training plan that outlines how the policy will be implemented and include a schedule for completion of the first round of refresher training. 3. Develop and implement a tool to measure competency that is based on current DSOP policies including, but not limited to 10-006, 10-022, and 10-023. 4. Provide evidence of implementation of the refresher-training program as established in the provision.

APPENDIX B*1

Materials Reviewed Prior To and Following Miami Dade Tour 3

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. DSOP 10:006, "Emergency Procedures Re: Evacuation;" Effective 6/6/2012
7. Draft Revision DSOP 1:006 Fire Drills and 10:022 Fire Response and Prevention; June, 2014; Provided Comments
8. Draft Revision DSOP 11:023 Key Control July, 2014; Provided Comments
9. Draft 11:020 Facility Checklist Procedures and forms for each facility 8/14
10. Draft DSOP 13:001 Sanitation; Provided Comments 9/14
11. Sign in Sheets for Fire Drill Procedures 2 hour training dated 10/17/14, 11/19/13, 11/21/13, 11/25/13, 12/19/13, 7/24/14, 7/25/14, 7/28/14, 7/30/14, and 8/12/14
12. DSOP 10:022 and DSOP 10:022 Fire Response and Prevention Plan Lesson Plan draft 2014
13. MDCR DSOP 10:010, "Chemical Control Effective;" 2014 draft
14. MDCR DSOP 11:023, "Key Control;" Effective 6/11/2012
15. Facility Specific Key Control SOPs and Post Orders for Boot Camp, TTC, TGK, PTDC, and MWDC
16. MDCR Dire Drill Procedure Training 10/17/13
17. Fire Drill Reports: Boot Camp 3/14:9/14
18. Fire Drill Reports: MWDC 3/14:9/14
19. Fire Drill Reports PTDC 23//14:9/14
20. Fire Drill Reports, TGK 3/14:9/14
21. Fire Drill Reports: TTC 3/14:9/14
22. Facility specific location list of sprinklers, smoke detectors, strobes, pull stations, heat sensors, and shut off valves
23. Miami Fire Rescue Department 2014 annual fire inspections for Boot Camp, TTC, TGK, PTDC, MWDC
24. MDCR's CIAB monthly fire safety inspections 3/14:9/14/2014 for Boot Camp, TTC, TGK, PTDC, MWDC
25. Miami Dade Contract Award for Fire Alarm testing and inspection with Florida Fire Alarm
26. Florida Fire Alarm Inc. annual inspections for Boot Camp, TTC, TGK, PTDC, and MWDC
27. Miami Dade Contract Award for Fire Sprinkler inspection and testing with Fred McGilvray Inc.
28. National Fire Protection LLC, Fire Pump Flow Test for MWDC, and TGK
29. National Fire Protection LLC Fire Sprinkler System inspection and Testing for MWDC, TGK, PTDC
30. Triangle Fire Inc. kitchen hood inspections for MWDC, PTDC, and TGK
31. Underwater Unlimited receipts of SCBA testing (not facility specific)
32. Copy of work orders to replace all fire hoses
33. Security Fire's Fire Extinguisher checks and hydro tests to Boot Camp, TTC, TGK, PTDC, MWDC, Feb & Mar, 2014
34. MDCR Fire Extinguisher Inventory Boot Camp, MWDC, WDC, PTDC, TGK, TTC
35. SCBA Inventory: Boot Camp, MWDC, WDC, PTDC, TGK, TTC
36. PTDC Facility Weekly Fire Safety Report 3/7/14 and 3/31/14
37. MDCR Fire Extinguisher/Hoses and SCBA Inspection Schedule for March, 2014
38. MDCR Organizational Chart 1/20/2014

APPENDIX B:2

Persons Interviewed During the Tour

Marydell Guevara, Director
Division Chief Edwin Cambridge, Stable Housing
Commander Debra Graham, Food Services
Lt. Jan Smith, Compliance and Audit Bureau
Division Chief Cassandra Jones, Compliance Division
Cpl Gonzalez
Lt. Brown TGK
Sgt. Beyer, TGK
Lt. Rose Green, Boot Camp
Officer Anita Robbins, FSSO Boot Camp
CPL Gillario Boot Camp
Cpl. Delacruz, FSSO TGK
Capt. John Johnson, Compliance and Audit Bureau
Capt. Angela Lawrence, Training
Assistant Director Walter Shuh
Captain Enrique Rodriguez, MWDC
Mike Galvin, Facility Maintenance Manager MWDC
Key Control Officer MWDC
Captain Cynthia Young, TTC
Captain Yvonne Richardson, TGK
Captain Ed Denson, PTDC
Simon Waterman, Chief, Facilities Management Bureau
Ed Villavacencio, Facility Management

Report C (Previously Reports C and Report D)

Compliance Report # 3

Medical and Mental Health Care

Report of Tour October 21C24, 2014

Foreword

In previous Compliant Reports, Report C (Medical Care) and Report D (Mental Health Care) were separate reports. In the interest of simplicity, and after concurrence by jail authorities[1], the Monitors are combining these two reports into a single integrated report. We are providing separate narratives focusing on the two areas. The sections of the report detailing information about each of the provisions have been combined such that the order of the provisions matches the order of the Consent Agreement. Each provision is clearly marked to indicate whether the input was provided by the Medical Monitor (Dr. Stern) or Mental Health Monitor (Dr. Ruiz). The appendices are also combined showing the documents reviewed, persons interviewed, and patient cases reviewed.

It is our hope that the new format it more user friendly and facilitates the jail's success in this venture.

Medical Care

Introduction

The Medical Monitor conducted this tour with the assistance of Catherine M. Knox, RN, MN, CCHPURN, and Angela Goehring, RN, MSA, CCHP. During the course of the tour, this team of three interviewed custody and health care leaders, middle managers, and front line staff, interviewed patients, reviewed administrative documents, reviewed medical records, and observed operations.[2]

In response to the Medical and Mental Health Monitors' request, prior to the tour, the jail informed the Monitors of the groups of provisions of the CA on which it was prepared to be audited (Intake Screening, Record Keeping, Discharge Planning, Use of Force, and Suicide Prevention Training). Accordingly, the Monitors limited their formal audits to those

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[1] In its comments to this report, custody and health representatives asked us to clarify which department (MDCR/CHS) has primary responsibility for remediation of the various provisions. The Monitors appreciate that the terms MDCR and CHS have a legal significance. However, the respective roles of each in remediation is a matter internal to the jail operation and beyond the scope of what the Monitors should direct. Thus to remain sensitive to the legal issue, but not overstep our scope, we have changed the relevant references in our report to "the jail."

[2] Each provision of the CA in the structured section of this report below calls for "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):" Where this box is blank, it should be assumed that the Monitor used a combination of the data sources described above.

provisions. With rare exception,[3] all the provisions for which Miami Dade County indicated they were not prepared are thus rated as non-compliant.

The health service at MDCR has undergone four changes in leadership since our first tour. During that time some progress has been made toward compliance with these provisions, but it has been slow. Three months ago Mr. Manny Estrada was hired as Health Services Director. Mr. Estrada has made a number of changes to his own leadership team that should increase its effectiveness. Director Estrada and his team have started to make changes to operational infrastructure. Those changes are not directly measured in most of the provisions we audited. Hence very few provisions were assessed as Compliant. However, the changes are important for creating the foundation for the improvements that are measured by the provisions, and thus the Medical Monitor is hopeful that these changes will bear measurable improvements in coming audit cycles.

Leadership

The Monitor observed a significantly increased level of joint management by the custody and medical leaders in comparison to his last tour.

The Monitor did not evaluate staffing levels at the front-line level. At the mid-management level there are significant gaps. There is a single health service administrator (HSA) at each of the three major facilities. These HSAs each have around 100 direct reports and are also responsible for day-to-day operations, nursing supervision, 24U7 coverage, and facility leadership. It is unreasonable to expect any single person to do this job. A single physician serves as the medical director for two of the three major facilities. Given the size and complexity of these two operations, the distance between them, and the intensity of changes that the jail will be experiencing over the next couple of years, this is another challenging job for a single person. Thus there is an urgent need for additional mid-management positions. There is also need to bolster the core team at the upper level of health care management at the jail. Among other expertise, consideration should be given to positions dedicated to human resources, budget and finance, and information technology.

Technical Assistance

The jail requested technical assistance on two additional groups of provisions (Mortality and Morbidity Reviews and Access to Care). During the tour the Medical Monitor provided the requested assistance on these two groups of provisions: The Monitors discussed ways of improving the way the jail analyses adverse events and implements resultant system changes, and he discussed approaches to clinic management, included access to care for episodic care.

[3] For a few provisions, it was obvious to the Monitors that Miami-Dade County was in compliance or partial compliance, even though the jail had not requested, and the Monitors had not planned, a formal audit. In those cases, the most appropriate rating was assigned.

The Monitor provided technical assistance on two additional areas: the role of custody staff in ensuring unimpeded access to acute care, and detoxification services. In addition to more detailed recommendations about detoxification, both Monitors encouraged the jail to adopt an overall approach to managing detoxification care in which medical professionals take the lead, and mental health professionals provide specialty support as needed. To honor that recommendation on our own part, the Monitors have modified the format of provision Consent006/IIIA1f in this report such that it is no longer a provision shared by the Medical and MH Monitors, but rather is the primary responsibility of the Medical Monitor.

Though not specifically addressed in the CA, drug and alcohol abuse treatment services are an integral part of chronic disease care and correctional health services, as addressed in CONSENT019/IIIA3b, the introduction to IIIB, and CONSENT040/IIIB2a. The scientific evidence for the efficacy (and cost efficiency) of drug and alcohol treatment in reducing addiction (and recidivism) is strong. Thus provision of care for this serious medical need is necessary in a constitutionally adequate health care system. While detoxification and/or referral to community providers may be adequate care for patients who stay in MDCR for short periods of time, chronic care is necessary for others. Whether provided by the jail or other organizations or agencies, the jail will need to continue to assure that chronic care is provided.

Mental Health Care

Introduction

The Mental Health Monitor conducted this tour with the assistance of Brian Betz, PhD.

As previously noted by the Medical Monitor, Dr. Stern, in response to our request, prior to the tour, MDCR informed the Monitors of the groups of provisions of the Consent Agreement (CA) on which it was prepared to be audited. These included: Intake Screening, Record Keeping, Discharge Planning, Use of Force, and Suicide Prevention Training. Accordingly, we limited our formal audits to those provisions and those are the only provisions on which we report in the following sections.

In July 2014, MDCR and Jackson collaborated to hire Mr. Manny Estrada as its Director of Healthcare. Mr. Estrada and his healthcare team are beginning the process of assessing the landscape and implementing slow change. Because the healthcare leadership has been in a state of transition for several months, it may be that very few provisions were assessed as Compliant. A well thought out plan that encompasses both accountability as well as data-driven analysis of the factors impeding success will be a key factor in turning the corner.

Mental Health Staffing

Staffing levels are difficult to evaluate for a variety of reasons. The primary reason mental health staffing is difficult to assess is that there are no crisp and clean rules: essentially, one needs as many staff as one needs to get the job effectively and adequately done.

Thus, measures of adequate staffing include access to adequate screening, access to timely health care, access to adequate discharge planning, appropriate management of patient care in use of force situations, etc. Relative to these variables, we were informed that no psychiatrist is available for consultation at intake screening. Patients that are triaged to Level 1 9C are generally seen by a psychiatrist within 24 hours within arrival to the jail. However, patients screened Level II, III or Level IV are not seen in a timely manner.

Vacancies exist at both the psychiatrist as well as in other mental health positions. In one case, a patient screened at intake was described as "profane, rambling incoherently, and not oriented to time or place." He was not seen by a psychiatrist until over one month after his admission when he was urgently referred to the mental health unit. Within one week of attempting to decrease his level of care, this patient expired. As such, mental health staffing was inadequate to cover the needs of the facility.

Dual Diagnosis and Detoxification

Many patients with alcohol use disorders are at risk of withdrawal. In these cases, frequent checks of heart rate and vital signs are vital. Withdrawal seizures may be life threatening. The Mental Health Monitor encourages MDCR to adopt an overall approach to managing detoxification care in which medical professionals take the lead, and mental health professionals provide specialty support and consultation as needed. To honor that recommendation on our own part, the Monitors have modified the format of provision IIIA1f in this report such that it is no longer a provision shared by the Medical and Mental Health Monitors, but rather is the primary responsibility of the Medical Monitor, utilizing the Mental Health Monitors as consultants as needed.

Many patients with alcohol abuse or substance use disorders have dual diagnoses. In these cases, the Mental Health Monitor urges our medical staff and colleagues to consult and call on their mental health colleagues for support and advice.

Use of Force

Policies with regard to Use of Force, Response to Resistance and inmates with special needs are discordant with respect to the Consent Agreement, generally accepted practices, and current operating procedure. The Mental Health Monitor noted several notations of intramuscular medications that were not documented as a restraint and for which no progress note existed documenting the circumstances requiring the restraint. Further, the Mental Health Monitor was informed that the facility does not use the restraint chair or other restraint(s), yet it has made elaborate plans for the future use of these modalities. It has purchased both restraint chairs as well as beds that can be utilized with four-point restraints. It is the Mental Health Monitor's opinion that these events are happening and that they are not being adequately documented. While this is not problematic if it is done safely, it should always be documented. This is not occurring. The Monitor's opinion is based upon medical record review, staff interview, and review of video of incident(s) that occurred. It is not clear whether patients with mental health disorders were routinely

being assessed by a qualified health professional when they were involved in a use of force or response to resistance incident. A separate report will follow with details regarding specific cases.

Appendices

List of Documents Reviewed by the Monitor teams (Appendix CU1)
List of Staff Interviews by the Monitor teams (Appendix CU2)
List of Patients Reviewed by Monitor teams (Appendix C U3) (not available in the public version of this document)

Report C/D: Summary of Status of Compliance 7 Consent Agreement (Medical and Mental Health) for all Tours

Report #	Compliance	Partial Compliance	Non-Compliance	Not Applicable/Not due/Other	Total
1	1	56	40	22	119
2	0	38	73	8	119
3	2	19	98	0	119

Report C/D: Summary of Status of Compliance 7 Consent Agreement (Medical and Mental Health) for Tour October 20 – 24, 2014

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

Subsection of Agreement	Page	Compliance	Partial Compliance	Non7Compliance	Comments:
A. MEDICAL AND MENTAL HEALTH CARE					
1. Intake Screening					
III.A.1.a.	92		MH; Med		
III. A. 1. b.	95		MH		
III. A. 1. c.	96			MH	
III.A.1.d.	97			MH; Med	MH/Med Not Audited
III.A.1.e.	99		MH	Med	Med Not Audited
III.A.1.f.	101		MH; Med		
III.A.1.g.	103		MH; Med		
2. Health Assessments					
III.A.2.a.	104			Med	Med Not Audited
III. A. 1. b.	105			MH	MH Not Audited
III. A. 1. c.	106			MH	MH Not Audited
III. A. 1. d.	107			MH	MH Not Audited
III.A.2.e.	108			Med	Med Not Audited
III.A.2.f. (Covered in (IIIA1a) and C (IIIA2e))	109			MH; Med	MH/Med Not Audited
III.A.2.g.	111			MH; Med	MH/Med Not Audited
3. Access to Med and Mental Health Care					
III.A.3.a.	112		MH; Med		
III.A.3.a.(1)	113	MH; Med			
III.A.3.a.(2)	114	Med		MH	MH Not Audited
III.A.3.a.(3)	115	MH; Med			
III.A.3.a.(4)	116			MH; Med	MH/Med Not Audited
III.A.3.b.	117			MH; Med	MH/Med Not Audited

Subsection of Agreement	Page	Compliance	Partial Compliance	Non7Compliance	Comments:
4. Medication Administration and Management					
III.A.4.a.	119			MH; Med	MH/Med Not Audited
III.A.4.b(1)	121			MH; Med	MH/Med Not Audited
III.A.4.b(2)	123			MH; Med	MH/Med Not Audited
III. A. 4. c.	135			MH	MH Not Audited
III. A. 4. d.	126			MH	MH Not Audited
IIIA.4.e.	137			MH; Med	MH/Med Not Audited
III.A.4.f. (Covered in (III.A.4.a.)	128			MH; Med	MH/Med Not Audited
5. Record Keeping					
III.A.5.a.	129		MH; Med		
III.A.5 b.	133		MH		
III.A.5.c.(Covered in III.A.5.a.)	134		MH; Med		
III.A.5.d.	135		MH; Med		
6. Discharge Planning					
III.A.6.a.(1)	137		MH; Med		
III.A.6.a.(2)	139		MH; Med		
III.A.6.a.(3)	141		MH; Med		
7. Mortality and Morbidity Reviews					
III.A.7.a.	143			MH; Med	MH/Med Not Audited
III.A.7.b.	145			MH; Med	MH/Med Not Audited
III.A.7.c.	146			MH; Med	MH/Med Not Audited
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1. Acute Care and Detoxification					
III.B.1.a.	147			Med	Med Not Audited.
III.B.1.b. (Covered in (III.B.1.a.)	149			Med	Med Not Audited.
III.B.1.c.	151			Med	Med Not Audited.
2. Chronic Care					
III.B.2.a.	152			Med	Med Not Audited.
III.B.2.b. (Covered in (III.B.2.a.)	153			Med	Med Not Audited.
3. Use of Force Care					
III.B.3.a.	154			Med	
III.B.3.b.	156			Med	
III.B.3.c. (1) (2) (3)	157		Med		

C. MENTAL HEALTH CARE AND SUICIDE PREVENTION					
1. Referral Process and Access to Care					
III. C. 1. a. (1) (2) (3)	158			MH	MH Not Audited
III. C. 1. b.	160			MH	MH Not Audited
2. Mental Health Treatment					
III. C. 2. a.	161			MH	MH Not Audited
III. C. 2. b.	162			MH	MH Not Audited
III. C. 2. c.	163			MH	MH Not Audited
III. C. 2. d.	164			MH	MH Not Audited
III. C. 2. e. (1) (2)	165			MH	MH Not Audited
III. C. 2. f.	166			MH	MH Not Audited
III. C. 2. g.	168			MH	MH Not Audited
III. C. 2. g. (1)	169			MH	MH Not Audited
III. C. 2. g. (2)	170			MH	MH Not Audited
III. C. 2. g. (3)	171			MH	MH Not Audited
III. C. 2. g. (4)	172			MH	MH Not Audited
III. C. 2. h.	173			MH	MH Not Audited
III. C. 2. i.	174			MH	MH Not Audited
III. C. 2. j.	175			MH	MH Not Audited
III. C. 2. k.	176			MH	MH Not Audited
3. Suicide Assessment and Prevention					
III. C. 3. a. (1) (2) (3) (4) (5)	177			MH	MH Not Audited
III. C. 3. b.	178			MH	MH Not Audited
III. C. 3. c.	179			MH	MH Not Audited
III. C. 3. d.	180			MH	MH Not Audited
III C. 3. e.	181			MH	MH Not Audited
III. D. 3. f.	182			MH	MH Not Audited
III.C.3.g.	183			MH; Med	MH/Med Not Audited
III. C. 3. h.	185			MH	MH Not Audited
4. Review of Disciplinary Measures					
III. 4. a. (1) (2) and b.	186			MH	MH Not Audited
5. Mental Health Care Housing					
III. 5. a.	187			MH	MH Not Audited
III. 5. b.	188			MH	MH Not Audited
III. 5. c.	189			MH	MH Not Audited
III. 5. d.	190			MH	MH Not Audited
III. 5. e.	191			MH	MH Not Audited

6. Custodial Segregation					
III. 6. a. (1)	192			MH	MH Not Audited
III. 6. a. (2)	194			MH	MH Not Audited
III. 6. a. (3)	195			MH	MH Not Audited
III. 6. a. (4) i	196			MH	MH Not Audited
III. 6. a. (4) ii	197			MH	MH Not Audited
III. 6. a. (5)	198			MH	MH Not Audited
III. 6. a. (6)	199			MH	MH Not Audited
III. 6. a. (7)	200			MH	MH Not Audited
III. 6. a. (8)	201			MH	MH Not Audited
III. 6. a. (9)	202			MH	MH Not Audited
III.C.6.a.(10)	203			MH; Med	MH/Med Not Audited
III. 6. a. (11)	205			MH	MH Not Audited
7. Staffing and Training					
III. C. 7. a.	206			MH	MH Not Audited
III. C. 7. b.	207			MH	MH Not Audited
III. C. 7. c.	208			MH	MH Not Audited
III. C. 7. d.	209			MH	MH Not Audited
III. C. 7. e.	210			MH	MH Not Audited
III. C. 7. f.	211			MH	MH Not Audited
III. C. 7. g. (1)(2)(3)	212			MH	MH Not Audited
III. C. 7. h.	213			MH	MH Not Audited
8. Suicide Prevention Training					
III. C. 8. a. (1 – 9)	214		MH		
III. C. 8. b.	216		MH		
III. C. 8. c.	217		MH		
III. C. 8. d.	218		MH		
9. Risk Management					
III. C. 9. a.	219			MH	MH Not Audited
III. C. 9. b. (1)(2)(3)(4)	220			MH	MH Not Audited
III. C. 9. a. (1)(2)(3)(4)(5)	221			MH	MH Not Audited
III. C. 9. d. (1)(2)(3)(4)(5)(6)	222			MH	MH Not Audited
D. AUDITS AND CONTINUOUS IMPROVEMENT					
1. Self Audits					
III.D.1.a.					
III.D.1.b.	223			MH; Med	MH/Med Not Audited
III.D.1.c.	224			MH; Med	MH/Med Not Audited

2. Bi-annual Reports					
III.D.2.a. (1)	225				Not Audited
III.D.2.a. (2)	225			MH; Med	MH/Med Not Audited
III.D.2.a. (3)	226				Not Audited
III.D.2.a. (4)	227				Not Audited
III.D.2.a. (5)	228				Not Audited
III.D.2.a.(6)	229			MH; Med	MH/Med Not Audited
III.D.2.b.(Covered in (IIID1c)	230			MH; Med	MH/Med Not Audited
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IV.B	233			MH; Med	MH/Med Not Audited
IV.C	235			MH; Med	MH/Med Not Audited
IV. D.					Not Audited
JOINT REPORTING – Settlement Agreement					
III.A.1.a. Ruiz					See Report A
III.A.2.b.					See Report A
III.A.3.					See Report A
III.A.4.d.					See Report A
III.A.4.f.					See Report A
III.A. 5. b. Ruiz					See Report A
III.A. 5.e. Ruiz					See Report A
III.A.5.c.2.vii.					See Report A
III.A.5.c.5.					See Report A
III.A.5.c.6.					See Report A
III.A.5.c.10.					See Report A
III.A.5.c.11.					See Report A
III.A.5.c.12.					See Report A
III.C.1-6					See Report A
III.D.2.a.4v .(Covered in (III.D.2.a.(6))					See Report A
V.A. (Covered in (IV.A)					See Report A
IV.B. (Covered in (IV.B)					See Report A
IV.C. (Covered in (IV.C)					See Report A

Abbreviations:

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

A. MEDICAL AND MENTAL HEALTH CARE

1. Intake Screening

Paragraph Author: 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' 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; 10/14	Non-Compliance: 3/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14; 10/14; 3/14	Non-Compliance: 7/13 (Not audited)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Intakes conducted in a confidential setting • 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 or training documents specify an appropriate training strategy for nurses who perform intake medical screening (e.g. who is trained, how often, qualifications of trainers, curriculum, lesson plans, teaching materials, assessment of competency with knowledge and skills). • Audit Step j: (Inspection) Training records show that nurses who perform intake medical screening receive training as specified in policy. Mental Health Care, as above and: 1. Record review that qualified mental health staff are conducting mental health screening and evaluation 2. Results of internal audits 3. Review for policies, procedures, practices. 4. Review of in-service training. 5. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	Medical Care: MDCR has completed its re-staffing of the Intake Screening area such that screening is only conducted by RNs. They have also completed a major renovation of the health assessment area that results in much improved work area, patient flow, and confidentiality. There are 3 stations available for MH assessments and 2 areas for medical practitioner assessments. MDCR has added auxiliary telephone handsets in Pre-Screening, Intake Screening, and Assessment areas that allow confidential use of Interpreter Lines (i.e. by averting the need to use a speaker phone). Soundproofing		

	material for the Intake Screening booths is now on site and expected to be installed in the next few 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):	<u>Medical Care:</u> The Monitor reviewed numerous medical records, toured the Intake area, and spoke with front line staff and managers. The following problems remain. 1. The MH assessment area was originally designed for 2 stations. A clerical station was converted to a 3rd station. This third station does not provide for adequate confidentiality from the other 2 stations. 2. Some information in the Intake Screening form is left blank. 3. MDCR is orienting nurses, social workers, and practitioners to the Pre-Screening, Intake Screening, and Health Assessment functions. <u>Mental Health Care:</u> We reviewed numerous medical records, toured the Intake area, and spoke with front line staff and managers. There has been a vast improvement in the LEO Lobby and the intake screening area as a whole. Staff have access to translation lines and confidentiality has been improved with the exception of one station. The following problems remain: • The intake screen does not assess for 'emergent' vs. 'urgent' psychiatric referrals. • It is difficult to determine whether the social worker screening the inmate at booking has read prior mental health records (no notation is made in the record of such).
Monitors' Recommendations:	<u>Medical Care:</u> 1. MDCR has revised the policy governing Intake Screening and Booking. The policy is improved but still requires further work to make it short, clear, accurate, and easily usable. The training program also requires further development and/or documentation. Whether in policy or training materials, the following elements of training should be clear: who is trained, how often, qualifications of trainers, curriculum, lesson plans, teaching materials, assessment of competency with knowledge and skills. 2. If MDCR needs to continue to use a 3rd MH assessment station, the area should be configured to ensure auditory confidentiality. 3. The recommendation from the previous report is reiterated: Nurses collect clinical information during Pre-Screening that may be of importance for the nurse conducting Intake Screening. However, there is no indication that Intake Screening nurses actually review this information. Changes should be made to make it easy for Intake Screeners to see this information, to ensure that it is reviewed, and to document such review. To this end, the following changes (or changes that have similar effect) should be implemented: a) the information collected during Pre-Screening should appear automatically when an Intake Screener begins a screening; b) the Intake Screening form should include documentation that this information was reviewed (and provide a mechanism for annotating it if necessary) – the easiest way to do this would be by adding a check-off box indicating that the information was reviewed; c) optimally, the electronic health record (EHR, Cerner) should have a forcing function that does not allow the nurse to complete the Intake Screening unless the check-off box has been checked or there is documentation why not. 4. Nurses should collect all information required during Intake Screening or should document why they did not. In an

	EHR this should be accomplished by a forcing function that does not allow the nurse to complete the form unless all fields are completed or an explanation for blank fields is provided. 5. Though not a patient safety issue nor a requirement of the CA, and therefore not enforceable, MDCR should consider eliminating the blanket patient consent form signed during Intake Screening. Due to its vagueness and broadness it is insufficient to constitute informed consent for any intervention for which informed consent might later be required. Thus it serves no purpose, but consumes time for the health care team and generates work for medical records staff. <u>Mental Health Care:</u> 1. The Consent Agreement specifically makes reference to 'emergent' vs. 'urgent' psychiatric referrals.

Paragraph Author: Ruiz	III. A. 1. Intake Screening: b. CHS shall sustain its policy and procedure implemented in May 2012 in which all inmates received a mental health screening and evaluation meeting all compliance indicators of National Commission on Correctional Health Care J-E-05. This screening shall be conducted as part of the intake screening process upon admission. All inmates who screen positively shall be referred to qualified mental health professionals (psychiatrist, psychologist, psychiatric social worker, and psychiatric nurse) for further evaluation.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/2014; 10/14	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	1. Results of internal audits demonstrating compliance with NCCHC indicator J-E-05 2. Results of internal audits demonstrating completion of intake screening upon admission 3. Result of internal audit demonstrating 90% or more of inmates who screen positively shall be referred to qualified mental health professionals for further evaluation 4. Record review 5. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	CHS has written policy: 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 14-008) 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 the factual basis for finding(s)	CHS has retrofitted clinical space for improved confidentiality and it has QMHPs (social workers) available at intake to screen patients with signs or symptoms of mental illness. To date, the night shift from 11 pm to 7 am remains without a social worker, mental health mid-level, or psychiatrist. No internal audits were provided for review.		
Monitor's Recommendations:	The Monitor recommends: 1. CHS update its policies and procedures so that they are consistent with the Consent Agreement 2. 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. 3. Train all medical and mental health staff on intake procedure and process. 4. Complete self-audits of accuracy of level / triage system for mental health care and access to care.		

Paragraph Author: Ruiz	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:	Non-Compliance: 3/14; 10/14
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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 and updated policies relevant to Basic Mental Health Care, Suicide Prevention and Use of Restraint and Seclusion. 2. MDCR policy (DSOP 12-003) outlines Suicide Prevention and Response Plan. It covers the responsibility of all staff to identify inmates at risk of suicide. In reference to housing, it states: 3. If an inmate displays signs of suicidal tendencies, he/she shall be placed in a single suicidal non-stripped cell separate from other inmates. The inmate shall be under direct observation until IMP mental health staff has evaluated the inmate's degree of risk. A Physical Sight Check Sheet shall be documented at intervals not to exceed 15 minutes by sworn staff and/or medical staff. Checks may be documented more than 4 times per hour.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR/CHS policy requires "appropriate intervention" for inmates at risk of suicide. In practice, our review was unable to find cases of patients placed on constant observation or defined as 'emergent' referrals to psychiatry. In practice, the facility does not differentiate between urgent and emergent mental health referrals.		
Monitor's Recommendations:	The Mental Health Monitor recommends CHS differentiate urgent referrals from emergent referrals and assign / triage care as needed. In addition, she recommends review of all adverse events related to inmates with mental health and/or and substance use issues for qualitative analysis and corrective action.		

Paragraph Author: 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); 10/14
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited): 10/14
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Interview with Intake nurses reveals that after identification of "emergency referral" in Intake, patient stays under constant observation. • Audit Step b: (Chart Review) A patient identified as having an emergency medical need is seen by a practitioner immediately. Mental Health Care, as above and: 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:	Medical: MDCR identifies people who are unstable medically or psychiatrically and require urgent referral with a pink wristband. Mental Health Care: MDCR identifies persons who are unstable medically or psychiatrically and require urgent referrals with a pink wristband. This includes patients that are returns from State mental hospitals or purple bands.		
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: According to staff, this provision does not really apply to medical patients, because anyone sick enough to need constant observation for medical reasons is so sick that they would be evacuated to the hospital. One patient who was referred urgently to a practitioner (i.e. within 4 hours) was not seen for 9 hours. A more common problem is that despite having identified a patient has being unstable (medical or MH) and requiring evaluation by a practitioner within 4 hours, these patients may be removed from MDCR to go to court without any approval by health care staff. This creates a very dangerous situation. Mental Health Care: The Medical Monitor was told that MH patients identified as requiring constant observation are placed in one of two rooms in the booking area. In that location, custody staff observe them every 15 minutes, and nursing staff observe them "as required." Nurses document their rounds in custody records, thus there is no record of their nursing assessments in the patient's medical record.		

Monitors' Recommendations:	Medical Care: 1. If this document is revised, the concept of "emergency referral" in this provision should be clarified to be consistent with MDCR's terminology; it should be clear what constitutes a medical or MH emergencies, the designation used for patients with MH emergencies, and how the pink wristband applies to these various patients. 2. Patients identified as being unstable ("pink band"), whether for medical or MH reasons, cannot be removed from the premises without involvement of health care personnel for any reason. Mental Health Care: 1. Patients identified as requiring closer observation for MH reasons require an individualized order for monitoring by health care personnel. In the absence of such order, they should be placed on the highest level of observation (constant, one-on-one) until further evaluation by a MH professional. 2. If a patient is placed on intermittent observation (15 minutes), the interval of observation should be random intervals of 15 minutes or less, not constant (and therefore predictable) intervals of 15 minutes. 3. Nursing assessments done during periods of closer observation **may** be recorded in a custody log, but they **must** be recorded in the patients' health care record.

Paragraph Author: Stern and Ruiz	CONSENT005 (III.A.1.e.) CHS shall obtain previous medical records to include any off-site specialty or inpatient care as determined clinically necessary by the qualified health care professionals conducting the intake screening.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited), 3/14 (Not audited); 10/14
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14	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 Care, as above and:</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> Implementation of an EHR has vastly improved the access to previous medical records as the vast majority of patients have had their previous care in the JMS system, and therefore their records are already in the EHR. This is a pivotal improvement. <u>Mental Health Care:</u> The electronic health record contained prior records from Jackson. In addition, many of the charts reviewed contained records from outside providers, as well, which had been scanned into the EHR.		
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> Though most records are already in the EHR and therefore do not have to be requested, the Monitor found 2 cases where non-JMS records existed but were not requested, one medical and one MH. As to the records already in the EHR, the Monitor could find no documentation that those records were reviewed by the practitioner during Health Assessments. While observing one practitioner, that practitioner did not review previous records. <u>Mental Health Care:</u> Although many records are available from prior contacts within the Jackson system, few progress notes made reference to the content of outside medical records. In the cases reviewed of persons returning from the State hospital, medications were generally continued indicating that the records had been reviewed.		

Monitors' Recommendations:	<u>Medical Care:</u> 1. To ensure that necessary non-JMS medical records are requested, MDCR should add this step to Intake Screening as part of the screening form. 2. Practitioners conducting Health Assessments should review available previous medical records or should document why they did not. In an EHR this should be accomplished by a forcing function that does not allow the practitioner to complete the form unless review is documented or an explanation is provided. <u>Mental Health Care:</u> 1. To ensure that records are reviewed from contacts both within JMS and outside JMS, MDCR should add a notation within the progress note that reminds the provider to summarize prior notes including prior diagnoses and relevant findings such as medications administered in the emergency department or discharge medications. 2. Practitioners should review available medical records or should document why they did not.

Paragraph Author: Stern	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; 10/14	Non-Compliance: 3/14 (Not audited)
Measures of Compliance:	• 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 & f: (Inspection) Policy or training documents specify an appropriate training strategy for nurses who perform intake screening for drug and alcohol use and withdrawal (e.g. who is trained, how often, qualifications of trainers, curriculum, lesson plans, teaching materials, assessment of competency with knowledge and skills) . • 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.		
Steps taken by the County to Implement this paragraph:	MDCR has a policy that addresses some aspects of training. They have also developed some teaching materials for this training. Staff training records were provided.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	There have not been any significant developments since the last tour. The system for identifying, and beginning monitoring of, patients at risk for drug or alcohol withdrawal is not yet robust. Additionally, during the tour, the Mental Health Monitor identified patients who had been referred to mental health because of changes in mental status or slurred speech who were actually in withdrawal or were acutely intoxicated and belonged in the detoxification unit instead with appropriate monitoring of vital signs and access to medical care. During Intake Screening, the form calls for the nurse to ask a single history question about substance abuse ("Do you abuse or overuse drugs or alcohol?"). In the physical examination portion of the form, the form calls for the nurse to make two additional assessments ("Appears to be under the influence of and/or withdrawing from drugs or alcohol" and "Current Withdrawal Symptoms"). There is second form ("Addiction History") that calls for the nurse to document the use of drugs and alcohol in more depth. These tools are potentially good, but there are two problems with the way they are used. First, it appears that the second form is only used if the patient answers "yes" to the history question (i.e. the history question serves as a "gateway question" to the second form). This is too high a bar. Patients will only answer "yes" if <u>they</u> believe they have a problem. Second, even when the nurse has other information suggesting that the patient has a substance abuse problem, if the patient did not respond "yes" to the gateway question, the nurse does not automatically use the second form to inquire further into substance use. For example, the second patient in Appendix C-3 responded "no" to the gateway question. However, the nurse noted that he appeared to be under the influence of and/or withdrawing from drugs or alcohol, yet did not use the Addiction History form to document drug		

	and alcohol use in more depth; the nurse's summary/disposition was "No behavioral health or medical health problems, approved to general population." In light of the fact that the nurse found the patient to be intoxicated, this conclusion was incorrect and potentially dangerous.
Monitors' Recommendations:	1. The current Addiction History form should be used during Intake Screening, whether the patient acknowledges he/she has a substance abuse problem or not. 2. Electronic "forcing functions" should be incorporated into the Intake Screening forms to help prevent the kind of error described above. For example, if the answer to a question or assessment about substance abuse indicates an elevated risk of withdrawal, at the time the nurse determines final disposition, the EHR should force the nurse to document that he/she acknowledges that a significant problem was identified during the screening, but still chooses to assign the patient to general population. 3. CHS should consider adding questions to the Intake Screening form from the "Simple Screening Instrument for Substance Abuse [SSI-SA]," a validated questionnaire developed by the Substance Abuse and Mental Health Services Administration (SAMSHA) of the US DHHS. It can be found within SAMSHA TIP 42 at http://www.ncbi.nlm.nih.gov/books/NBK64197/pdf/TOC.pdf. 4. For patients at high risk for (or already in) alcohol or opiate withdrawal, the initial symptom scoring (COWS or CIWA) should be completed in the Intake area. 5. MDCR's Medical Director wisely noted that one of the best outcome measures of the adequacy of the system for screening for risk of substance withdrawal is the degree to which few if any patients are discovered to be in withdrawal while in general population (in other words, if the system is working well, all patients in withdrawal in the Detoxification Unit should have been admitted there from the Intake area, not general population). As this is a high risk/high liability issue, MDCR should develop a simple tool that allows managers to monitor this metric (e.g. EHR report) 6. The policy or training materials for this provision need some clarification and amendment to embrace the recommendations above. 7. Mental health care staff should be consulted on any patient or person suspected of dual diagnosis or who develops emotional issues in the setting of substance abuse, intoxication, or withdrawal.

Paragraph Author: 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: 10/14	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14	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 Care, as above: See Medical Care		
Steps taken by the County to Implement this paragraph:	[See CONSENT001/IIIA1a]		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	[See CONSENT001/IIIA1a]		
Monitor's Recommendations:	[See CONSENT001/IIIA1a]		

2. Health Assessments

Paragraph Author: Stern	CONSENT008 (III.A.2.a.) Qualified Medical Staff shall sustain implementation of CHS Policy J-E-04 (Initial Health assessment), revised May 2012, which requires, inter alia, staff to use standard diagnostic tools to administer preventive care to inmates within 14 days of entering the program. [NB: This requirement is not about diagnostic tools or prevention – it is about the entirety of the health assessment. It was driven by detainees not getting, or getting inadequate initial health assessments. /MS]		
Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited); 10/14 (Not audited)
Measures of 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/IIIA4b(2), and CONSENT008/IIIA2a.		

Paragraph Author: Ruiz	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	Non-Compliance: 10/14: Not audited
Unresolved/partially resolved issues from previous tour:	3/2014: 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.		
Measures of Compliance:	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 CHS-059. 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)			
Monitor's Recommendations:	3/2014: It is recommended that CHS consider developing and implementing policy for suicide risk assessment by QMHPs. 10/2014: None		

Paragraph Author: Ruiz	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	Non-Compliance: 10/14: Not audited
Unresolved/partially resolved issues from previous tour:	3/2014: It is recommended that CHS develop and implement a policy for suicide risk assessment by QMHPs. As noted by the NCCHC[4], suicide risk assessment should be viewed as an ongoing process, as it may be necessary at any point during incarceration.		
Measures of Compliance:	1. Review of policy regarding mental health evaluation and screening 2. Record review for adherence to trigger events, referral and assessment as described in Appendix A. 3. Interview of staff and inmates. 4. Review of all adverse events involving inmates with mental health and substance misuse issues.		
Steps taken by the County to Implement this paragraph:	CHS Suicide Prevention policy is covered in J-G-05. 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:			

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

Paragraph Author: Ruiz	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	Non-Compliance: 10/14: Not audited
Unresolved/partially resolved issues from previous tour:	3/2014: 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.		
Measures of Compliance:	1. Review of policy regarding mental health evaluation, risk management and documentation 2. Record review for adherence to screening, trigger events, referral and assessment as described in Appendix A. 3. Interview of staff and inmates.		
Steps taken by the County to Implement this paragraph:	Treatment plans and their implementation are outlined in CHS policy, J-G-04 Addendum 1. MDCR does not have a companion correctional policy for interdisciplinary treatment plans.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	1. Section 2 of J-G-04 states, "2. Inmates arriving to the jail and who are assessed as Level I or II and who remain in the jail for 30-days and who remain as Level I or II will have an interdisciplinary team meeting and assessment with a plan of care by day 45 of their initial evaluation and placement as Level I or II." 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. The Monitor 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:			

Paragraph Author: Stern	CONSENT012 (III.A.2.e.) An inmate assessed with chronic disease shall [be] seen by a practitioner as soon as possible but no later than 24-hours after admission as a part of the Initial Health Assessment, when clinically indicated. At that time medication and appropriate labs, as determined by the practitioner, shall be ordered. The inmate will then be enrolled in the chronic care program, including scheduling of an initial chronic disease clinic visit.		
Medical Care Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited); 10/14 (Not audited)
Measures of Compliance:	• 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 Author: Stern and Ruiz	CONSENT013 III A. 2. f. (Covered in CONSENT001 (IIIA1a) and CONSENT012 (IIIA2e)) All new admissions will receive an intake screening and mental health screening and evaluation upon arrival. If clinically indicated, the inmate will be referred as soon as possible, but no longer than 24-hours, to be seen by a practitioner as a part of the Initial Health Assessment. At that time, medication and appropriate labs as determined by the practitioner are ordered.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14; 10/14 (Not audited)
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 Care, as above and: 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: 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 Care: None		

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 Care: NA

Paragraph Author: 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14 (Not audited); 10/14 (Not audited)
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 Care, as above and: 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 Mental Health 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: Mental Health Care: NA		
Monitor's Recommendations:	Medical Care: None Mental Health Care: NA		

3. Access to Medical and Mental Health Care

Paragraph Author: 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: 10/14	Non-Compliance: 7/13; 3/14 (Not audited)
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 10/14	Non-Compliance: 7/13; 3/14
Measures of Compliance:	Medical Care: Compliance on this umbrella provision is achieved by compliance with the component sub-provisions: CONSENT015-CONSENT018 (III.A.3.a.(1)-(4)) Mental Health: Compliance on this umbrella provision is achieved by compliance with the component sub-provisions: CONSENT015-CONSENT018 (III.A.3.a.(1)-(4)		
Steps taken by the County to Implement this paragraph:	Medical Care: See CONSENT015-CONSENT018 (III.A.3.a.(1)-(4)) Mental Health: See CONSENT015-CONSENT018 (III.A.3.a.(1)-(4))		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: See CONSENT015-CONSENT018 (III.A.3.a.(1)-(4)) Mental Health: See CONSENT015-CONSENT018 (III.A.3.a.(1)-(4))		
Monitors' Recommendations:	Medical Care: See CONSENT015-CONSENT018 (III.A.3.a.(1)-(4)) Mental Health: See CONSENT015-CONSENT018 (III.A.3.a.(1)-(4))		

Paragraph Author: 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; 10/14	Partial Compliance:	Non-Compliance: 3/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance: 3/14; 10/14	Partial Compliance: 7/13	Non-Compliance:
Measures of Compliance:	<u>Medical Care:</u> • Audit Step a: (Inspection) Health care slips on the living units are available in English, Spanish, and Creole. <u>Mental Health Care:</u> 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:	<u>Medical Care:</u> N/A <u>Mental Health Care:</u> NA		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care & Mental Health Care:</u> The Monitor found multilingual slips in the living units. Though MDCR only requested a Technical Assistance review of this provision and not an audit, because performance is adequate, the provision is being rated as Compliant, rather than Non-Compliant due to not being audited.		
Monitor's Recommendations:	<u>Medical Care:</u> None <u>Mental Health Care:</u> NA		

Paragraph Author: 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: 10/14	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited); 10/14 (Not audited)
Measures of Compliance:	<u>Medical Care:</u> • Audit Step a: (Inspection) Interviewed COs report a confidential way for detainees with impaired communication skills to access care. <u>Mental Health Care:</u> 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:	<u>Medical Care:</u> N/A <u>Mental Health Care:</u> 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):	<u>Medical Care and Mental Health Care:</u> The Monitor found an adequate system in place for patients with communication challenges. Living unit officers consistently described the availability and use of the "point" book and availability of sign language interpreters. Though MDCR only requested a Technical Assistance review of this provision and not an audit, because performance is adequate, the provision is being rated as Compliant, rather than Non-Compliant due to not being audited. <u>Mental Health Care:</u> During this tour the Monitor did not audit for evidence of cognitive (as opposed to simply communication) challenges, such as those with autism or mental retardation. When MDCR indicates that this provision is ready for audit, this is an aspect of the provision that will be examined.		
Monitors' Recommendations:	<u>Medical Care:</u> None <u>Mental Health Care:</u> NA		

Paragraph Author: 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: 10/14	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance: 10/14	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 Care: 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: N/A Mental Health Care: N/A		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Nurses and patients reported that the system for collection of sick call slips is confidential. Though MDCR only requested a Technical Assistance review of this provision and not an audit, because performance is adequate, the provision is being rated as Compliant, rather than Non-Compliant due to not being audited. Mental Health Care: NA		
Monitor's Recommendations:	Medical Care: None Mental Health Care: NA		

Paragraph Author: 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14; 10/14 (Not audited)
Measures of Compliance:	<u>Medical Care:</u> • 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. <u>Mental Health Care, as above and:</u> 1. Review of policy and procedure 2. Review of number of mental health grievances 3. Review of submitted sick call slips for evidence of triage 4. Review of emergency grievances and mental health grievances		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> Not audited <u>Mental Health Care:</u> 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):	<u>Medical Care:</u> Not audited <u>Mental Health Care:</u> Not audited		
Monitors' Recommendations:	<u>Medical Care:</u> Technical assistance was provided on parts of the sick call system. The grievance system was not reviewed. <u>Mental Health Care:</u> Not audited		

Paragraph Author: 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); 10/14 (Not audited)
Mental Health : Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited); 10/14 (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 "catchall" 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 Care: 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 Care: 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: During observation of a clinic session for other purposes, a monitor observed an officer inform a nurse that a patient who had requested care for an episodic problem and had been scheduled to come to clinic had refused his appointment, and that his refusal was in the living unit. The monitor drew the conclusion that the refusal had been obtained by custody, not health care, staff, and that the refusal would be accepted by the nurse as is. In a correctional setting there are reasons – other than the patient making a voluntary informed decision to decline care – for a patient to miss or refuse and appointment. For this reason, second hand refusals are not acceptable. During observation of another clinic session for other purposes, a monitor observed an inmate worker come into the clinic room (during a patient examination) 3 times (to replace paper towels, empty garbage, and empty hazardous waste). Moments later the worker similarly entered a room across the hall during an examination by a practitioner. Patient confidentiality was breached (and the intrusions are otherwise inappropriate disruptions of a clinical encounter). As this provision was not audited, the Monitor did not assess whether or not observations from the previous tour are remain the same. In the event that those observations are still relevant, the following comments from Report #2 are repeated here: 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		

	that 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 Care: Not audited
Monitors' Recommendations:	Medical Care: As part of its preparation for audit of this provision, MDCR should review policy and practice regarding refusals of care and assure that they are conducted appropriately. In general, health care interventions ordered by health care staff should only be cancelled after informed consent has been obtained by staff qualified to inform the patient of the risks, benefits, and alternatives of the intervention. In general this is a licensed health care professional who has been trained to obtain a refusal for this particular intervention, or a prescriber. For health care interventions requested by the patient, a more modest approach is reasonable, as long as the approach assures that the patient's refusal is made freely. As part of its further preparation for audit, MDCR should review the settings in which clinical encounters occur to assure that patients are provided the maximal amount of auditory and visual privacy during clinical encounters as allowed based on the specific safety risk of the patient. As this provision was not audited, the Monitor did not assess whether or not recommendations from the previous tour are remain the same. In the event that those recommendations are still relevant, the following comments from Report #2 are repeated here: 1. MCDR and JMH should develop an overarching 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 Care: Not audited

4. Medication Administration and Management

Paragraph Author: 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14	Non-Compliance: ; 10/14 (Not audited)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) The policies and procedures governing medication management and administration are adequate. This would include, among others, most of the provisions of NCCHC J-D-01 and J-D-02. • Audit Step b: (Inspection) Pill line is conducted in a calm, confidential setting. • Audit Step c: (Inspection) Patients are correctly identified prior to medication administration. • Audit Step d: (Inspection) Ordered medications are administered unless there is a legitimate reason. • Audit Step e: (Inspection) Patients receive the right the right medication, by the right route, at the right dose, at the right time. • Audit Step f: (Inspection) Medication administration is properly documented. • Audit Step g: (Chart and MARs) Medication administration is properly documented, including stop dates. • Audit Step h: (Inspection) The number of medication-related grievances (for medical and MH medications) will fall each 6 months, with a goal of <5 grievances/1000 detainees ADP/12 months. • Audit Step i: (Inspection) Policy specifies an appropriate training strategy (e.g. who is trained, how often) for health care staff involved in the medication management. • Audit Step j: (Inspection) An effective curriculum is used during training 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 Care, as above and: 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 Care: 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 Mental Health Care: Not audited
Monitors' Recommendations:	Medical Care: None Mental Health Care: Not audited

Paragraph Author: 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not yet due – Not audited); 3/14; 10/14 (Not audited)
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 Care: 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 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 Care: Not audited		

Monitor's Recommendations:	Medical Care: None Mental Health Care: Not audited

Paragraph] Author: 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not yet due – Not audited); 3/14 (Not audited); 10/14 (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 Care: See III A2e		
Steps taken by the County to Implement this paragraph:	Medical Care: Not audited (See CONSENT012 (IIIA2e)) Mental Health Care: Not audited (See CONSENT012 (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 Care: [See CONSENT012 (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 Care: [See CONSENT012 (IIIA2e)]

Paragraph Author: Ruiz	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: 3/14 (Not audited);10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: CHS appears to be following Level I patients on a daily basis. Review of cases of patients on Levels II-IV was notable for lapses in adequate psychiatric care.		
Measures of Compliance:	1. Policy/procedure to track, analyze data, and review Levels of Care and access to care 2. Review of records to assess psychiatrist-patient visits 3. Interview with staff and inmates		
Steps taken by the County to Implement this paragraph:	CHS Policy J-G-04 Addendum 2 defines level of care and follow-up by the psychiatrist: **Level I.** Psychiatrist will conduct follow-up encounter with the inmate on a daily basis, including weekends and holidays. **Level II & Level III.** Psychiatrist will conduct follow-up encounter at a frequency of no less than at least once every 30 days. **Level IV.** Psychiatrist will conduct follow-up encounter at a frequency of no less than once every 90 days.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The CHS policy is adequate.		
Monitor's Recommendations:			

Paragraph Author: Ruiz	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: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: 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.		
Measures of Compliance:	1. Policy regarding medication administration and reporting 2. Review of Medication Administration Records 3. Review of reports to Qualified Mental Health Professionals		
Steps taken by the County to Implement this paragraph:	CHS Policy J-D-02-e states: If an inmate refuses or missed a prescribed medication (s) for two consecutive time intervals, the nurse must notify the physician/ARNP/PA or psychiatrist promptly (not to exceed eight hours) for timely medical psychiatric interventions. If a psychotropic medication is missed 24 hours or greater than the psychiatrist must be notified. CHS reported plans to have the Health System Administrator perform weekly rounds and observations to validate proper medication preparation and delivery.		
Monitor's analysis of conditions to 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:			

Paragraph Author: 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14; 10/14 (Not audited)
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 Care, as above and: 1. Policy regarding physician orders, laboratories and reporting 2. Review of medical and mental health records 3. Review of reports by psychiatrist regarding emergent or abnormal results 4. Review of response by psychiatrist to abnormal lab results		
Steps taken by the County to Implement this paragraph:	Medical Care: Not audited Mental Health Care: 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: Not audited Mental Health Care: Not audited		
Monitor's Recommendations:	Medical Care: None Mental Health Care: Not audited		

Paragraph Author: 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not yet due – Not audited); 3/14; 10/14 (Not audited)
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 Care: 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 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 Care: Not audited		
Monitor's Recommendations:	Medical Care: None Mental Health Care: Not audited		

5. Record Keeping

Paragraph Author: 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; 10/14	Non-Compliance: 3/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14; 10/14	Non-Compliance: 7/13
Measures of Compliance:	<u>Medical Care:</u> • Audit Step a: (Chart Review) Paper medical records are adequate. This would include, among others, the provisions of NCCHC J-H-01 and J-H-04. (This audit will sunset when an EHR is implemented.) • Audit Step b: (Chart Review) Electronic medical records (contained in one or more electronic programs) are adequate. This would include, among others, the provisions of NCCHC J-H-01 and J-H-04. <u>Mental Health Care, as above and:</u> 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, individualized treatment plan and collateral information, as needed.		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> MDCR uses 4 electronic systems to manage health care records: Cerner (the core EHR), CARL (for scheduling), Sapphire (for pharmacy), and the jail management system (JMS). The new corporate director of health services has recognized the need to optimize the systems and improve their interoperability, and has made this one of his priorities. MDCR achieved compliance with a subpart of audit step a ("There is a system for the timely reactivation of records when requested by a treating professional" <u>Mental Health Care:</u> MDCR has implemented an Electronic Medical Record System. In that respect, it is partially compliant with the CA.		

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: Medical record keeping suffers from serious deficiencies, in part due to the lack of interoperability among the 4 record systems and in part due to problems within the main record system (Cerner). 1. Health information for a patient must be contained within a unified medical record. In the era of EHRs, it is common to have different software packages dedicated to different functions. However, the interface among these packages needs to be relatively transparent to the user. At MDCR the various systems do not communicate with each other, thus it is the user who must provide the interface. Thus, for example, there is no explicit indication in the Cerner EHR of when a patient has been admitted to or discharged from the jail. That information is in the JMS. So it is the user who must look up admission and discharge dates in JMS and remember it as he/she makes use of Cerner. Further, it is exceedingly time consuming for the user to switch back and forth among these systems. 2. Another fallout from having systems that do not communicate (especially communication between JMS and Cerner) is that there can be – and are - two or more medical records for some patients. If the user is not aware of this, the user may miss valuable information contained in the other record. 3. Not all health professionals have the same access to medical record information: nurses cannot see some of the documents that are visible to doctors. This is dangerous. 4. The electronic signature of staff who write in the EHR is missing the writer's credential. Thus it is impossible to discern (unless one happens to recognize a name) whether a note was written by a nurse, doctor, etc. 5. When searching for progress notes written by a specialist, it is impossible to identify the note unless one is familiar with the specialist's names. 6. For some codified information (i.e. information entered by checking a box) it is impossible to discern if clinical information is patient history of physical finding. For example, within some Nursing Evaluation forms, there is a box for "cough." It is impossible to know if a check in that box means that the patient reported that he coughed or if the nurse observed him coughing. The distinction between these two facts could have important clinical implications. 7. The EHR is rife with nonsense and nonsense entries. For example the word "trazodone" appeared in the middle of a note. It was impossible to discern if this meant the patient had taken the medication in the past, was on it currently, was allergic to it, etc. Apparently in this particular case, the word had been entered in a form, and the note in which it finally appeared had been populated by information from the form, without regard to its original context. In other cases, chart notes are created which have no information other than the demographics of the patient. A third example is a chart note entitled "zzVital Signs." "zz" may have some meaning to computer programmers, but it is a nonsense term in a medical record. The EHR also contains nonsense entries. For example, the chart of one patient contained a document entitled Discharge Instructions on the day he was admitted to the jail. The document was addressed to the patient and contained extensive information that appears to be appropriate for a patient being discharged from an emergency department. The information was not only irrelevant in this case, it is also unlikely that the document was actually given to the patient, as indicated by the record. 8. Another serious side effect of the above-cited auto-creation of documents populated with information from check-off forms is that the auto-created document sometimes far overstates the information in the form. For example, one form calls for the nurse to simply indicate whether or not the patient's skin was normal. However, when this information is translated to the second document, it indicates that the nurse checked several dimensions of skin, including such things as moisture of the skin on the inside of the patient's eyelids and mouth; it is highly unlikely

	that the nurse actually examined this nor that he/she intended this documentation. 9. Paper documents (e.g. external non-JMS records, internal forms still filled out by hand) are scanned into the EHR. There are a number of challenges associated with this process. First, scanned document s are not always named properly. Second, the computerized date assigned to the scanned document is not always the date of its creation (as it should be) but the date it was scanned. Third, the computerized time assigned to the scanned document is sometimes imaginary (and therefore wrong). For example, a patient was not admitted to the jail until mid-afternoon, but a number of scanned documents bear the time of midnight – hours before they could have possibly been generated. Fourth, scanned documents can be difficult to read and obviously cannot contribute data to the patient's electronic record. 10. Patient problem lists are incomplete or incomprehensible. There is no delineation between problems which are active or resolved. Some diagnoses are missing. Some problem lists contain nonsense diagnoses which users do not understand (e.g. "s/e/f" or "Evaluation Confirmed"). It was not clear to the Monitor whether the EHR allows a clinician to easily enter a diagnosis of "possible" or "rule out" for a disease under investigation. 11. Some staff who see patients in clinic do not enter their notes into the EHR until hours afterwards. This creates two problems. First, due to the lapse in time (and memory) the entries are not always accurate. For example, one of the monitors observed a patient telling a nurse his pain level was 10 out of 10. When the nurse entered that information in the EHR sometime later, she entered it as 8 out of 10. Second, the progress note bears the time the staff member keyed the entry, not the time the care was actually delivered; this is misleading documentation. 12. Patient care and appointment scheduling are handled in two separate and non-interoperable systems. As a result, some key information is not contained in either system. Specifically, when patients are referred from one clinician to another within MDCR, it is difficult if not impossible to find documentation of the actual request, including the reason for the referral and the desired urgency of the referral. <u>Mental Health Care:</u> In discussing the EMR with Director Estrada and the healthcare leadership, the mental healthcare providers recognize that the EMR has several problems which they need to address. These issues include the examples cited above. Other problems include the fact that medications, appointments, progress notes and housing are contained in separate systems and each patient contact requires an individual registration event. As a result, it takes a provider several minutes (or longer) to look up valuable information. At times, it may be impossible to complete a contact if one of the systems is 'down.' A paper system is still required as a backup in order to track patients.
Monitors' Recommendations:	<u>Medical Care:</u> 1. MDCR must unify its 4 record systems such that they appear to the user as a single operating system. 2. MDCR must program the EHR in such a way as to allow a single unique medical record for each patient. Avoiding duplicate records is challenging for health care systems. However, one advantage of operating a health care system within a custodial system is that law enforcement agencies have great expertise at determining the identities of citizens. Thus this challenge should be surmountable. 3. All clinical users of the EHR must have access to all patient information in each patient record. 4. All electronic signatures must include the author's credential and, where appropriate, role (e.g. RN, Charge Nurse; MD, Facility Medical Director). 5. The EHR must include a mechanism to search for specialty notes by specialty (i.e. without requiring that the reader be familiar with the names of all specialists). 6. All forms must make it patently clear whether patient information taken during an evaluation is history

	information or a physical finding. 7. Information in the EHR must be clear, understandable, and accurate. Nonsense documents and verbiage must be removed. A record must be comprehensible to any medical professional who reads it, even if he or she is not familiar with the names of MDCR/JMS employees, local computer programmer lingo, or Cerner idiosyncrasies. If information from forms is used to populate a more readable document, the translation from one format to the other should have enough fidelity to the original form, that the original form is no longer necessary (and should only be viewable by administrators conducting audits). 8. The use of paper-and-pen forms at the jail (which must subsequently be scanned) should be reduced or eliminated. One driver of such forms is the need to have a patient signature. Patient signatures can be entered into electronic records with the use of electronic signature pads. 9. For those paper forms which cannot be eliminated, they must be labeled and filed correctly and clearly, i.e. bearing an accurate and descriptive document name, and the date and time they were generated. 10. Patient problem lists must be complete, clear, and accurate, devoid of nonsense information. 11. Staff should document in the EHR at the time care is delivered. In the rare case that a late entry must be made, it needs to be so documented. 12. For all internal referrals from one professional to another, there needs to be documentation of the referral in the patient's medical record, including the reason for the referral and its urgency. Due to the intrinsic challenges of comprehending the Cerner EHR described above, along with difficulties in obtaining computer access for the monitoring team, during the tour the monitors were not able to fully assess the medical record in operation at MDCR. Thus it is possible that the above analysis is not complete and further recommendations will be forthcoming. <u>Mental Health Care:</u> 1. MDCR should unify its record systems such that they appear to the user as a single operating system. 2. MDCR should program the EHR in such a way as to allow a single unique medical record for each patient. 3. All electronic signatures must include the author's credential. 4. All forms should make it patently clear whether patient information taken during an evaluation is history information or a physical finding. 5. Specific to mental health, progress notes are recommended to be noted as either 'cell-side' or other / clinic / confidential setting, as applicable. 6. It is recommended that clinicians use only standard abbreviations. Information in the EHR should be clear, understandable, and accurate.

Paragraph Author: Ruiz	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; 10/14	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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. The Mental Health Monitor was unable to verify what appointments had been made for the patients and how often it was being utilized.		
Monitor's Recommendations:	CHS is aware of issues identified above regarding the fact that the EHR and its several separate systems are problematic. Modifications and enhancements are pending to this system.		

Paragraph Author: 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; 10/14	Non-Compliance: 3/14 (Not audited)
Mental Health Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14; 10/14	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 J-H-01 and J-H-04. (This audit will sunset when an EHR is implemented.) • (duplicate) CONSENT027 (IIIA5a) Audit Step b: (Chart Review) Electronic medical record are adequate. This would include, among others, the provisions of NCCHC J-H-01 and J-H-04. Mental Health Care: 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: [See CONSENT027 (IIIA5a)] Mental Health Care: [See IIIA5a]		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: [See CONSENT027 (IIIA5a)] Mental Health Care: See above		
Monitors' Recommendations:	Medical Care: [See CONSENT027 (IIIA5a)] Mental Health Care: See above		

Paragraph Author: 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: 10/14	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14 2014; 10/14	Non-Compliance:
Measures of Compliance:	<u>Medical Care:</u> • 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 ER visit or inpatient hospitalization, 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. When a patient returns from an outside consultation, treatment, or test, there is documented evidence of review by an RN prior to the patient's return to his/her living unit and further action as clinically indicated. In both cases, there will be an assessment (including vital signs) as clinically indicated. • 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). • Audit Step f: (Chart Review) All orders are implemented in a clinically appropriate time frame. <u>Mental Health Care:</u> 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:	<u>Medical Care:</u> <u>Mental Health Care:</u>		
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> Staff responsible for preparation of patients for outside consultations were familiar with, and followed policy. The reason for consultation was clear in all the records we reviewed. As almost all patients are referred to JMS and JMS has access to patient records (except medications – see below), transfer of non-medication related medical records appears to be seamless. The main venue for non-JMS consultations is the Bascom-Palmer Eye Clinic, and for these patients we assumed that relevant previous records are already at the clinic.		

	When patients go to outside consultants (including at JMS) staff are supposed to print out and send current medication records. We were unable to find a policy governing this. Further, while we believe this probably does take place, there is no record in the patient's medical record that these medication records are sent. Upon return from ER or inpatient hospitalizations, there is evidence that patients are seen and assessed by nurses, and that a practitioner is directly involved in decision-making before the patient returns to his/her living unit. However, upon return from other outside trips (consultations and testing) assessment by a nurse and implementation of consultant orders is not as seamless. In one case reviewed, failure to review a visit resulted in a few week break in chemotherapy for cancer. We also found that upon return from an outside consultation, practitioners modified or did not institute consultant recommendations without explanation or obvious clinical appropriateness. <u>Mental Health Care:</u> Some cases reviewed demonstrated that mental health clinicians did not have a working knowledge of treatment that was rendered at Jackson in the emergency department and did not review the record in a timely manner. Other cases demonstrated that patients returning from State hospitals were maintained or continued on the basic regimen of medications they were stabilized upon while hospitalized. Review of outside records was not consistent nor was it routinely reflected in psychiatrist or social work intake progress notes.
Monitors' Recommendations:	<u>Medical Care:</u> 1. Policy should describe the process for producing medication records for outside consultations. This production should be documented in the patient's medical records. 2. Upon return from an outside consultation, treatment, or test (other than ER visit or inpatient hospitalization) an RN should review the results of the trip, conduct further assessment as indicated, and take appropriate action, prior to the patient's return to his/her living unit. This recommendation is a relaxation of the original requirement and the corresponding Audit Step has been modified. In other words, involvement of a practitioner is not always required when patients return from trips other than the ER or inpatient hospitalization, as long as the patient is immediately evaluated by an RN and appropriate clinical action is taken. <u>Mental Health Care:</u> ***1.*** Policy should describe the process for producing medication records for outside consultations and their production. In addition, ***all staff should be trained and tested for proficiency with the policy.*** 2. Specific to mental health, because there are no psychologists or psychiatrist nurse practitioners mid-levels at intake, all pertinent positives and pertinent negatives should be reviewed by a psychiatrist upon return from an emergency department or higher level of care within a timely manner as needed.

6. Discharge Planning

Paragraph Author: 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: 10/14	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14	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 an appropriate care provider of their choice. A referral is a scheduled appointment. (This audit step is under review by the Parties and Monitor to develop clearer definitions of what constitutes an adequate arrangement for referral and under what circumstances referrals are necessary.) • Audit Step b: (Inspection) Custody staff notify medical staff at least 2 weeks prior to planned releases. Mental Health Care, as above and: 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: MDCR notifies patients upon admission of their right to request referrals prior to discharge. Patients are required to notify the health services unit at least 2 weeks prior to discharge. Custody staff currently have a system in place to notify health care staff of impending discharges. Mental Health Care: MDCR hired a discharge planner. Patients are required to notify the discharge planner or health services unit at least two weeks prior to their discharge if they are interested in bridge medications.		

Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: The Medical Monitor reviewed this provision with DOJ and confirmed its applicability to medical patients. Currently the trigger for these referrals is a passive one, i.e. patients must request the referral. A passive system alone will not be sufficient. Limiting referrals exclusively to Jackson Health Systems is not only unnecessary, it may be contraindicated for patients who already have, or prefer, a relationship with a different health system. Audit step b was moved from provision CONSENT033 (III.A.6.a.(3)) to this provision, where it more aptly belongs. Mental Health Care: The Mental Health Monitor was informed that the onus for discharge planning in the current system is placed on the mental health patient. This is insufficient. MDCR will need to augment its current system with an active component.
Monitor's Recommendations:	Medical Care: 1. To become compliant, MDCR will need to add an active component in which patients with chronic medical problems are identified prior to discharge and appropriate referrals are made. 2. MDCR will also need to implement an electronic report identifying discharged patients with chronic medical problems from which the Monitor (and eventually MDCR itself) can test how well the system was working. 3. Referrals should be made to an appropriate care provider of the patient's choice. Mental Health Care: MDCR will need to augment its current system with an active component. The Mental Health Monitor also recommend documenting its efforts in both the medical record as well as an independent log (whether it be held in the pharmacy or otherwise).

Paragraph Author: 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: 10/14	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14	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). • Audit Step b: (Inspection) Custody staff notify medical staff at least 2 weeks prior to planned releases. Mental Health Care, as above and: 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: MDCR notifies patients upon admission of their right to request medications prior to discharge. Patients are required to notify the health services unit at least 2 weeks prior to discharge. Custody staff currently have a system in place to notify health care staff of impending discharges. Mental Health Care: MDCR notifies patients via the inmate handbook of their right to request medications prior to discharge. Patients are required to notify health services at least two weeks prior to discharge.		
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: The Medical Monitor reviewed this provision with DOJ and confirmed its applicability to medical patients. Currently the trigger for provision of discharge medications is a passive one, i.e. patients must request the referral. A passive system alone will not be sufficient. In addition, whether passive or active, requiring 2-week advance notice is inadequate if a patient is started on an essential medication within the 2 weeks prior to discharge. Audit step b was moved from provision CONSENT033 (III.A.6.a.(3)) to this provision, where it more aptly belongs. Mental Health Care: MDCR has hired a discharge planner. In addition, they provided a log entitled, 'Discharge Planning: Referrals to Jackson System (July, August, September 2014). The Mental Health Monitor reviewed this log. Page 1 of the log indicated bridge medications were ordered for 4/38 patients or 10%. This could not otherwise be verified, as it was not verified in the medical record or the pharmacy.		

Monitor's Recommendations:	Medical Care: 1. To become compliant, MDCR will need to add an active component in which patients with chronic medical problems are identified prior to discharge and appropriate medications provided if the patient needs them. 2. MDCR will also need to implement an electronic report identifying discharged patients with chronic medical problems from which the Monitor (and eventually MDCR itself) can test how well the system was working. Mental Health Care: MDCR should document its discharge planning efforts in the medical record as well as its individual log. In that manner, it will be able to track its efforts at community placement, etc.

Paragraph Author: Stern and Ruiz	CONSENT033 (III.A.6.a.(3)) Adequate discharge planning is contingent on timely notification by custody for those inmates with planned released dates. For those inmates released by court or bail with no opportunity for CHS to discuss discharge planning, bridge medication and referral assistance will be provided to those released inmates who request assistance within 24-hours of release. Information will be available in the handbook and intake admission awareness paper. CHS will follow released inmates with seriously critical illness or communicable diseases within seven days of release by notification to last previous address.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 10/14	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14	Non-Compliance: 3/14
Measures of Compliance:	<u>Medical Care:</u> • Audit Step a: (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 b: (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. <u>Mental Health Care, as above and:</u> 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:	<u>Medical Care:</u> MDCR developed a mechanism and handout to provide referrals and medications to patients after discharge. <u>Mental Health Care:</u> MDCR has hired a discharge planner.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care:</u> Upon admission, patients are notified of the availability of referrals and medications for eligible patients following an unplanned release, provided they notify the jail within 24 hours. The Inmate Handbook is currently under revision. When abnormal test results are received after a patient has been discharged, there is an established procedure to notify the patient. This notification is currently limited to certified mail. There is currently no mechanism to audit the reliability of this procedure. <u>Mental Health Care:</u> Patients receive information that they are eligible for discharge planning services upon discharge in the Inmate Handbook that they receive at admission. The Mental Health Monitor was informed that the onus is on the patient to actively seek the discharge services regardless of whether the patient is floridly psychotic, suicidal depressed, or manic. This is insufficient.		

	The Mental Health Monitor reviewed the log provided by MDCR of the discharge services tracked by its planner. It is a good beginning. It is noteworthy that many of the patients could not be seen because "an officer was not present." The first page of the log stated that 8/38 persons had discharge services provided, or 21%.
Monitor's Recommendations:	<u>Medical Care:</u> 1. MDCR may consider offering patients the choice of medications or a prescription; such a choice may reduce workload for MDCR's pharmacy. 2. The method of patient notification when an abnormal test result is received after a patient has been discharged should be a function of the severity of the abnormality. If clinically warranted, staff should attempt to notify the patient by some more immediate method than certified mail. 3. MDCR should develop an EHR-based program to monitor (in real time) and audit the effectiveness of the procedure for notifying patients of abnormal test results after they have been discharged. <u>Mental Health Care:</u> 1. MDCR may consider prioritizing patient treatment need. Once patients properly triaged and leveled, an active system of discharge planning should be implemented for all patients with active symptomatology and recent stabilization 2. MDCR should document its discharge planning efforts in the medical record as well as its individual log. In that manner, it will be able to track its efforts at community placement, etc.

7. Mortality and Morbidity Reviews

Paragraph Author: 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); 10/14 (Not audited)
Mental Health Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13; 10/14 (Not audited)
Measures of Compliance:	<u>Medical Care:</u> • 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. <u>Mental Health Care, as above and:</u> 1. Review of comprehensive mortality reviews and corrective action plans for each inmate's death 2. Review of comprehensive morbidity review and corrective action plan for all deaths of inmates with severe mental illness and/or serious suicide attempts. 3. Within 45 days of each death or serious suicide attempt, provide report for review to Monitor and United State 4. In cases where the final medical examiner report and toxicology takes longer than 45 days, a final mortality and morbidity review will be provided to the Monitor and United States upon receipt. 5. Interviews with staff. 6. Receipt of timely mortality reviews which reflect an interdisciplinary review and corrective action plan. This will include inclusion of the Chief Psychiatrist among the interdisciplinary team.		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> <u>Mental Health Care:</u> CHS Policy J-A-10-a 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. 5. The Mortality Review Committee will be called to order within 72 hours of the incident.
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: The Monitor provided requested Technical Assistance on the process of reviewing adverse events and translating findings into actions. Mental Health Care: Not formally audited
Monitors' Recommendations:	Medical Care: The Monitor made recommendations to MDCR as part of Technical Assistance discussions Mental Health Care: Not formally audited

Paragraph Author: 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13; 10/14 (Not audited)
Measures of Compliance:	<u>Medical Care:</u> • 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. <u>Mental Health Care:</u> 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:	<u>Medical Care:</u> <u>Mental Health Care:</u> 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):	<u>Medical Care:</u> See comments in CONSENT034 (III.A.7.a.). <u>Mental Health Care:</u> Not audited		
Monitors' Recommendations:	<u>Medical Care:</u> See comments in CONSENT034 (III.A.7.a.). <u>Mental Health Care:</u> Not audited		

Paragraph Author: Stern and Ruiz	CONSENT036 (III.A.7.c.) Defendants will review mortality and morbidity reports and corrective action plans bi-annually. Defendants shall implement recommendations regarding the risk management system or other necessary changes in policy based on this review. Defendants will document the review and corrective action and provide it to the Monitor.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14; 10/14 (Not audited)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Records reflect that bi-annually MDCR reviews and monitors the progress it's making in response to system changes made as a result of the mortality and morbidity [suicide attempt] reports generated under CONSENT035/IIIA7b and CONSENT034/IIIA7a and is making additional system changes/adjustments as needed. Mental Health Care: 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 Mental Health Care:		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Not audited during this visit See comments in CONSENT034 (III.A.7.a.). Mental Health Care: Not formally audited		
Monitors' Recommendations:	Medical Care: See comments in CONSENT034 (III.A.7.a.). Mental Health Care: Not formally audited		

B. MEDICAL CARE

1. Acute Care and Detoxification

Paragraph Author: Stern	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);10/14 (Not audited)
Measures of Compliance:	• 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:			

Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	
Monitor's Recommendations:	Though MDCR did not flag the Acute Care and Detoxification section of the CA as ready for formal audit, some components of this section were observed during the tour. Due to the critically important nature of this section, the Monitor shared feedback with the MDCR health care leadership team regarding operation of clinic.

Paragraph Author: Stern	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); 10/14 (Not audited)
Measures of Compliance:	• (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 episodic care is low.		
Steps taken by the County to Implement this paragraph:			

Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	
Monitor's Recommendations:	Though MDCR did not flag the Acute Care and Detoxification section of the CA as ready for formal audit, some components of this section were observed during the tour. Due to the critically important nature of this section, the Monitor shared feedback with MDCR's custody leadership team regarding officers' role in this process.

Paragraph Author: Stern	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); 10/14 (Not audited)
Measures of Compliance:	• Audit Step a (Chart Review) Patients in withdrawal or at risk for withdrawal receive appropriate monitoring and care, including, but not limited to the provisions of NCCHC Jail Standard J-G-06 and Appendix H. In general, these provisions fall into the following items: a) monitoring and treatment is conducted pursuant to patient-specific orders from a practitioner, b) monitoring is conducted by trained staff, c) monitoring is conducted using validated instruments (e.g. COWS) if they exist, and otherwise under clear and specific orders, d) while clinical data collection may be collected by any appropriately trained staff, assessments may only be made by RNs or practitioners, e) appropriate treatment is provided.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):			
Monitor's Recommendations:	Though MDCR did not flag the Acute Care and Detoxification section of the CA as ready for formal audit, some components of this section were observed during the tour. Due to the critically important nature of this section, the Monitor shared feedback with the MDCR health care leadership team regarding our observations of the detoxification program.		

2. Chronic Care

Paragraph Author: Stern	CONSENT040 (III.B.2.a.) CHS shall sustain implementation of the Corrections Health Service ("CHS") Policy J-G-01 (Chronic Disease Program), which requires, inter alia, that Qualified Medical Staff perform assessments of, and monitor, inmates' chronic illnesses, pursuant to written protocols.		
Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited); 10/14 (Not audited)
Measures of Compliance:	• Audit Step a: (Inspection) Practitioners have access to, and either know, or demonstrate the skills to access, nationally accepted chronic disease guidelines. • Audit Step b: (Chart Review) Practitioners provide chronic care consistent with nationally accepted chronic disease guidelines, including the frequency and content of care.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	None		
Monitor's Recommendations:	None		

Paragraph Author: Stern	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); 10/14 (Not audited)
Measures of Compliance:	• (duplicate) CONSENT041 (IIIB2b) Audit Step b: (Chart Review) Practitioners provide chronic care consistent with nationally accepted chronic disease guidelines, including the frequency and content of care.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	None		
Monitor's Recommendations:	None		

3. Use of Force Care

Paragraph Author: Stern and Ruiz	CONSENT042 (III.B.3.a.) The Jail shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15-minute in-person visual observation by trained custody. Qualified Medical Staff shall perform 15-minute checks on an inmate in restraints. For any custody-ordered restraints, Qualified Medical Staff shall be notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.		
Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited); 10/14
Measures of Compliance:	<u>Medical Care:</u> • 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 clinical 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. <u>Mental Health Care, as above and:</u> • Review of adequate care provided for patients placed in restraint, including chemical restraint or involuntary intramuscular injection. Adequate documentation shall include evidence of attempts to de-escalate the incident and attempts at lesser restrictive means of treatment. • Review of mental health care provided to patients repeatedly involved in episodes of restraint for assessment of possible co-morbid mental health conditions • Review of differentiation between custody vs. clinical restraint in patients with mental health conditions, as noted by proper utilization of a medical order before initiation		
Steps taken by the County to Implement this paragraph:	<u>Medical Care</u> N/A <u>Mental Health Care:</u> N/A		

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 Policies are consistent with this provision. There were no uses of clinical or custody restraints (based both on records that were provided to the Medical Monitor as well as discussion with front line personnel at different facilities). Mental Health Care: Policies with regard to Use of Force, Response to Resistance and inmates with special needs are discordant with respect to the Consent Agreement, generally accepted practices, and current operating procedure. The Mental Health Monitor noted several notations of intramuscular medications that were not documented as a restraint. Further, the Mental Health Monitor was informed by CHS that the facility does not use the restraint chair or other restraint, yet it has made plans for the future use of these modalities. It has purchased both restraint chairs as well as beds that can be utilized as four-point restraint. It is the Mental Health Monitor's opinion that these events (i.e. the use of restraint by custody with and without a medical order on patients with mental health conditions for reasons that are non-disciplinary) are happening and that they are not being adequately documented. The Mental Health Monitor requested a log and/or a list of all patients on the mental health caseload in which restraint, chemical or physical had been utilized. The Mental Health Monitor was informed by CHS that no such log or list existed. The Mental Health Monitor's opinion that these events are occurring and not being adequately tracked or documented is based upon medical record review, staff interview, and review of video of incident(s) which occurred. From January 1, 2014 to October 30, 2014, there were 12 RTR classified as medical/mental health assistance, one 4-point restraint and one utilization of the restraint chair. It is not clear whether patients with mental health disorders were routinely being assessed by a qualified mental health professionals when they were involved in a use of force or response to resistance incident.
Monitor's Recommendations:	Medical Care: None Mental Health Care: MDCR may want to consider utilizing a 1800 number or another modality for anonymous reporting of incidents that staff may have concerns about.

Paragraph Author: Stern	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); 10/14
Measures of Compliance:	• Audit Step a: (Chart Review) Detainees subjected to Use of Force are evaluated immediately afterwards: a) documentation reflects the nature of the force and any patient symptoms, b) evaluation is conducted by, or under the direct supervision of, an RN or practitioner, c) the content of the evaluation is clinically appropriate, including evaluation of reasonably possible injuries based on the nature of the force, symptoms, or findings.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	We found a number of deficiencies. First, examinations are not always conducted by qualified health professionals. We found one case in which an examination was conducted by an LPN operating independently (i.e. without collaboration with an RN or practitioner). Second, nurses usually do not elicit the nature of the use of force. It is necessary to know the nature of the incident to adequately examine the patient. For example, if a nurse were to learn that during a struggle, staff needed to apply pressure to the patient's chest to subdue him, examination of the chest wall would be imperative, even in the absence of symptoms. One cannot rely on patient symptoms alone because a) in the adrenalin-laden minutes after an incident, patients do not always feel pain, and b) some injuries may not become symptomatic for hours or days. Instead, nurses tended to focus on the visible injuries or voiced symptoms. Third, regardless of the history, nurses tended to not look beyond obvious findings. For example, a nurse treating a patient who suffered a laceration of his head failed to consider (and then assess for) the possibility of a internal brain injury. Fourth, some assessments included minimal to no examination. Fifth, it is not clear whether patients with mental health disorders were routinely being assessed by a qualified health professionals when they were involved in a use of force or response to resistance incident.		
Monitor's Recommendations:	1. Post-use-of-force evaluations must be completed by RNs or practitioners. If conducted by LPNs, the LPNs role must be limited to collection of data which must then be passed on to an RN or practitioner for assessment. 2. Assessors must always inquire into (and document) the nature of the incident and then use that information to conduct an appropriate assessment (including examination). 3. Depending on the result of the assessment, medical staff might consider scheduling a follow-up appointment for re-assessment.		

Paragraph Author: Stern	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: 10/14	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited)
Measures of Compliance:	• Audit Step a: (Inspection) Detainees interviewed following evaluation for an injury from a use of force, report being questioned by Qualified Medical Staff regarding the cause of the injury outside the hearing of other inmates or officers • Audit Step b: (Inspection) When interviewed, nurses and practitioners on staff report that when they evaluate patients with any injury, they always consider whether the injury might be the result of staff-on-inmate abuse, and if so, (1) take all practical steps to preserve evidence of the injury (e.g., photograph the injury and any other physical evidence); (2) report the suspected abuse to the appropriate Jail administrator; and (3) complete a Health Services Incident Addendum describing the incident.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	We found variable results during audit of this provision. Most staff were able to verbalize their attentiveness to possible staff-on-inmate injury during post-use-of-force encounters. There were some examples of excellent care. At MWDC, for example, patients are often placed in a room with the door closed, so officers cannot hear the conversation. A PA at TTC was observed during an encounter during which he elicited sensitive and important information about the patient's safety in his living unit. On the other hand, officers are not universally excluded from overhearing interviews, and one staff member initially expressed hesitancy regarding communicating staff-on-inmate injury. Medical staff are expected to hand their documentation of injuries to officers. Since the officer to whom they are supposed to give the paperwork might have been involved in the incident, this practice may create barriers to open reporting.		
Monitor's Recommendations:	1. Health care staff should conduct at least part of the post-use-of-force evaluation out of earshot of custody staff, especially when there is a possibility that the injury resulted from staff-on-inmate assault. 2. MDCR should consider modifying policy such that the health professional's report of injury is given to someone other than the front line officer. 3. MDCR might consider developing a role-modeling video to train new staff members on recognizing possible staff-on-inmate assaults and how to respond. 4. MDCR should consider instituting a 1-800-number or an anonymous tip line for reporting of use of force and response to resistance, particularly for those inmates with mental illness and developmental disabilities.		

C. MENTAL HEALTH CARE AND SUICIDE PREVENTION

1. Referral Process and Access to Care

Paragraph Author: Ruiz	III. C. 1. 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; 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour	3/2014: The specific definitions of "emergency referrals" and "urgent referrals" have not been embedded into the MDCR or CHS policy. The CHS Action Plan states "all identified inmates as emergency referral for medical or mental health will be expedited for a medical evaluation within 30 minutes of emergency referral and 2 hours for mental health evaluation by a QMHP." Summary and disposition elements have been placed on the initial intake screening and mental health screening evaluation forms; 'emergency referrals' and 'urgent referrals' are checked under the same box.		
Measures of Compliance:	e. 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: a. "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. b. "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. c. "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. d. Review of medical records for implementation of policy. e. Review of internal audits. f. Review of emergency, urgent and routine referral logs.		
Steps taken by the County to Implement this paragraph:	1. Booking and screening was moved to Turner Guildford Knight Correctional Center (TGK) in the LEO Lobby on June 18, 2013. 2. MDCR policy (DSOP 14-008) regarding access to mental health care states, "It is the policy of the Miami-Dade Corrections and Rehabilitation Department (MDCR) to provide inmates with medical, dental and mental health services while housed in a MDCR detention facility. All inmates in need of health services shall be identified and given access to care in a timely manner as well as afforded continuity of care. Healthcare encounters, including medical and mental health interviews, examinations and procedures shall be conducted in a private setting and in a manner that encourages the inmate's subsequent use of health		

	services. In accordance with Departmental Standard Operating Procedure (DSOP) 17-005 "Limited English Proficiency," MDCR shall provide assistance to an inmate whose primary language is not English and requires an interpreter/translator." 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 representations, and the factual basis for finding(s)	None
Monitor's Recommendations:	None

Paragraph Author: Ruiz	III. C. 1. Referral Process and Access to Care b. CHS will ensure referrals to a Qualified Mental Health Professional can occur: 1. At the time of initial screening; 2. At the 14-day assessment; or 3. At any time by inmate self-referral or by staff referral.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 10/14 (Not audited); 3/14 (Not audited)
Unresolved/partially resolved issues from previous tour	3/2014: As indicated above, access to care is limited in administrative segregation. In addition, enhancements are pending to the electronic scheduling system.		
Measures of Compliance:	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, J-E-02, Receiving Screening and policy, J-E-07, Non-emergency Health Care Requests and Services. These policies encompass "opportunity for daily requests" for mental health services. Per policy, verbal and written requests for service are to be triaged within twenty-four (24) hours. Inmates with positive screens "are referred to a qualified mental health professional." 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)	None		
Monitor's Recommendations:	None		

2. Mental Health Treatment

Paragraph Author: Ruiz	III. C. 2 Mental Health Treatment 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:	Non-Compliance: 3/14; 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour	3/2014: CHS acknowledges that it is not in compliance with this provision. CHS policy for basic mental health care was outlined in J-G-04. 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."		
Measures of Compliance:	1. Review of manual of mental health policies and procedures 2. Level of care and provision of mental health services including medication management, group therapy and discharge planning 3. Review of mental health staffing vs. mental health population 4. Review of internal audits 5. Review implementation of projected changes in mental health services including: Medical Appointment Scheduling System (MASS), Sapphire (Physician Order Entry System and Electronic Drug 6. Monitoring) and the Electronic Medical Record, Cerner, all projected in August 2014.		
Steps taken by the County to Implement this paragraph:			
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.		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III C. 2 Mental Health Treatment 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: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	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.		
Measures of Compliance:	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 the Monitor's opinion, this target may be reduced to 90%.		
Steps taken by the County to Implement this paragraph:	CHS has a policy for mental health screening and treatment.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS policy for basic mental health care is outlined in J-G-04. During this on-site tour, the Mental Health Monitor interviewed various staff and inmates. The Mental Health Monitor 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 the Mental Health Monitor reviewed with staff indicated a delay in access to care "because there is no social worker at night." Another chart the Mental Health Monitor 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 the Mental Health Monitor requested the chart, she 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:	None		

Paragraph Author: Ruiz	III. C. 2. Mental Health Treatment 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:	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	1. Progress notes / 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.		
Measures of Compliance:	1. Review of manual of mental health policies and procedures 2. Results of internal audits 3. Review of medical records for presence of treatment plans and evidence of their implementation		
Steps taken by the County to Implement this paragraph:	CHS policy J-E-12, Section 5 outlines the use of individualized treatment plans to guide patient care.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	During the tour of the PTDC, the Mental Health Monitor requested that CHS nursing staff randomly select cases for me to review, including the medical record. The medical record documentation of these cases included typical progress notes. None of the cases reviewed had formal treatment plans, including inmates that had been present for seven days or longer. CHS policy J-G-04, Addendum 2 Section 2 states, "Psychiatrist will document each follow-up encounter on the *Psychiatric Progress Note* (C-255Nb). The progress note will then be filed on the inmate's unified medical and mental health record." The progress notes the Mental Health Monitor reviewed were written by a medical staff member and co-signed by the psychiatrist.		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III C. 2 Mental Health Treatment 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: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour			
Measures of Compliance:	1. Manual of mental health policies and procedures 2. Results of internal audits 3. Review of medical records for presence of treatment plans and evidence of their implementation		
Steps taken by the County to Implement this paragraph:	Treatment plans and their implementation are outlined in CHS policy, J-G-04 Addendum 1. MDCR does not have a companion correctional policy for interdisciplinary treatment plans.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III C. 2 Mental Health Treatment 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; 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour	3/2014: Although no CHS policy was identified that outlined the policy or procedure for referral and tracking of inmates through the criminal justice competency determination process, several of the inmates reviewed in the PTDC had been referred to additional care as noted by their medical records and / or cell designations through the Baker Act. The Baker Act allows for involuntary examination (at times call involuntary commitment). Judges, law enforcement officials, physicians, or mental health professionals can initiate it. CHS reported plans to develop and design a tracking log of inmates in need of Forensic Mental Health Facility placement. This tracking log was not available for review at the time of the on-site tour July 2013 or 2014.		
Measures of Compliance:	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 to see if individualized treatment plans are provided at 7 days and at 30 days 4. Evidence of contact with mental health coordinators in the State of Florida's criminal justice system to facilitate the inmate's movement through the criminal justice competency determination process and placement in an appropriate forensic mental health facility. 5. Review of the interdisciplinary treatment team notes for evidence of individualized plans 6. Evidence of care meetings for patients at intervals no less than 45 days		
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 finding(s)	Not audited		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III 2. C. 2 Mental Health Treatment e.3 The interdisciplinary team will: (1) Include the treating psychiatrist, a custody representative, and medical and nursing staff. Whenever clinically appropriate, the inmate should participate in the treatment plan. (2) Meet to discuss and review the inmate's treatment no less than once every 45 days for the first 90 days of care, and once every 90 days thereafter, or more frequently if clinically indicated; with the exception being inmates housed on 9C (or equivalent housing) who will have an interdisciplinary plan of care at least every 30 days.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/14; 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour	CHS reported that they are non-compliant with this provision.		
Measures of Compliance:	1. Review of manual of mental health policies and procedures 2. Review of medical record for signed interdisciplinary treatment plan 3. Review of internal audits, if any		
Steps taken by the County to Implement this paragraph:	Treatment plans and their implementation are outlined in CHS policy, J-G-04 Addendum 1. No corrections policy was available in reference to definition and procedure for IDT.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III 2. C. 2 Mental Health Treatment 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: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	1. Manual of mental health policies and procedures 2. Review of medical records for evidence of implementation of policies 3. Review of internal audits 4. Review of mental health roster / log to be managed by Program Director of Mental Health		
Steps taken by the County to Implement this paragraph:	Psychiatric level of care and follow-up is outlined in CHS policy J-G-04 Addendum 2.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III 2. C. 2 Mental Health Treatment g. Stage I is defined as the period of time until the Mental Health Treatment Center is operational. In Stage I, group-counseling sessions targeting education and coping skills will be provided, as clinically indicated, by the treating psychiatrist. In addition, individual counseling will be provided, as clinically indicated, by the treating **psychiatrist.**		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	1. Manual of mental health policies and procedures. 2. Results of internal audits, if any 3. Review of medical records for implementation of policies consistent with appropriate treatment in Stage I, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	CHS policy J-G-04 Addendum 4 describes individual and group counseling services. "Qualified Mental Health Professional (QMHP) will provide individual and group counseling as deemed clinically appropriate by the psychiatrist."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III. C.2.g.(1) Mental Health Treatment Inmates classified as requiring Level IV level of care will receive: i. Managed care in the general population; ii. Psychotropic medication, as clinically appropriate; iii. Individual counseling and group counseling, as deemed clinically appropriate, by the treating psychiatrist; and iv. Evaluation and assessment by a psychiatrist at a frequency of no less than once every 90 days.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: The response to the Consent Agreement dated April 2013 specifically outlines the elements of adequate care of inmates in Level IV. CHS reported plans to monitor these provisions via the Appointment Scheduler System, Sapphire (the anticipated electronic physician order and medication provider), training and audits. These audits were not available for review and/or had not been completed at the time of our on-site tour in July 2013.		
Measures of Compliance:	1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies consistent with appropriate treatment in Stage I, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	CHS policy J-G-04 Addendum 2 and Addendum 4 describe frequency of follow-up, individual and group counseling services for each level in general terms.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 2. G. (2) Mental Health Treatment Inmates classified as requiring Level III level of care will receive: i. Evaluation and stabilizing in the appropriate setting; ii. Psychotropic medication, as clinically appropriate; iii. Evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; iv. Individual counseling and group counseling, as deemed clinically appropriate by the treating psychiatrist; and v. Access to at least one group counseling session per month or more, as clinically indicated.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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 J-G-04 Addendum 2 and Addendum 4 describe frequency of follow-up, individual and group counseling services for each level in general terms.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III. C. g. (3) Mental Health Treatment Inmates classified as requiring Level II level of care will receive: i. evaluation and stabilizing in the appropriate setting; ii. psychotropic medication, as clinically appropriate; iii. private assessment with a Qualified Mental Health Professional on a daily basis for the first five days and then once every seven days for two weeks; iv. evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; and v. access to individual counseling and group counseling as deemed clinically appropriate by the treating psychiatrist.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies consistent with appropriate treatment in Level II, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	CHS policy J-G-04 Addendum 2 and Addendum 4 describe frequency of follow-up, individual and group counseling services for each level in general terms.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 2. g. (4) Mental Health Treatment Inmates classified as requiring Level I level of care will receive: i. evaluation and stabilizing in the appropriate setting; ii. immediate constant observation or suicide precautions; iii. Qualified Mental Health Professional in-person assessment within four hours, iv. psychiatrist in-person assessment within 24 hours of being placed at a crisis level of care and daily thereafter v. psychotropic medication, as clinically appropriate; and vi. individual counseling and group counseling, as deemed clinically appropriate by the treating psychiatrist.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies consistent with appropriate treatment in Level I, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	CHS policy J-G-04 Addendum 2 and Addendum 4 describe frequency of follow-up, individual and group counseling services for each level in general terms.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 2. Mental Health Treatment 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: Pending 12/14
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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:	None.		

Paragraph Author: Ruiz	III. C. 2. Mental Health Treatment 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: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies including a five day step down and meeting with the psychiatrist a minimum of every 30 days or as clinically necessary		
Steps taken by the County to Implement this paragraph:	CHS policy J-G-04 Addendum 5 describes the procedures for follow-up from Level I to Level II. CHS plans to train the mental health staff and track this via the Medical Appointment Scheduler. Chart audits are to be conducted for review of implementation of this policy.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 2. Mental Health Treatment 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; 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	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.		
Measures of Compliance:	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)	Not audited		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	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: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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)	Not audited		
Monitor's Recommendations:	None.		

3. Suicide Assessment and Prevention

Paragraph Author: Ruiz	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	Non-Compliance: 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	CHS Suicide Prevention Program is covered in policy #CHS-059, J-G-05. It is currently being reviewed and updated with input from an outside consultant, Ms. Judith Cox. MDCR policy specific to suicide prevention is outlined in DSOP 12-03, Inmate Suicide and Response Plan. While this policy outlines specific provisions such as the Ferguson Safety Garment and first aid response tools, it does not state that inmates will have access to suicide-resistant mattresses or blankets.		
Measures of Compliance:	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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	None		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III. C. 3 Suicide Assessment and Prevention b. When inmates present symptoms of risk of suicide and self-harm, a Qualified Mental Health Professional shall conduct a suicide risk screening and assessment instrument that includes the factors described in Appendix A. 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:	Non-Compliance: 3/14; 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: 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 of inmates		
Measures of Compliance:	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 #CHS-059, J-G-05. 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)	Not audited		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 3 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	Non-Compliance: 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: 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.[i]		
Measures of Compliance:	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 15-minute checks as the 'default' for suicidal inmates. "An inmate with suicidal tendencies, statements or attempts shall not be stripped, unless requested and documented by IMP or IMP mental health staff. Unless otherwise authorized in writing by the appropriate medical authority, inmates determined by IMP or IMP mental health staff to have suicidal tendencies shall be assigned to quarters that provide close supervision in accordance to the facilities' classification plan."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 3 Suicide Assessment and 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	Non-Compliance: 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	1. 3/2014: 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		
Measures of Compliance:	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)	None		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III. C. 3 Suicide Assessment and 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:	Non-Compliance: 3/14; 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 3 Suicide Assessment and 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	Non-Compliance: 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	Due to physical plant issues, cut down tools and other emergency rescue items are placed at long distances from first responders at PTDC.		
Measures of Compliance:	1. On-site check for cut-down tool. 2. Manual of mental health policies and procedures 3. Results of internal audits or on-site inspections, if any 4. Incident reports documenting use of cut-down tool		
Steps taken by the County to Implement this paragraph:	MDCR policy 12-003 section J states, "Rescue tools shall be secured and maintained in all facilities in designated locations prescribed in each facility's SOP."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None		

Paragraph Author: Stern and Ruiz	III. C. 3 Suicide Assessment and Prevention (CONSENT068) 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14 (Not audited); 10/14 (Not audited)
Measures of Compliance:	<u>Medical Care:</u> • 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. <u>Mental Health Care:</u> 1. On-site review of first aid kit and resources. 2. Review of record of education / training to CHS and officers in emergency response 3. Review of adverse events		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> <u>Mental Health Care:</u> 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 Mental Health Care: Not audited
Monitors' Recommendations:	Medical Care: None Mental Health Care: Not audited

Paragraph Author: Ruiz	III. C. 3 Mental Health Care and Suicide Prevention: h. County shall conduct and provide to the Monitor and DOJ a documented quarterly review of a reliable and representative sample of inmate records demonstrating*:* (1) adequate suicide screening upon intake, and (2) adequate suicide screening in response to suicidal and self-harming behaviors and other suicidal ideation.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/14; 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: The Quality Department and Director of CHS plan to develop a dashboard of key performance indicators related to the quarterly review of a reliable and representative sample of inmate records demonstrating*:* (1) adequate suicide screening upon intake, and (2) adequate suicide screening in response to suicidal and self-harming behaviors and other suicidal ideation. This report is pending.		
Measures of Compliance:	1. Result of internal quarterly review and dashboard with key performance indicators 2. Review of morbidity and mortality reports from inmate death 3. Representative sample of inmate records.		
Steps taken by the County to Implement this paragraph:	CHS is in the planning phases to comply with this provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None.		

4. Review of Disciplinary Measures

Paragraph Author: Ruiz	III. C. 4. Review of Disciplinary Measures a. The Jail shall develop and implement written policies for the use of disciplinary measures with regard to inmates with mental illness or suspected mental illness, incorporating the following (1) The MDCR Jail facilities' staff shall consult with Qualified Mental Health Staff to determine whether initiating disciplinary procedures is appropriate for inmates exhibiting recognizable signs/symptoms of mental illness or identified with mental illness; and (2) If a Qualified Mental Health Staff determines the inmate's actions that are the subject of the disciplinary proceedings are symptomatic of mental illness, no disciplinary measure will be taken. b. A staff assistant must be available to assist mentally ill inmates with the disciplinary review process if an inmate is not able to understand or meaningfully participate in the process without assistance.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/14;10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: 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.		
Measures of Compliance:	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 16-001V 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)	Not audited.		
Monitor's Recommendations:	None.		

5. Mental Health Care Housing

Paragraph Author: Ruiz	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; 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: On-site inspection included tours of the Stockade, Turner Guilford Knight, the Pre Trial Detention Center, and sections of facility in which inmates are placed in custodial segregation. The physical plant of the PTDC was not intended for mental health treatment. As such, direct visibility is limited and there are numerous points between the cells and the recreation area in which mentally ill patients could harm themselves if not properly supervised. Physical plant issues are further complicated by narrow stairwells that we were informed hinder rescue efforts, periods of over-crowding, and lack of private or semi-private treatment space.		
Measures of Compliance:	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 J-G-02 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 12-005 states, "It is the policy of the Miami-Dade Corrections and Rehabilitation Department (MDCR) to establish and maintain guidelines for the health, safety, welfare, treatment, and special housing of inmates with mental illness in our custody." It subsequently outlines the housing assignment of suicidal inmates. There is no policy that specifies 'therapeutic environments' for inmates with SMI.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 5. Mental Health Care Housing: 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;10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: This on-site inspection included tours of the Stockade, Turner 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.		
Measures of Compliance:	1. On-site inspection of facility, including inspection of tie-off points that may pose risk for suicidal inmates, areas with low visibility and low supervision. 2. Manual of mental health policies and procedures 3. Review of medical records and observation logs for implementation of policies, including results of adverse events and suicides, if any.		
Steps taken by the County to Implement this paragraph:	The Monitor was informed that inmates at risk of suicide are placed on suicide precaution; this did not always include constant observation. Specifically, as per DSOP 12-003, Inmate Suicide Prevention and Response Plan indicates that "inmates with suicidal tendencies (suspected or diagnosed) that are separated from the general population are considered to be in administrative confinement. An inmate who is identified as a suicide risk shall not be housed in a 'single occupancy cell' unless direct observation is utilized 24 hours a day and sworn staff and/or IMP/IMP mental health staff document checks at intervals not to exceed 15 minutes." In the same paragraph, the Mental Health Monitor 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)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 5. Mental Health Care Housing c.1 The Jail shall allow suicidal inmates to leave their cells for recreation, showers, and mental health treatment, as clinically appropriate. If inmates are unable to leave their cells to participate in these activities, a Qualified Medical or Mental Health Professional shall document the individualized clinical reason and the duration in the inmate's mental health record. c. 2 The Qualified Medical or Mental Health Professional shall conduct a documented re-evaluation of this decision on a daily basis when the clinical duration is not specified.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/14; 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: 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.		
Measures of Compliance:	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 non-compliant with this provision. MDCR policy 12-005 regarding recreation states that "mentally ill inmates will be eligible to participate in recreational activities in accordance with the directives of IMP mental health staff."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 5. Mental Health Care Housing 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; 10/14	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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)	Although not formally audited, the Mental Health Monitor did tour area(s) in TGK which are proposed as the Mental Health Treatment Center. These treatment and cell spaces are a vast improvement over the space in PTDC.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 5. Mental Health Care Housing 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:	Non-Compliance: 3/14; 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	MDCR policy does not define or provide a procedure for interdisciplinary treatment plans.		
Measures of Compliance:	1. Manual of mental health policies and procedure 2. Results of internal audits, if any 3. Review of medical records for implementation of policies, including implementation of timely screening and inter-disciplinary plans of care within seven days of placement on 9C or overflow unit		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	None		
Monitor's Recommendations:	None		

6. Custodial Segregation

Paragraph Author: Ruiz	III. C. 6. Custodial Segregation: 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:	Partial Compliance:	Non-Compliance: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: DSOP 12-002 states the results of the psychosocial evaluation will be documented on the Psychosocial Evaluation Check Sheet. This sheet was not available for review and it is unclear where this sheet will be kept. Relevant information, assessments and observations (or a copy) should be available in the patient's medical record.		
Measures of Compliance:	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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	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:	Non-Compliance: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	CHS reported that it is not compliant with this provision. DSOP 12-002 Section C states that suicidal and acute psychiatric inmates will be checked as follows: "Sworn staff shall visit each confinement cell to conduct and document physical sight checks of the following classifications of inmates at intervals, not to exceed 15 minutes."		
Measures of Compliance:	1. Review of policy mental health policies and procedures 2. Review of medical records and observation logs for SHUs for staggered 15 minute checks 3. Review of internal audits		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 6. Custodial Segregation (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:	Non-Compliance: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	CHS reported that it is not compliant with this provision. DSOP 12-002 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.		
Measures of Compliance:	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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III. C. 6. Custodial Segregation (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:	Non-Compliance: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: CHS reported that it is not compliant with this provision.		
Measures of Compliance:	1. Manual of mental health policies and procedures 2. Review of log of inmates placed in custodial segregation for greater than 8 hours 3. Review of medical records and observation logs for implementation of policies, including results of adverse events and suicides, if any.		
Steps taken by the County to Implement this paragraph:	As indicated above, DSOP 12-002 V Section C outlines that acute psychiatric inmates will be observed every 15 minutes.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III. C. 6. Custodial Segregation (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:	Non-Compliance: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: 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.		
Measures of Compliance:	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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 6. Custodial Segregation (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:	Non-Compliance: 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: 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.		
Measures of Compliance:	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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 6. Custodial Segregation 5. Inmates with SMI shall not be placed in custodial segregation for more than 24 hours without the written approval of the Facility Supervisor and Director of Mental Health Services or designee.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14 (Not audited); 10/14 (Not audited)
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 12-002 states: "An inmate may be placed in administrative confinement when deemed necessary by the Medical Care Provider (IMP) Director or designee (e.g., the inmate has a diagnosed contagious disease, or is in psychological distress, etc.). " Another section of the policy states that the Facility/Bureau Supervisor has the authority to place an inmate in administrative confinement in order to protect the inmate or others. A review does not occur for 72 hours.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III. C. 6. Custodial Segregation 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; 3/14 (Not audited) 10/14 (Not audited)
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 non-compliant 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)	Not audited		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III. C. 6. Custodial Segregation 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:	Non-Compliance: 3/14 (Not audited); 10/14 (Not audited)
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:	CHS reported that they non-compliant with this provision. DSOP 12-002 does not address this provision specifically. As indicated above, it states that inmates with acute psychiatric issues will be monitored be sworn staff and they will have a psychosocial assessment at 24 hours, 5 days, 30 days and every six months thereafter. The policy does allude to referral for treatment: "In the event that a Psychosocial Evaluation Check Sheet needs to be completed and IMP mental health staff is not available at the facility, the inmate shall be transported to a facility conducting mental health assessments (e.g., the Pre-Trial Detention Center)."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III. C. 6. Custodial Segregation 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; 3/14 (Not audited); 10/14 (Not audited)
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)	Not audited		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III. C. 6. Custodial Segregation 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: 10/14 (Not audited)
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:	DSOP-12-002 Section VI A describes confinement documentation.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None		

<table>
<tr><td>Paragraph
Author: Stern and Ruiz</td><td colspan="3">III. C. 6. Custodial Segregation (CONSENT088)
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.</td></tr>
<tr><td>Medical Care: Compliance Status:</td><td>Compliance:</td><td>Partial Compliance:</td><td>Non-Compliance: 7/13 (Not completely audited); 3/14 (Not audited); 10/14 (Not audited)</td></tr>
<tr><td>Mental Health Care: Compliance Status:</td><td>Compliance:</td><td>Partial Compliance: 7/13</td><td>Non-Compliance: 3/14; 10/14 (Not audited)</td></tr>
<tr><td>Measures of Compliance:</td><td colspan="3"><u>Medical Care:</u>
• Audit Step a: (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.

<u>Mental Health Care:</u>
1. Manual of MDCR and mental health policies and procedures
2. On-site tour of facility
3. Review of grievances
4. Inspection that mechanism for placement of sick call and access to care is timely</td></tr>
</table>

Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health Care: 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 Care: None
Monitors' Recommendations:	Medical Care: None Mental Health Care: None

Paragraph Author: Ruiz	III. C. 6. Custodial Segregation 11. Mental health referrals of inmates in custodial segregation will be classified, at minimum, as urgent referrals		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/14 (Not audited); 10/14 (Not audited)
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)	Not audited		
Monitor's Recommendations:	None		

7. Staff and Training

Paragraph Author: Ruiz	III. C. 7. Staffing and Training 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: 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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 • Staffing currently consists of seven FTEs. • Per diem psychiatry time has been unpredictable and unreliable • There is no psychiatrist at booking / intake • Current plans include recruitment of staff to full-time positions. Other incentives and creative staffing options are also being explored. Social work • A discharge planner has been implemented • Staffing at TGK (intake) includes coverage on day and evening shifts. However, the night, 11 to 7 am shift remains without a QMHP. Psychologists • There are 2 psychology FTEs.		
Monitor's Recommendations:	A comprehensive staffing plan that includes vacancies in the mental health staff remains outstanding. Staffing plans previously submitted were not completed in an interdisciplinary manner. As such, they may lead to gaps in care. 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. • Staffing and hiring plans for CHS will depend partially on data that remains outstanding at the time of this report: total mental health caseload numbers per level were not available. • Inter-disciplinary training was not comprehensively reviewed during this tour.		

Paragraph Author: Ruiz	III. C. 7. Staffing and Training 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: 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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:	Mental health is understaffed. Please see the cover page.		

Paragraph Author: Ruiz	III. C. 7. Staffing and Training c. CHS shall staff the facility based on the staffing plan and analysis, together with any recommended revisions by the Monitor. If the staffing study and/or monitor comments indicate a need for hiring additional staff, the parties shall agree upon the timetable for the hiring of any additional staff.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 10/14 (Not formally audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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:	Specific to mental health, CHS is still processing data to assess its staffing needs. It is actively recruiting for several vacancies in psychiatry positions and psychiatric nurses. It is understaffed.		

Paragraph Author: Ruiz	III. C. 7. Staffing and Training d. Every 180 days after completion of the first staffing analysis, CHS shall conduct and provide to DOJ and the Monitor staffing analyses examining whether the level of staffing recommended by the initial staffing analysis and plan continues to be adequate to implement the requirements of this Agreement. If they do not, the parties shall re-evaluate and agree upon the timetable for the hiring of any additional staff.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 10/14(Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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 above.		

Paragraph Author: Ruiz	III. C. 7. Staffing and Training 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	Non-Compliance: 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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 Author: Ruiz	III. C. 7. Staffing and Training 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; 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	1. Review of organizational chart and staffing matrix 2. Review of in-service training sign-in sheets 3. Review of in-service training materials 4. Interview of staff 5. County, MDCR and mental health policies and procedures		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 7. Staffing and Training g. The Jail and CHS shall develop and implement written training protocols in the area of mental health for correctional officers. A Qualified Mental Health Professional shall conduct the training for corrections officers. This training should include pre-service training, annual training for officers who work in forensic (Levels 1-3) or intake units, and biennial in-service training for all other officers on relevant topics, including: (1) Training on basic mental health information (e.g., recognizing mental illness, specific problematic behaviors, additional areas of concern); (2) identification, timely referral, and proper supervision of inmates with serious mental health needs; and (3) Appropriate responses to behavior symptomatic of mental illness; and suicide prevention.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14 (Not audited); 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour			
Measures of Compliance:	1. Review of organizational chart and staffing matrix 2. Review of in-service training sign-in sheets 3. Review of in-service training materials for officers in identification of specific mental health needs, as per agreement 4. Interview of staff 5. MDCR and mental health policies and procedures		
Steps taken by the County to Implement this paragraph:	In reference to training, DSOP 12-005 states, "It is imperative that good judgment be exercised when dealing with mentally ill inmates. All staff assigned to supervise mentally ill inmates, (suicidal and non-suicidal as determined by IMP/mental health staff), must have previously received in-service training or specialized training in the management and supervision of inmates with conditions of mental illness; e.g., crisis intervention, human behavior, etc. The hours of training and the training content shall be in accordance with current requirements, standards and guidelines."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III. C. 7. Staffing and Training 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	Non-Compliance: 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	During the on-site in March 2014, a provisional organizational change in chart was initiated to ensure regular and effective communication between custody, medical and mental health staff. Daily huddles involving mental health patients are not being attended by mental health staff.		
Measures of Compliance:	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)	Not audited.		
Monitor's Recommendations:	None.		

8. Suicide Prevention Training

Paragraph Author: Ruiz	III. C. 8. Suicide Prevention Training 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.		
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14	Non-Compliance: 3/14; 7/13
Measures of Compliance:	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: a. Suicide prevention policies and procedures; b. The suicide screening instrument and the medical intake tool; c. Analysis of facility environments and why they may contribute to suicidal behavior; d. Potential predisposing factors to suicide; e. Highs risk suicide periods; f. Warning signs and symptoms of suicidal behavior; g. Case studies of recent suicides and serious suicide attempts; h. Mock demonstrations regarding the proper response to a suicide attempt; and i. The proper use of emergency equipment.		
Steps taken by the County to Implement this paragraph:			
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	The Response to Consent Agreement reflects plans to train medical, mental health and custodial staff in suicide prevention. This training has begun. No mental health staff have completed CIT training. However, mental health, medical and correctional staff have began suicide prevention training and are scheduled to complete CIT training.		
Monitors' Recommendations:	The Monitor recommends that CHS and MDCR implement and track Competency Based Training. This approach		

	places emphasis on the participant demonstrating that they have met the competency standard through the training program and related work, not just by time spent in training. The Monitor suggests that in the overall training SOP, there be a matrix created within MDCR and CHS 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. 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 Warning signs and symptoms of suicidal behavior; 8. Case studies of recent suicides and serious suicide attempts; 9. Mock demonstrations regarding the proper response to a suicide attempt; and 10. The proper use of emergency equipment.

Paragraph Author: Ruiz	III. C. 8. Suicide Prevention Training 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.		
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14	Non-Compliance: 3/14; 7/13
Measures of Compliance:	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:	The Response to Consent Agreement reflects plans to train medical, mental health and custodial staff. This training has commenced.		
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):	An outline of the CIT lesson plan was previously reviewed. The Mental Health Monitor also reviewed the post-test for the CIT course. Staff that work on mental health units stated that the course had been helpful.		
Monitors' Recommendations:	Please submit a matrix including level of competency according to position and percentage of staff trained.		

Paragraph Author: Ruiz	III. C. 8. Suicide Prevention Training 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.		
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14	Non-Compliance: 3/14; 7/13
Measures of Compliance:	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 mental health training materials		
Steps taken by the County to Implement this paragraph:			
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	MDCR submitted information indicating that it has jointly developed an enhanced CIT course increasing it to a 40-hour training module with 8 hours of suicide prevention. Suicide Prevention Training has also continued as a stand-alone course. To date, since July 2013, 1749 correctional officers have been trained. Information regarding level of competency post-training was not provided.		
Monitors' Recommendations:	Please provide matrix as described above.		

Paragraph Author: Ruiz	III. C. 8. Suicide Prevention Training d. CHS and the County shall ensure all correctional custodial staff are certified in cardiopulmonary resuscitation ("CPR").		
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14	Non-Compliance: 3/14; 7/13
Measures of Compliance:	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. It is not clear what percentage of the staff is scheduled for certification.		
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):	Information provided indicated that MDCR is tracking CPR certification for its staff. According to documents submitted indicated that 1,863 (over 96%) correctional staff have been certified in CPR with the remaining 4% pending completion which is anticipated by January 31, 2015.		
Monitors' Recommendations:	Audit, review, and track certification of medical, mental health, and custody staff.		

9. Risk Management

Paragraph Author: Ruiz	III. C. 9. Risk Management 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: 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: In addition to the Quantros system, the Mental Health Monitor 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.		
Measures of Compliance:	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)	Not audited.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	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: 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	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)	Not audited		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	III. C. 9. 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: 10/14 (Not audited)
Unresolved/partially resolved issues from previous tour:	3/2014: The Mental Health Review Committee has been implemented. Individuals have not been referred to the committee.		
Measures of Compliance:	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)	Not audited		
Monitor's Recommendations:	None		

Paragraph Author: Ruiz	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: 10/14 (Not audited)
Unresolved/partially resolve issues from previous tour:	3/2014: 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.		
Measures of Compliance:	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)	Not audited.		
Monitor's Recommendations:	None.		

D. Audits and Continuous Improvement
1. Self Audit Steps

Paragraph Author: 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14	Non-Compliance: 10/14 (Not audited)
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 Care: 1. Review of Mental Health Review Committee minutes 2. Review of Quality Assurance Committee minutes 3. Review of any reports or analyses generated by MDCR Medical Compliance		
Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health 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 Care: Not audited		
Monitor's Recommendations:	Medical Care: None Mental Health Care: Not audited		

Paragraph Author: 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited); 10/14 (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, and training curricula.) Mental Health Care: Review of corrective action plans. Corrective plans shall be submitted in a timely manner and shall be qualitative; addressing causes not just symptoms of harm.		
Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health 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 Care: Not audited		
Monitor's Recommendations:	Medical Care: None Mental Health Care: Not audited		

2. Bi7annual Reports

Paragraph Author: Stern and Ruiz	CONSENT113 (III.D.2.a.) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: (1) All psychotropic medications administered by the jail to inmates. (2) All health care delivered by the Jail to inmates to address serious medical concerns. The report will include: i. number of inmates transferred to the emergency room for medical treatment and why; ii. number of inmates admitted to the hospital with the clinical outcome; iii. number of inmates taken to the infirmary for non-emergency treatment; and why; and iv. number of inmates with chronic conditions provided consultation, referrals and treatment, including types of chronic conditions.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not yet due – Not audited); 3/14 (Not audited); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not yet due – Not audited); 3/14 (Not audited); 10/14 (Not audited)
Measures of Compliance:	<u>Medical Care:</u> • Audit Step a: (Inspection) The Medical Monitor receives bi-annual reports of health care delivered to inmates including the volume of and reason for episodic clinic visits, chronic care clinic visits, ER transfers, and hospitalizations. Mental Health Care: Review of bi-annual reports, to be submitted in a timely manner and to include accurate data.		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> <u>Mental Health Care:</u> 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):	<u>Medical Care:</u> None <u>Mental Health Care:</u> Not audited		
Monitor's Recommendations:	<u>Medical Care:</u> None <u>Mental Health Care:</u> Not audited		

<table>
<tr><td>Paragraph
Author: Ruiz</td><td colspan="3">III.D.2.a. (3)
Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following:
All health care delivered by the Jail to inmates to address serious medical concerns. The report will include:

All suicide-related incidents. The report will include:

• all suicides;
• all serious suicide attempts;
• list of inmates placed on suicide monitoring at all levels, including the duration of monitoring and property allowed (mattress, clothes, footwear);
• all restraint use related to a suicide attempt or precautionary measure; and
• information on whether inmates were seen within four days after discharge from suicide monitoring.</td></tr>
<tr><td>Mental Health: Compliance Status:</td><td>Compliance:</td><td>Partial Compliance:</td><td>Non-Compliance:
10/14 (Not audited)</td></tr>
<tr><td>Measures of Compliance:</td><td colspan="3">• The Mental Health Monitor receives bi-annual reports of health care delivered to inmates including the volume of and reason for episodic clinic visits, follow-up/chronic care clinic visits, ER transfers, and hospitalizations.
• Bi-annual reports are be submitted in a timely manner and to include accurate data supportive of its conclusions.</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="3">NA</td></tr>
<tr><td>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):</td><td colspan="3">Not audited during this visit</td></tr>
<tr><td>Monitor’s Recommendations:</td><td colspan="3">None</td></tr>
</table>

Paragraph Author: Ruiz	III.D.2.a. (4) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: All health care delivered by the Jail to inmates to address serious medical concerns. The report will include: (4) Inmate counseling services. The report and review shall include: 1. inmates who are on the mental health caseload, classified by levels of care; II. inmates who report having participated in general mental health/therapy counseling and group schedules, as well as any waitlists forgroups; 111. inmates receiving one-to-one counseling with a psychologist, as well as any waitlists for such counseling; and IV. inmates receiving one-to-one counseling with a psychiatrist, as well as any waitlists for such counseling.		
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/14 (Not audited)
Measures of Compliance:	• The Mental Health Monitor receives bi-annual reports of health care delivered to inmates including the volume of and reason for episodic clinic visits, evidence of timely follow-up/chronic care clinic visits, group therapy and individual therapy. • Bi-annual reports are be submitted in a timely manner and to include accurate data supportive of its conclusions.		
Steps taken by the County to Implement this paragraph:	NA		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Not audited during this visit		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	III.D.2.a. (5) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: The report will include: (5) Total number of inmate disciplinary reports, the number of reports that involved inmates with mental illness, and whether Qualified Mental Health Professionals participated in the disciplinary action.		
Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/14 (Not audited)
Measures of Compliance:	• The Mental Health Monitor receives bi-annual reports of health care delivered regarding inmates involved in disciplinary reports at each level of care, the date of any hearing that may have resulted as a result of the disciplinary hearing, whether a QMHP participated in the disciplinary action, and the outcome. • Bi-annual reports are be submitted in a timely manner and to include accurate data supportive of its conclusions.		
Steps taken by the County to Implement this paragraph:	NA		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Not audited during this visit		
Monitor's Recommendations:	None.		

Paragraph Author: Stern and Ruiz	CONSENT117 (III.D.2.a.(6)) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following:… Reportable incidents. The report will include: i. a brief summary of all reportable incidents, by type and date; ii. [Joint audit with MH] a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit; and iii. number of grievances referred to IA for investigation.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not audited); 3/14 (Not audited); 10/14 (Not audited)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) The Medical Monitor receives bi-annual reports of inmate injuries, medical emergencies and in-custody deaths. [NB: For the purpose of this report, MDCR should include deaths which occur outside the MDCR facility (e.g. hospital) and regardless of whether or not the inmate was in custody, if the death resulted from a health status/condition that existed while the inmate was at MDCR. Mental Health Care: 1. Review of bi-annual reports 2. Review of incident reports 3. Review of inmate deaths, including those which died following transfer from MDCR to Jackson Healthcare		
Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health Care: 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 Mental Health Care: Not audited		
Monitors' Recommendations:	Medical Care: None Mental Health Care: Not audited		

Paragraph Author: 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13 (Not audited); 10/14 (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 Care: 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: Mental Health Care: 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 Care: Not audited		
Monitors' Recommendations:	Medical Care: None. See CONSENT111 (IIID1c) Mental Health Care: Not audited		

IV. COMPLIANCE AND QUALITY IMPROVEMENT

Paragraph Author: 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13 (Not audited); 10/14 (Not audited)
Measures of Compliance:	<u>Medical Care:</u> • 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. <u>Mental Health Care:</u> 1. Policies and procedures 2. Schedule for production, revision, etc. of written directives, logs, screening tools, handbooks, manuals, forms, etc. 3. Schedule for pre-service and in-service training 4. Lesson plans 5. Evidence training completed and knowledge gained (e.g. pre and post tests) 6. Observation 7. Staff interviews.		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> <u>Mental Health Care:</u> 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):	<u>Medical Care:</u> None <u>Mental Health</u> Not audited		

Monitor's Recommendations:	Medical Care: None Mental Health Care: Not audited

Paragraph Author: 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); 10/14 (Not audited)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14	Non-Compliance: ; 10/14 (Not audited)
Measures of Compliance:	<u>Medical Care:</u> • 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.) <u>Mental Health Care:</u> 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:	<u>Medical Care</u>: <u>Mental Health Care:</u> 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):	<u>Medical Care:</u> None <u>Mental Health Care:</u> Not audited		

Monitors' Recommendations:	Medical Care: None Mental Health Care: Not audited

Paragraph Author: Stern and Ruiz	CONSENT121 (IV.C) 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); 10/14 (Not audited)
Mental Health Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13 (Not audited); 10/14 (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. <u>Mental Health Care:</u> 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:	<u>Medical Care</u>: <u>Mental Health Care:</u> 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):	<u>Medical Care:</u> None <u>Mental Health Care:</u> Not audited		
Monitor's Recommendations:	<u>Medical Care:</u> None <u>Mental Health Care:</u> Not audited		

Appendix C*1
List of Documents Reviewed by the Monitor Teams
(Patient medical records are listed separately in Appendix C‐3)

1. Select CHS Policies
2. Mortality Review, Mr. Lopez
3. Draft Inmate Handbook

Appendix C*2
List of Staff Interviews by the Monitor Teams

1. Mr. Carlos Migoya
2. Mr. Don Steigman
3. Dr. Shashi Razdan
4. Dr. Dauphin
5. Dr. Zambrano
6. Dr. Mercy Gonzalez
7. Mr. Eli Montoya
8. Ms. Paulette Johnson
9. Ms. Belkys Teodokore
10. Ms. Odalys Pereira
11. Ms. Marydell Guevara
12. Mr. Manny Estrada
13. Lieutenant Angram
14. Dr. Monserrate
15. Ms. Brookings
16. Ms. Bonaby
17. Ms. Hanna
18. Mr. Carcia
19. Ms. Etienne
20. Ms. Hanchard
21. Ms. Dominique
22. Ms. Bitters
23. Ms. Saguinsin
24. Officer Z. Jones
25. Officer Cunningham
26. Officer A. Johnson
27. Officer T. Williams
28. Ms. Luzod
29. Ms. Johnson
30. Ms. Haslem
31. Ms. Esprella
32. Dr. Lewis
33. Dr. Paoli‐Bruno
34. Ms. Ward
35. Ms. Daubon
36. Ms. St. Louis
37. Ms. DeSantos
38. Officer A. Vega
39. Officer D. Soltis
40. Ms. R. Martin
41. Ms. Brown
42. Incidental interactions with other front line custody and health care staff

Appendix C * 3
List of Patients Reviewed by the Monitor Teams

This is a list of medical documents reviewed or patients interviewed (or both). Document reviews 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). Names of patients available only upon request by an authorized party.