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

Independent Monitors' Report No. 5

February 15, 2016

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Introduction – Compliance Report # 5
United States v. Miami-Dade County

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

This report addresses compliance with both the Settlement Agreement (SA) and the Consent Agreement (CA). Shared comments from the Monitors regarding compliance for the Miami-Dade Department of Corrections and Rehabilitation (MDCR) and Corrections Health Services, Jackson Health System (CHS) are provided herein.

The Monitors toured the week of January 4, 2016. Prior to the tour, the Monitoring team reviewed materials, and individually and collectively conferred with the parties through telephone conferences. For both MDCR and CHS specific paragraphs were identified as those the parties wished to have reviewed for compliance. The draft report was provided to all parties for their review on January 21, 2016. All parties provided comments on the due date of February 4, 2016. The Monitors considered all comments in the preparation of this final report.

The Monitors express their thanks for the hard work and leadership of both MDCR Director Marydell Guevara and CHS Director Jesus Estrada. We also extend our thanks to: Deputy Mayor Russell Benford, Carlos A. Migoya, President and CEO of Jackson Health System, and Don Steigman, Chief Operating Officer, Jackson Health System for their time in meeting with the independent Monitors and their advice.

The Monitors note that the defendants are: Miami-Dade County, the Miami-Dade County Board of County Commissioners, and the Miami-Dade County Public Health Trust. In the opinion of the Monitors, a continuing unnecessary and counterproductive struggle for the defendants are their individually and collectively held strong internal beliefs that they are separate entities (e.g. Miami-Dade Department of Corrections and Rehabilitation (MDCR) and Corrections Health Services (CHS)) and, therefore, each should not be held accountable for the actions (or inactions) of their partners. The Monitors see this clearly elucidated in the County's comments regarding the draft of this compliance report. The defendants cannot hope to gain and sustain compliance with the provisions of either of the agreements with this baggage at the operational level. The Monitors believe that the parties intellectually understand this internal barrier– and we urge the leadership to assure that this true collaborative approach is adopted throughout all levels in both organizations. Said another way, the Monitors hear the leadership say that this process is collaborative, but the results and the operational dialogue suggest otherwise.

On a very positive and significant note both CHS/JHS and the County made commitments of financial resources for staffing for MDCR and for CHS to reach and sustain compliance with these two agreements. This is, in the view of the Monitors, a monumental way to

demonstrate the County's desire not only to comply with the provision of the SA and the CA, but also to sustain compliance.

Format of this Report

In Report # 4, in an effort to reduce the number of pages in the compliance report, and focus on the paragraphs deemed most important by the County, the paragraphs NOT reviewed for compliance in May 2015 were not included in the final report. This strategy did not work for the parties or the Monitors, so Report #5 includes *all* paragraphs of both agreements, regardless if reviewed or not. Paragraphs not reviewed are noted in the compliance matrix for each item.

Compliance Update

The report provides a summary update of compliance changes:

Future Reviews of Compliance and Documentation

The Monitors have worked with the Defendants to develop a process to encourage the County to sequence activities to achieve compliance. An element of that collaboration has been the Monitors agreeing to not audit paragraphs the defendants believed *not* prepared for review. Going forward from this report, the Monitors will assign a compliance rating to all paragraphs of the Settlement Agreement and Consent Agreement whether or not the defendants assert they are prepared for a compliance assessment or not. Beginning with Compliance Report # 6, therefore, all paragraphs will be assessed as compliant, partially compliant or non-compliant based on the best information available to the Monitors prior to, or during the on-site tour. Additionally, to clarify, the Monitors will not accept the defendants' offered proofs of compliance (or partial compliance) *after* the conclusion of an on-site tour. The defendants are encouraged to submit their proofs of compliance for any paragraph of the Settlement Agreement or Consent Agreement to the lead Monitor at any time. The County does not have to wait until just prior to an on-site compliance tour to provide the relevant documentation.

Sustaining Compliance

Beginning with the next compliance tour, scheduled for late July 2016, the Monitors will ask the County to demonstrate *continuing* compliance, or partial compliance, with all paragraphs of both agreements.[1] As noted in a letter to the County dated January 25, 2016, the Monitors have an obligation to review compliance not only with the paragraphs for which the defendants are claiming a change in compliance, but the Monitors also must

[1] As governed by due dates established by the Summary Action Plan, developed with the County and DOJ and filed with the Court (as revised).

review *continuing* compliance (or partial compliance) for areas assessed during previous tours.[2] Section VII. C of both the Settlement Agreement and Consent Agreement address the need for the County to remain in substantial compliance for a period of 18 months. Because many of the paragraphs in the Settlement Agreement (see Attachment A) were not reviewed by the Monitors in May 2015 and in January 2016, the demonstration of continuing compliance will need to cover, by sampling, the period of one year. The Monitors note that the on-going compliance may be linked to the "measures of compliance" which are included in all reports. The Monitors are available to work with the County to either refine or clarify the measures. The goal is not to produce paper, but to provide meaningful measures of the County's accomplishments.

The Monitors understand that the Department of Justice and the County have adopted a Summary Action Plan that defines when documentation regarding paragraphs of the Consent Agreement will be ready for review. As the Monitors are not part of that process we will work with the parties to assure there is minimal confusion about the deadlines.

Areas of Progress, Areas of Concern

The most notable areas of progress and concerns are:

Progress and Concern: CHS Staffing

CHS/JHS' commitment to improved staffing based on the Monitors' findings in May 2015 is remarkable. The "on-boarding" of a significant number of professionals was accomplished in a fairly short period of time. The Monitors urge CHS and MDCR to assure that these individuals are oriented and trained so that they will continue with CHS.

Concern: Mental Health Housing

The number of beds needed for acute and step-down mental health housing is increasing. We urge the County to evaluate why this is occurring, and assure that screening instruments and supervision identify appropriate patients for appropriate beds. The re-location of mental health beds from the Pre-Trial Detention Center to Metro West is welcome given the limits and challenges of the architecture of the Pre-Trial Detention Center, but there needs to be continual collaborative evaluation to assure appropriate bed use.

[2] The Monitors want to be clear that we provided direction to the defendants regarding this matter on April 9, 2015. The Monitors noted that, prior to the May 2015 compliance tour and production of Compliance Report # 4, we would continue the rating (e.g. compliance, partial compliance, non-compliance) for a specific paragraph unless information came to our attention that documented a change needed to be made in the rating. This direction was provided to attempt to alleviate the confusion created by the generation of the Summary Action Plan and Internal Working Document developed between the defendants and DOJ. The confusion surrounded whether a particular paragraph was deemed, by the defendants, as ready for review by the Monitors. The Monitors affirm that from Report # 5, forward, the County must document continued compliance (or partial compliance) with the each relevant paragraph.

Progress – Collaboration CHS and MDCR

CHS and MDCR continue to work together to assure collaborative management for the jail system. This is not without its challenges. We applaud the efforts to date; and look for improvements in the future.

Concern – Completion of Policies/Procedures/Written Directives

As noted in Compliance Report #4 - both MDCR and CHS need to complete their written directives that address provisions of both Agreements, develop lesson plans, train staff, and evaluate the implementation.

New Initiative - Improved Communication with Inmates and Inmate Families

During this tour, the Monitoring team provided their contact information to inmates who requested it. While the SA and the CA don't require that the County provide the SA and/or CA documents to inmates, nor require information about how to contact the Monitors to be available, the Monitors believe transparency is essential. The Monitors' provision of this contact information is not intended to suggest that the parties are not providing information to the Monitors and to DOJ, but is intended to add a level of assurance that issues are surfaced and addressed. The Public Defender has agreed to provide this contact information to their clients. Any relevant information obtained by the Monitors through this process will be promptly provided to the County.

Concern – Prison Rape Elimination Act of 2003

In Report # 4, the Monitors identified several issues regarding compliance with the provisions of the SA regarding compliance with the Prison Rape Elimination Act of 2003. These issues were not addressed in the intervening time between these two compliance tours, resulting in the compliance rating changing from compliance to partial compliance. The parties have the information to conclude activities needed to regain compliance, and the Monitors anticipate this change will allow compliance to be re-instated in July 2016 tour.

Progress– MDCR's Future Leadership

The Monitors acknowledge the County's proactive actions to identify the new leadership for MDCR resulting from pending retirements.

Concern – Jail Bed Replacement

The Monitors were briefed concerning the County's plans to replace beds at the TTC. We are pleased to learn about these options and look forward to receiving more information as the process moves forward. While TTC is a concern, the County's attention should also be focused on the conditions of the Pre-Trial Detention Center.

Progress/Concern – Data Driven Jail, CHS Bi-Annual Reporting

The Monitors look forward to the County's more robust and comprehensive quality management program. As noted in previous compliance reports, the County is urged to remember that the processes around data collection, analysis and correction action plans are for the use of the County, not the Monitors. This work is critical to sustaining compliance.

Progress – Use of Force (Response to Resistance)

The Trend Analysis and Action Planning Unit (TAAP) are continuing to mature in its role of reviewing significant events, including uses of force. There are few large jail systems that are using this strategy and the County is commended. The Monitors have documented concerns about recording events/injuries.

Looking Ahead

The Monitors congratulate the County, MDCR and CHS for the progress to date. The next steps toward achieving and sustaining compliance are institutionalizing the quality management and quality assurance programs, determining, collecting and analyzing the significant data, and developing action plans to address any areas of concern. The Monitors look forward to reviewing documentation of not only improved compliance, but also sustained compliance in the July 2016 tour.

References/Abbreviations:

- "the County" - Miami-Dade County, the Miami-Dade County Board of County Commissioners, and the Miami-Dade County Public Health Trust (inclusive of Miami-Dade Department of Corrections and Rehabilitation and Corrections Health Services, Jackson Health System)
- CA - Consent Agreement (effective May 22, 2013)
- CHS - Corrections Health Services, Jackson Health System
- MDCR - Miami-Dade Department of Corrections and Rehabilitation
- Metro West Detention Center (MW)
- Pre-Trial Detention Center (PTDC)
- SA – Settlement Agreement (effective April 30, 2013)
- Training and Treatment Center/Stockade (TTC)
- Turner Guilford Knight Correctional Center (TGK)

Settlement Agreement

Introduction

For this compliance tour, THE COUNTY put forward 19 paragraphs of the 56 total paragraphs. As noted in the Introduction to Report # 5, it in the future, the Monitors anticipate reviewing the status of compliance will all paragraphs. Activities during the week of January 4th included touring by a member of the Monitoring team to all four facilities, meetings, and review of documents. Mr. Darnley R. Hodge, Sr. participated in the tours as part of the monitoring team.

In order to perform the functions required of the Monitors, a review of all paragraphs is needed in the next, and subsequent tours. Attachment A notes the review status of each of the paragraphs.

Summary of Compliance - Settlement Agreement

Report #	Compliance	Partial Compliance	Non-Compliance	Not Applicable/Not Due/Other	Total
1	1	26	23	6	56
2	7	27	22	0	56
3	13	31	10	2	56
4	23	32	0	1	56
5	30	26	0	0	56

Protection From Harm

Safety and Security

MCDR is planning for the implementation of a new jail management information system in the next year. An important part of that will be the module to further the reforms for Classification.[1] This system will also allow THE COUNTY to begin the process of validating the classification system. A significant achievement in the last year was the reclassification and re-housing of the population of inmates previously housed based solely on their charges (e.g. Lewd and Lascivious). THE COUNTY is commended for this culture shift and inmate/staff reeducation. With the July 2016 tour, the Monitors will review samples of logs indicating welfare checks, and supervisory rounds.

[1] As the jail information system is being provided at "no cost" by the inmate telephone system vendor, and with the Federal Communications Commission's recent ruling regarding "profits" generated from inmate use to these vendors, the Monitors suggests that the County be sure that there is not a lessening of the vendor's commitment to the details of the original project deliverables. See: https://www.fcc.gov/consumers/guides/inmate-telephone-service

Security Staffing

As noted in the Introduction to Report # 5, the County is commended on making the fiscal investments necessary to assure an adequate level of staffing in THE COUNTY after years of cuts. THE COUNTY is, therefore, challenged to use these resources wisely. Subsequent Monitors' review will include review of the attrition rate of staff as a measure of organizational health.

Sexual Misconduct

The County needs to complete work to provide a documented consolidated response to allegations of sexual violence and misconduct. The Monitor has a level of confidence that there is effective practice, but the documentation is not at the level required by the Monitor. With the information in both this report and Report #4 the County should be able to regain compliance after the July '16 tour.

Incidents and Referrals

Of these six paragraphs, five are in compliance. Lesson plans are needed to address the remaining paragraph.

Use of Force by Staff

The County's TAAP Unit is charged with evaluating all uses of force for the facilities. Data provided by the County indicates 355 uses of force for the first three quarters of 2015, as contrasted with 322 for the same period in 2014. The reporting from TAAP and in the quarterly reports provides significant information about the uses of force.

The Monitor reviewed 36 of the 39 uses of force for September 2015, including written reports, the TAAP summary, and any video. The Monitor's summary of those events and recommendations were provided to the County on December 4, 2015. Generally, the work of TAAP is good, but, as anticipated, additional refinements are needed. These include: coordination with completing the TAAP forms, clarity regarding any needed employee retraining, revision to the Response to Resistance Worksheet (underway) to make reporting more discrete particularly regarding inmates on the mental health caseload, management of inmate witness statements, coordination with Miami-Dade Police regarding incidents in the booking area, eliminating hand corrections (ink) to printed reports, engaging in more self-critical review of incidents, assuring gaining statements from any involved CHS employee, avoiding 'standardized' language from reports such as "guided the inmate to the floor", and challenging the facility commander or supervisor in critiquing the incident.

The Use of Force provisions of the Settlement Agreement are moving toward compliance. It is important for the County to note the concerns in the review of the

parallel provisions of the Consent Agreement regarding use of force treatment. There are concerns that the documentation from CHS needs to be more robust and comprehensive regarding not only use of force medical reviews, but notes regarding injuries resulting from inmate/inmate altercations.

It is the Monitors' intent to review another month's use of force incident reports prior to the next tour to document the improvements to the system. In this same interval, THE COUNTY will produce the year-end report for 2015 with trend data and any action plans that are indicated by the information. Evaluation of the action plans will be a critical part of the July '16 tour.

Early Warning System

All paragraphs of the requirements for the early warning system are now in compliance. The next phase is to evaluate the effectiveness and outcomes of the EWS. This will be done through the required quarterly reporting and implementation of any needed plans of action.

Fire and Life Safety[2]

Compliance Report No. 5 is being 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 1:13-CV-21570-CIV-ZLOCH. A tour of the Miami-Dade County Corrections and Rehabilitation Department (MDCR) facilities took place from January 4-6, 2016 including Boot Camp, Turner Guilford Knight Correctional Center (TGK), Metro West Detention Center (MW) Pretrial Detention Center (PTDC) and the Training and Treatment Center (TTC). Prior to the tour, the documents provided by the County for these five facilities were reviewed.

The purpose of Report #5 is to assess compliance with the Settlement Agreement Part B Fire and Life Safety Provisions. The report summarizes the findings for each provision and provides recommendations for improvement to reach compliance with the Settlement Agreement.

Again, the Monitor expresses appreciation for the leadership and commitment of Director Marydell Guevara and for her passion to improve the conditions of confinement throughout all the County's jail facilities. Her dedication and skills to delegate responsibility with accountability continues to have a strong positive influence on her staff to their assessment of alternatives and creating solutions to not only comply with the Settlement Agreement, but in many cases go beyond that Agreement's provisions to establish benchmarks that can be used by large jails nationally. Her understanding of the issues, and more importantly her cooperation

[2] A listing of documents reviewed and individuals interviewed is available upon request.

and demands for excellence from staff, continue to serve well the citizens of Miami Dade, the inmates and the employees of MDCR.

The success thus far of the County's compliance with the Settlement Agreement cannot have occurred without hard work and dedication of the employees of MDCR who have invested hours to review policies, procedures, develop training lesson and prepare documents for the Monitors' review.

The County made several improvements in the six months since the previous compliance tour in May 2015:

- There have been significant improvements to reduce the backlog of work orders. For example, in reviewing the monthly fire safety inspections, work orders for non-functioning equipment were resolved and closed out within 24 to 48 hours except where part had to be ordered.
- Monthly fire safety inspections are completed as required.
- The 4-hour fire and life safety training lesson plan is completed.

Housing unit cells and dormitories continue to be generally maintained with no significant fire hazards in the cells. Inmates were storing commissary and personal belongings in their personal property bags as required by policy. At PTDC, TGK, and Boot Camp housing dormitories, cells, showers, and toilets were clean and well organized. At MWDC Facilities Maintenance continues its project to replace shower units throughout.

In order to obtain and sustain compliance with the Settlement Agreement, the County needs to finalize revisions to several fire and life safety policies including DSOP 10-006(Emergency Procedures Re: Evacuation), DSOP 10-010 (Chemical Control) DSOP 10-022 (Fire Response and Prevention Plan), and DSOP 10-023 (Key Control). When the policies are completed, training lesson plans can be completed. The four-hour fire and life safety lesson plan that was provided is very well done including Power Point slides, practical exercises, pre and post testing instruments and a course evaluation. It should be the model for the development of other required training programs.

The County must continue improving its self-critical assessments of each fire drill to identify improvements in both in emergency response procedures, evacuation policies and training. It will be helpful to assure fire safety officers, shift supervisors, and shift commanders receive training on how to evaluate employees' performance during the drills.

The Compliance and Accreditation Bureau must reinstitute the compliance audit program for each facility. The audits will identify where existing policies are not being followed.

The County is in the process of issuing a Request for Proposal for installing chemical

control mechanical dispensing equipment for all facilities as currently installed at TGK. This will resolve chemical control and inventory process differences at each facility.

When the revised policies are authorized, evaluation of the implementation of processes in accordance with the departmental procedures specified, including effectiveness of training cab be determined. The focus of future tours will be review evidence of compliance and review corrective action that addresses breakdowns in implementation.

Inmate Grievances

The Monitors will review compliance with the grievance requirements in conjunction with the July '16 tour. Recommendations were provided regarding the quarterly reporting including reviewing the topics of unsubstantiated grievances, assuring that the County's data and outcomes regarding medically related grievances match, evaluating response times, and providing the outcome of appealed grievances by topic.

Audits and Continuous Improvement and Compliance and Quality Improvement

This is the largest significant work remaining to be done. The written directive draft was provided to the Monitors for review, and returned with suggestions to simply the process. The County needs to assure significant collaboration occurs between CHS and MDCR. As noted in the Introduction, the information, data, recommendations, *plans of action,* etc. that evolve from the quality improvement processes are for the benefit of the County, not the Monitors and should be viewed as such by the end-users.

Conclusion

The County is now in compliance with 33 of the 56 paragraphs in the Settlement Agreement. This is significant progress. With the next tour, not only do the Monitors anticipate that more compliance will be gained, but also there will be sufficient demonstration of sustaining compliance.

The County is congratulated on the work to date, with substantial additional progress anticipated before the next tour in July 2016.

Settlement Agreement - Summary of Compliance
Tour the Week of January 4, 2016

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
Safety and Supervision				
III.A.1.a. (1)		x		
III.A.1.a. (2)		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.1.a. (3)	x			Evidence of continued full compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.1.a. (4)	x			Evidence of continued full compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.1.a. (5)	x			Evidence of continued full compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.1.a. (6)	x			Evidence of continued full compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.1.a. (7)	x			Evidence of continued full compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.1.a. (8)	x			For the July 2016 tour evidence of plans of action (if indicated by the data) will be reviewed.
III.A.1.a. (9)	x			For the July 2016 tour information about negotiations regarding the custom of 6 month bids will be reviewed, along with the impact on continuing compliance with the SA.
III.A.1.a. (10)		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.1.a. (11)		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
Security Staffing				
III.A.2. a.	x			Evidence of continued of full compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.2. b.	x			Evidence of continued full compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.2.c.	x			Evidence of continued full compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.2.d.	x			Assure that documentation is provided in future tours – see III.A.2.d.
Sexual Misconduct				
III. A.3.		x		See Executive summary and III. A. 3.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
Incident and Referrals				
III. A.4 a.	x			Evidence of continued full compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.4. b.	x			Evidence of continued full compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.4.c.	x			In the July '16 tour, sample reports are required, along with action plan implementation, if any, to document compliance.
III.A.4.d.	x			Evidence of continued full compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16. Consent III.A.5.c.2. vii.
III.A.4.e.		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.4.f.	x			Evidence of continued compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
Use of Force				
III.A. 5 a.(1) (2) (3)		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.5. b.(1), (2) i., ii, iii, iv, v, vi		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16. For MH see Consent Agreement III.B.3. 40
III.A. 5. c. (1)		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A. 5. c. (2)		x		See notes and also III.A.5.c.(1)
III.A. 5. c. (3)	x			Evidence of continued compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A. 5. c. (4)	x			Evidence of continued compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A. 5. c. (5)	x			Evidence of continued compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16. Per The County not reviewed See Consent Agreement III.B.3.
III.A. 5. c. (6)	x			Evidence of continued compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16. See Consent Agreement III.B.3.
III.A. 5. c. (7)	x			Evidence of continued compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16. See recommendations from the Monitor regarding reviews of uses of force.
III.A. 5. c. (8)	x			Evidence of continued compliance must be provided before

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
				the July '16 tour for the period 5/15/15 – 7/25/16. See recommendations from the Monitor regarding reviews of uses of force.
III.A. 5. c. (9)	x			
III.A. 5. c. (10)	x			Evidence of continued compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16. See recommendations from the Monitor regarding reviews of uses of force. See Consent Agreement III.B.3.
III.A. 5. c. (11)		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16. See recommendations from the Monitor regarding reviews of uses of force. See Consent Agreement III.B.3.
III.A. 5. c. (12)		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16. See recommendations from the Monitor regarding reviews of uses of force. See Consent Agreement III.B.3.
III.A. 5. c. (13)	x			Evidence of continued compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A. 5. c. (14)		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16. See recommendations from the Monitor regarding reviews of uses of force
III.A.5. d. (1) (2) (3) (4)		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.A.5. e. (1) (2)		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
Early Warning System				
III.A.6. a. (1) (2) (3) (4) (5)	x			
III.A.6.b.	x			
III.A.6.c.	x			Evidence of continued compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16
Fire and Life Safety				
III.B.1.		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.B.2.	x			Evidence of continued compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.B.3.		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
III.B.4.		x		
III.B. 5.		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.B.6		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
Inmate Grievances				
III.C. 1.,2.,3.,4.,5.,6.	x			Evidence of continued compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16. See also Consent Agreement III.A.3.a.(4)
Audits and Continuous Improvements				
III.D.1. a. b.		x		Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.
III.D. 2.a. b.		x		See also Consent Agreement III. D. 2. Pages 80 – 85.
Compliance and Quality Improvement				
IV. A.		x		
IV. B.		x		
IV. C.		x		Provide documentation before the July '16 tour of the annual review process for specific policies and procedures. Protection from harm, compliance, Fire, Life Safety – partial compliance.
IV. D.		x		Provide documentation before the July '16 tour of the annual review process for specific policies and procedures.

Settlement Agreement
January 21, 2016

III. A. PROTECTION FROM HARM

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

Paragraph	III. A. 1. Safety and Supervision: a. MDCR will take all reasonable measures to ensure that inmates are not subjected to harm or the risk of harm. While some danger is inherent in a jail setting, MDCR shall implement appropriate measures to minimize these risks, including: (1) Maintain implemented security and control-related policies, procedures, and practices that will ensure a reasonably safe and secure environment for all inmates and staff, in accordance with constitutional standards.			
Compliance Status:	Compliance:	Partial Compliance: 3/28/14, 7/19/13, 10/24/14, 1/8/16	Non-Compliance:	Other: Per MDCR not reviewed in 5/15
Unresolved/partially resolved issues from previous tour:	Evidence of compliance other than the written directive not provided. Additionally written directive to address SA IV. and V. not completed.			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Manual of security and control-related policies, procedures, written directives and practices, consistent with Constitutional standards and contents of the Settlement Agreement. 2. Internal audits. 3. Documentation of annual review(s). 4. Schedule of review for policies, procedures, practices.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Complete directives to address SA – IV and V.			
Monitor's Recommendations:	1. See above. 2. Assure subsequent materials to verify compliance include evidence that the policy is in effect and being followed.			

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	Other: Per MDCR not reviewed in 5/15, 1/16
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:	Work continues to implement the new jail information system and the classification modules.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Information system not completed; classification modules not completed.			
Monitor's Recommendations:	As the jail information system is being provided at "no cost" by the inmate telephone system vendor, and with the Federal Communications Commission's recent ruling regarding "profits" generated from inmate use to these vendors, the Monitor suggests that the County be sure that there is not a lessening of the vendor's commitment to the details of the original project deliverables. See: https://www.fcc.gov/consumers/guides/inmate-telephone-service			

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:	Other: Per MDCR not reviewed in 5/15, 1/16.

Unresolved/partially resolved issues from previous tour:	None
Measures of Compliance:	Protection from Harm: 1. Policies and procedures requiring conduct of rounds. 2. Review of housing unit logs. 3. Review of staffing in housing units through observation and logs. 4. Interviews with inmates, employees.
Steps taken by the County to Implement this paragraph:	
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	No evidence was provided regarding on-going compliance.
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance or partial compliance.

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: 5/15/15	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 1/16.
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	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)	No evidence was provided regarding on-going compliance.			
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.			

Paragraph	III. A. 1. Safety and Supervision: a. MDCR will take all reasonable measures to ensure that inmates are not subjected to harm or the risk of harm. While some danger is inherent in a jail setting, MDCR shall implement appropriate measures to minimize these risks, including: (5) MDCR shall document an objective risk analysis of maximum security inmates before placing them in housing units that do not have direct supervision or video monitoring, which shows that these inmates have no greater risk of violence toward inmates than medium security inmates. MDCR shall continue to increase the use of overhead video surveillance and recording cameras to provide adequate coverage and video monitoring throughout all Jail facilities to include: i. PTDC – 24 safety cells, by July 1, 2013 ii. PTDC – 10B disciplinary wing, by December 31, 2013; kitchen, by Jan. 31, 2014; iii. Women's Detention Center – kitchen, by Sept. 30, 2014; iv. Training and Treatment Center - all inmate housing units areas and kitchen, by Apr. 30, 2014; v. Turner Guilford Knight Correctional Center – kitchen; future intake center; by May 31, 2014; and vi. Metro West Detention Center – throughout all areas; by Aug. 31, 2014.			
Compliance Status:	Compliance: 10/24/14	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16.
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Re-classification screening documentation for inmates moved to maximum security housing that does not have direct supervision or video monitoring. 2. Plan to increase video surveillance and recording capacity; implementation dates; contracts; evidence of completion on required dates; plan of action if dates specified in the Settlement Agreement for completion not met.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation of partial or substantial compliance must be provided for the July 2016 tour.			
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance (or partial compliance) for the previous year to maintain rating of compliance.			

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:	Other: Per MDCR not reviewed in 5/15, 1/16
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:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation of substantial compliance must be provided for the July 2016 tour.			
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.			

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:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	NA			
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding daily supervisory rounds in inmate housing units on all shifts. 2. Examination of logs/documentation. 3. Inmate interviews. 4. Corrective actions for any supervisory findings from rounds (examples of), if any.			
Steps taken by the County to Implement this paragraph:				

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation of partial or substantial compliance must be provided for the July 2016 tour.
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance (or partial compliance) for the previous year to maintain rating of compliance.

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: 1/8/16	Partial Compliance: 10/24/14.	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 5/15.
Unresolved/partially resolved issues from previous tour:	Completion of written directives for SA IV. and V. The action plans for the data collection and analysis needed to document compliance are due after the first quarter of 2016 and therefore unable for Monitor's review and evaluation.			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding staff searches of inmate cells and living areas, meeting language in this Settlement Agreement. 2. Shakedown logs/records. 3. Operational plans for large scale searches; and post search evaluations/management reviews. 4. Reports provided by MDCR regarding contraband and shakedowns.			
Steps taken by the County to Implement this paragraph:	MDCR has improved the quarterly reporting, and additional improvements are needed, including completion of the written directive governing the process (address SA IV and V.)			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	A meeting was held on-site during the week of January 4th regarding Monitor's recommendations for reporting: inmate discipline, and Trend Analysis and Action Planning Unit (TAA), and shakedowns and contraband reports. Significant recommendations were made in December '15 regarding improvement to TAAP's operations regarding uses of force. MDCR is working on collecting the data, and providing some analysis. The benchmark for the July '16 tour is if there are plans of action initiatives following the review of the data from CY2015 and how those plans of action are implemented and evaluated.			
Monitor's Recommendations:	1. Assure that the data collected is meaningful and used in organizational operations. 2. Assure action plans are developed to address deficiencies identified in year-end reports. 3. Review and respond to Monitor's recommendations (1/2/16) regarding the quarterly report for the 3rd quarter of 2015. 4. Assure collaboration with CHS for contraband that involves medical care (e.g. medication, medical appliances, etc.)			

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: 1/8/16	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15.
Unresolved/partially resolved issues from previous tour:	This issue is being discussed with DOJ and is related to on-going labor/management negotiations.			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training for officers who transfer from one division to another. 2. Facility specific operational procedures/written directives. 3. Lesson plans on facility-specific safety and security. 4. Proof of attendance within 30 days of assignment. 5. Demonstration of knowledge gained (e.g. pre and post tests) 6. Examples of remedial training, if any.			
Steps taken by the County to Implement this paragraph:	Documentation of compliance was provided for the interim period since the May 2015 tour. A MAJOR unresolved issue is how the County's collective bargaining process will address the custom of bidding every six months, that potentially results in a large shift in staff to a new facility (for them) and the burden on the County of the required training.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As noted in the May report - awaiting finalization of discussions between DOJ and MDCR and outcomes of labor/management negotiations.			
Monitor's Recommendations:	1. Assure compliance is maintained whether the bidding process is modified or not. 2. Compute the costs for the bidding alternatives to assure compliance with the SA.			

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: (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:	Other: Per MDCR not reviewed in 5/15, 1/16
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.
Steps taken by the County to Implement this paragraph:	Protection from Harm: Evidence of the CIT program's implementation, lesson plans, and participant lists provided. Fiscal issues precluded training during the last quarter of the FY 2015 (July – September). MDCR assures that the training is now back on track. 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.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Documentation of partial or substantial compliance must be provided for the July 2016 tour.
Monitors' Recommendations:	Protection from Harm: Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance (or partial compliance) for the previous year to maintain rating of compliance.

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:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	See comments and recommendations for paragraph III. A.1.a (8)			
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:	See comments and recommendations for paragraph III. A.1.a (8)			

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See comments and recommendations for paragraph III. A.1.a (8)
Monitor's Recommendations:	1. Assure that the plans of action completed to provide proof of compliance with this (and other) paragraphs can be monitored and evaluated, adjusted as necessary to address issues identified in the data analysis. 2. Documentation of partial or substantial compliance must be provided for the July 2016 tour.

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: 5/15/15	Partial Compliance: 10/24/14, 3/28/14	Non-Compliance: Not yet due (11/27/13)	Other: Per MDCR not reviewed in 1/16.
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. 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:	The County provided a substantial increase to the MDCR budget to provide the staffing (over several years) as indicated by the staffing analysis. This is a remarkable commitment to the safety of the facilities. MDCR's burden will be to demonstrate that this increased staffing can be achieved, overtime reduced, and the facilities operated consistent with accepted correctional practice and the provisions of the SA.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation of substantial compliance must be provided for the July 2016 tour.			
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.			

Paragraph <u>Coordinate with Drs. Ruiz and Stern</u>	III. A. 2. Security Staffing: b. MDCR shall ensure that the staffing plan includes staffing an adequate number of correctional officers at all times to escort inmates to and from medical and mental health care units.			
Protection from Harm: Compliance Status:	Compliance: 5/15/15	Partial Compliance: 10/24/14, 3/28/14	Non-Compliance: 7/19/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:	None at this time. Pending review of the implementation plan for hiring.			
Measures of Compliance:	<u>Protection from Harm:</u>			

	1. Staffing plan; staffing for escorts in each facility. 2. Policies and procedure for officer escorts to and from medical and mental health care units. 3. Overtime records, if any. 4. Consultation with Drs. 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 credible reports of lack of staff from CHS, MDCR and/or inmates to escort inmates to and from the medical health care appointments. 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. Documentation of substantial compliance must be provided for the July 2016 tour. 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: See III. A. 2. a. The staffing adequacy and deployment will be reviewed prior to and during the next tour. Medical Care: Mental Health: As part of the audit, Monitors specifically asked nurses and patients about adequacy of availability of COs for escort to clinic at all 4 facilities: no problems were identified.
Monitors' Recommendations:	Protection from Harm: Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance. Medical Care: Mental Health:

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: 5/15/15	Partial Compliance: 10/24/14; 3/28/14	Non-Compliance: Not yet due 11/27/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues				

from previous tour:	
Measures of Compliance:	Protection from Harm: 1. Completed staffing plan; discussion of recommendations by the monitor, if any. 2. Determination of the need for more hiring, if any. 3. Hiring plan, if needed, with timetable. 4. Results of hiring, if needed.
Steps taken by the County to Implement this paragraph:	See III.A.2.a. MDCR has completed a hiring plan and is implementing.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation of partial or substantial compliance must be provided for the July 2016 tour.
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance (or partial compliance) for the previous year to maintain rating of compliance.

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: 1/8/16	Partial Compliance:	Not Yet Due: 5/15/15 10/24/14; 3/28/14
Unresolved/partially resolved issues from previous tour:	MDCR provided the analysis of the staffing plan. See also III.A.2.a.		
Measures of Compliance:	Protection from Harm: 1. Report from MDCR comparing if recommended staffing is adequate to implement the requirements of this agreement. 2. Review of overtime costs; vacancies and vacancy trends. 3. Re-evaluation of hiring and hiring timetable, if needed. 4. Review/comment by the monitor of report in III.A.2.a., above.		
Steps taken by the County to Implement this paragraph:	Preparation of the report as required.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Letter provided to the Monitor on 9/9/15. The letter asserting that the analysis was conducted was not sufficient; and upon request to MDCR the spreadsheets indicating that the substance of the review was provided.		
Monitor's Recommendations:	Assure that documentation is provided to demonstrate compliance. The Monitor will re-evaluate the staffing plan and associated hiring and attrition data, as well as continued County funding, in subsequent tour.		

III.A.3. Sexual Misconduct

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, **1/8/16**	Non-Compliance: MDCR did not request review during tour of 5/15; compliance was reviewed due to identifying issues of conflict with the PREA audit.
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:	During the May 2015 tour, the Monitor appraised MDCR regarding the issues of draft documents reviewed by the PREA auditor, in violation of the audit's procedures. Additionally, the confusion of whether the SART protocol was a written directive and how it applied to both MDCR and CHS was raised by the Monitor. The Monitor provided specific direction to resolve these issues (see Report #4, pages vi, 5). These matters were not resolved. The Monitor believes that MDCR, MDPD and CHS are working in a practical sense according to the PREA standards; but the absence of directives required by the Monitor, after seven months, results in this paragraph being moved from compliance to partial compliance.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. PREA policies and procedures 2. Self-audit (separate action plan to be based on MDCR's self-audit) [see http://static.nicic.gov/Library/026880.pdf] 3. Implementation of plans of action, etc., including audit based on self-audit. <u>Medical Care/Mental Health:</u> • Audit Step a: Substantial compliance with all medical-related elements of an external PREA audit by the PREA Resource Center will constitute compliance with the medical aspects of this provision		
Steps taken by the County to Implement this paragraph:	<u>Protection from Harm:</u> None taken based on the Monitor's comments in Report #4 during the interval between the May 2015 compliance tour and the January 2016 tour.		
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> The County failed to review and/or challenge the Monitor's recommendations and findings in May 2015, and did not resolve the issues.		
Monitors' Recommendations:	<u>Protection from Harm:</u> 1. Review requirements noted in Report #4, as well as in meetings during the week of January 4th, and develop the		

	materials needed. 2. Assure that all the recently hired CHS staff have been trained in the policies, procedures and protocols. Provide documentation of this training for the July 2016 tour. 3. Assure that internal monitoring takes place to document on-going compliance with the PREA standards (outside of whatever is required by the PREA Resource Center) in the tour of July '16. 4. Provide to the Monitor when prepared the Survey of Sexual Violence due to the U. S. Dept. of Justice, Bureau of Justice Statistics.

III. A. 4. Incidents and Referrals

Paragraph	4. Incidents and Referrals a. MDCR shall ensure that appropriate managers have knowledge of critical incidents in the Jail to 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:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	None at this time			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding notifications to managers regarding critical incidents; actions required. 2. Policies and procedures regarding reportable incidents. 3. Documentation of notification managers; checklists/incident reports. 4. Review of incident reports. 5. Review of critical incidents. 6. Interview with supervisory and management staff. <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:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation of substantial compliance must be provided for the July 2016 tour.			
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of 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	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				

Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding notifications for critical incidents, including suicides and deaths. 2. Documentation of notification checklists/documentation. 3. Review of incident reports/investigations.
Steps taken by the County to Implement this paragraph:	
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation of substantial compliance must be provided for the July 2016 tour.
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.

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: 1/8/16	Partial Compliance: 5/15/15; 10/24/14; 3/28/14	Non-Compliance: 7/19/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Protection from Harm: 1. Policies and procedures to track, analyze data, develop corrective action plans, as needed for all reportable incidents. 2. Definition of reportable incidents. 3. Review of reports, analysis, corrective action plans. 4. Review of elements in database. 5. Review of incident reports 6. Review of any external reviews/results.		

	7. Review of corrective action plan, if any. 8. Review of data/reports generated from the information in the system.
Steps taken by the County to Implement this paragraph:	See above.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The completed policy and procedures, and major incident checklist was provided; but no specific examples provided. Nor were any action plans provided as these are not due until after the last quarter of 2015 is reviewed. DOJ provides tracking for the reported incidents, rather than MDCR, which the Monitor notes was not requested of MDCR. Completion of the written directive implementing SA IV and V is required prior to the next compliance tour.
Monitor's Recommendations:	1. Assure that inmates in self-harm incidents who are taken to any emergency department for any period of time are promptly reported to the Monitors. 2. In the July '16 tour, the Monitor will review the action plans and outcomes to support compliance with this section. 3. In future pre-tour documents, MDCR must provide a sample of reports that support compliance with this provision. 4. Completion of the written directive implementing SA IV and V is required prior to the next compliance tour.

<u>Paragraph</u> <u>Coordinate with Drs. Ruiz</u>	4. Incidents and Referrals d. MDCR shall develop and implement a policy to screen incident reports, use of force reports, and inmate grievances for allegations of staff misconduct and refer an incident or allegation for investigation if it meets established policy criteria.			
Protection from Harm: Compliance Status:	Compliance: 5/15/15	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13 (not yet due)	Other: Per MDCR not reviewed in 1/16
Mental Health	Compliance:	Partial Compliance:	Non-compliance: 3/28/14	Other: 7/13, 10/14, 5/15 (not audited)
Unresolved/partially resolved issues from previous tour:	Repeat from Report # 4 Assure that companion CHS policies are in place, and medical providers are trained at recognizing signs and symptoms of use of force, use of excessive force, and inmate/inmate assault and sexual assault.			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding incident reports, including criteria for screening for critical incidents (see also III.A.3); 2. Documentation of referrals of grievances for investigations; outcomes. 3. Corrective actions for incidents not referred as required. 4. Review of medical and mental health policies and procedures regarding referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc. 5. Medical and mental health policies and procedure regarding review of medical grievances to screen for critical incidents. 6. Documentation of referrals to investigators by medical and/or mental health staff, if any. 7. Assure that companion CHS policies are in place, and medical providers are trained at recognizing signs and symptoms of use of force, use of excessive force, and inmate/inmate assault and sexual assault. <u>Mental Health:</u> 1. Policies and procedures regarding incident reports, including criteria for screening for critical incidents (see also			

	III.A.3); 2. Documentation of referrals of grievances for investigations; outcomes. 3. Corrective actions for incidents not referred as required. 4. Review of medical and mental health policies and procedures regarding referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc. 5. Medical and mental health policies and procedure regarding review of medical grievances to screen for critical incidents. 6. Documentation of referrals to investigators by medical and/or mental health staff, if any.
Steps taken by the County to Implement this paragraph:	
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> • Documentation of substantial compliance must be provided for the July 2016 tour. • Review the data for CY 2015 to determine if a plan of action is necessary. Monitor will evaluate any plans of action in the July '16 tour. <u>Mental Health:</u> None at this time.
Monitors' Recommendations:	<u>Protection from Harm/Mental Health:</u> 1. Need to coordinate with CHS to assure all inmates' medical care includes visual screening for these incidents. 2. Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.

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:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training on preparing incident reports; and notification criteria for critical incidents. 2. Lesson plans; pre-service and in-service. 3. Training schedule and attendance rosters. 4. Documentation of knowledge gained (e.g. pre and post tests) 5. Evidence of remedial training, if needed. 6. Review of incident reports.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to	Documentation of partial or substantial compliance must be provided for the July 2016 tour.			

assess compliance, verification of the County's representations, and the factual basis for finding(s)	
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance (or partial compliance) for the previous year to maintain rating of compliance.

Paragraph <u>Coordinate with Dr. Ruiz</u>	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: 1/8/16	Partial Compliance: 5/15/15, 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training for notifications for Medical Care and mental health emergencies. 2. Lesson plans; training schedule. 3. Documentation of knowledge gained (e.g. pre and post tests) 4. Evidence of remedial training, if needed. 5. Review of incidents in which medical/mental health issues reported and not reported. 6. Minutes of meetings between security and medical/mental health.		
Steps taken by the County to Implement this paragraph:			
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Evidence provided is of lesson plans. For subsequent compliance tours, MDCR and CHS must submit examples that demonstrate compliance.		
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance (or partial compliance) for the previous year to maintain rating of compliance. In the next report (#6) a review of compliance from the mental health monitor will be added.		

III. A. 5. Use of Force by Staff

Paragraph	III. A. 5. Use of Force by Staff a. Policies and Procedures (1) MDCR shall sustain implementation of the "Response to Resistance" policy, adopted October 2009. In accordance with constitutional requirements, the policy shall delineate the use of force continuum and permissible and impermissible uses of force, as well as emphasize the importance of de-escalation and non-force responses to resistance. The Monitor shall provide ongoing assistance and annual evaluation regarding whether the amount and content of use of force training achieves the goal of reducing excessive use of force. The Monitor will review not only training curricula but also relevant data from MDCR's bi-annual reports. (2) MDCR shall revise the "Decontamination of Persons" policy section to include mandatory documentation of the actual decontamination time in the response to resistance reports. (3) The Jail shall ensure that each Facility Supervisor/Bureau Commander reviews all MDCR incidents reports relating to response to resistance incidents. The Facility Supervisor/Bureau Commander will not rely on the Facility's Executive Officer's review.		
Compliance Status:	Compliance:	Partial Compliance: 1/8/16, 5/15/15, 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	The growth in experience of the TAAP Unit will continue to greatly enhance the review of uses of force by staff.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force, response to resistance, including reporting and review protocols. 2. Monitor's annual evaluation of relevant data, including whether the amount and content of use of force training achieves the goal of reducing use of excessive force; review of bi-annual reports from MCDR. 3. Policies and procedures regarding decontamination; corresponding medical policies/procedures. 4. Policies and procedures on review of incident reports (see also III.A.4.a, III.A. 4.b.) by Facility Supervisor/Bureau Commander. 5. Review of reports; data.		
Steps taken by the County to Implement this paragraph:	The implementation of the Trend Analysis and Action Planning (TAAP) Unit is a substantial commitment and their work hold the key, along with quality improvement, to inmate and staff safety.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR has delivered quarterly reports; which will be refined as their internal processes become more sophisticated. Additionally, there is a need for a written protocol between TAAP and Investigations to assure appropriate review and/or employee discipline. Without the written directive that addressed SA IV and V this paragraph remains in partial compliance.		
Monitor's Recommendations:	1. Continue training for TAAP members; provide meaningful critique of their work, data analysis and reports. Develop written protocols for collaboration/coordination between TAAP and SIAB. 2. Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance (or partial compliance) for the previous year to maintain rating of compliance. 3. Complete the written directive addressing SA IV an V		

	4. Provide the annual report and action plan for 2015 to the Monitor when completed (don't wait until the next tour) for review and discussion.

Paragraph See Consent Agreement III.B.3.	III. A. 5. Use of Force by Staff b. Use of Restraints (1) MDCR shall revise the "Recognizing and Supervising Mentally Ill Inmates" policy regarding restraints (DSOP 12-005) to include the following minimum requirements: i. other than restraints for transport only, mechanical or injectable restraints of inmates with mental illness may only be used after written approval order by a Qualified Health Professional, absent exigent circumstances. ii. four-point restraints or restraint chairs may be used only as a last resort and in response to an emergency to protect the inmate or others from imminent serious harm, and only after the Jail attempts or rules out less-intrusive and non-physical interventions. iii. the form of restraint selected shall be the least restrictive level necessary to contain the emerging crisis/dangerous behavior. iv. MDCR shall protect inmates from injury during the restraint application and use. Staff shall use the least physical force necessary to control and protect the inmate. v. restraints shall never be used as punishment or for the convenience of staff. Threatening inmates with restraint or seclusion is prohibited. vi. any standing order for an inmate's restraint is prohibited. (2) MDCR shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15 minute in-person visual observation by trained custodial staff. For any custody-ordered restraints, Qualified Medical Staff are notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.			
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance: 5/15/15, 10/24/14, 3/28/14, 7/19/14	Non-Compliance:	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding 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.			

Steps taken by the County to Implement this paragraph:	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: Documentation of partial or substantial compliance must be provided for the July 2016 tour.
Monitors' Recommendations:	Protection from harm: Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.

Paragraph	III.A. 5.c. (1) MDCR shall ensure that use of force reports: i. are written in specific terms and in narrative form to capture the details of the incident in accordance with its policies; ii. describe, in factual terms, the type and amount of force used and precise actions taken in a particular incident, avoiding use of vague or conclusory descriptions for describing force; iii. contain an accurate account of the events leading to the use of force incident; iv. include a description of any weapon or instrument(s) of restraint used, and the manner in which it was used; v. are accompanied with any inmate disciplinary report that prompted the use of force incident; vi. state the nature and extent of injuries sustained both by the inmate and staff member vii. contain the date and time any medical attention was actually provided; viii. include inmate account of the incident; and ix. note whether a use of force was videotaped, and if not, explain why it was not videotaped.			
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance: 10/24/14, 3/28/14	Non-Compliance: 7/19/13	Other: Not reviewed per MDCR 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 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			
Steps taken by the County to	Protection from harm:			

Implement this paragraph:	Although MDCR did not request a review of this paragraph, the Monitor notes that improvements need to be made in the level of description provided by CHS for inmates involved in inmate/inmate altercations and in uses of force.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: A review of all use of force reports for September 2015 indicates a need for training for CHS personnel regarding the detail needed in the narrative regarding inmate injuries (or no injuries). This was also an observation by the State's Attorney for the cases she reviews. Finally MDCR's SIAB indicates that they must follow-up in most incidents with the CHS staff person to gain more information on inmate injuries.
Monitors' Recommendations:	Protection from Harm: 1. MDCR and CHS must work together to assure that there is an adequate description provided of inmate injuries as the result of inmate/inmate altercation, injuries, and uses of force. MDCR and CHS should review their own internal efforts to get the information needed, as well as consult with the State's Attorney regarding her needs. 2. Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.

Paragraph	III.A. 5.c. (2) MDCR shall ensure that use of force reports: i. are written in specific terms and in narrative form to capture the details of the incident in accordance with its policies; ii. describe, in factual terms, the type and amount of force used and precise actions taken in a particular incident, avoiding use of vague or conclusory descriptions for describing force; iii. contain an accurate account of the events leading to the use of force incident; iv. include a description of any weapon or instrument(s) of restraint used, and the manner in which it was used; v. are accompanied with any inmate disciplinary report that prompted the use of force incident; vi. state the nature and extent of injuries sustained both by the inmate and staff member vii. contain the date and time any medical attention was actually provided; viii. include inmate account of the incident; and ix. note whether a use of force was videotaped, and if not, explain why it was not videotaped.			
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance: 1/8/16, 10/24/14, 3/28/14	Non-Compliance: 7/19/13	Other: Other: Not reviewed per MDCR 5/15
Unresolved/partially resolved issues from previous tour:	See notes above, III.A.5.c. (1) MDCR's reports are sufficient, but CHS' notes are not sufficient. As the County is the defendant, both entities must be consistent for this to be considered in compliance.			
Measures of Compliance:	Protection from Harm: 11. Policies and procedures regarding use of force reports; specifications for reporting. 12. Review of incident reports. 13. Review of investigations. 14. Review of inmate disciplinary reports. 15. Review of lesson plans. 16. Review of Medical Care/mental health records regarding injuries, including any required off-site hospitalizations.			

	17. Review of sample of staff workers' compensation claim relating to uses of force, inmate/inmate altercations. 18. Remedial, corrective action if necessary. 19. Review of digitally recorded incidents. 20. Review of MDCR Inmate Violence Report
Steps taken by the County to Implement this paragraph:	Protection from harm: See III.A.5.c. (1)
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.c. (1)
Monitors' Recommendations:	Protection from Harm: See recommendations above, III.A.5.c.(1).

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: 5/15/15	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	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:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation of partial compliance must be provided for the July 2016 tour.			
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance or partial compliance.			

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: Not reviewed per defendant May 2015.	Compliance: 10/24/14	Partial Compliance: 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	NA			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force reports; supervisory review of reports; time deadlines. 2. Review of MDCR Incident Report and Response to Resistance Summary, as specified above. 3. Review of memoranda with exceptions. 4. Review of investigations. 5. Remedial, corrective action if necessary 6. Review of post orders; job descriptions for Facility supervisor/Bureau Commander.			
Steps taken by the County to Implement this paragraph:	NA			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation compliance must be provided for the July 2016 tour.			
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.			

Paragraph	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:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	NA			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force reports; review of reports; time deadlines. 2. Review of incident reports. 3. Review of Division Chiefs' reports 4. Referrals to IAB. 5. Review of inmate medical records. 6. Review of investigations.			

	7. Remedial, corrective action if necessary. 8. Review of post orders/job descriptions of Division Chief.
Steps taken by the County to Implement this paragraph:	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: Documentation compliance must be provided for the July 2016 tour. Mental Health: Quality and Safety Meeting minutes indicate that inmate with mental illness are overrepresented in uses of force. For example, Level 1 – 4 patients comprise 40% of uses of force.
Monitors' Recommendations:	Protection from Harm: Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.

Paragraph	III. A. 5.c. See (duplicate) CONSENT044 (IIIB3c) (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: 5/15/15	Partial Compliance: 10/24/14	Non-Compliance: 7/19/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:	See III.A.5. c. (5)			
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.			
Steps taken by the County to Implement this paragraph:	Protection from Harm:			
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and	Protection from Harm: Documentation compliance must be provided for the July 2016 tour.			

the factual basis for finding(s)	
Monitor's Recommendations:	Protection from Harm: Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.

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:	Other: Per MDCR not reviewed in 5/15, 1/16
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:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	I reviewed 36 use of force investigations for September 2015. All appropriately included photos and/or video. However, MDCR needs to establish a more robust policy to conduct the level of review that the Monitor has done for three separately months of reporting. See recommendations in report dated 12/4/15 (and prior reports)			
Monitor's Recommendations:	1. Continue to self-monitor compliance via TAAP; if there is steady improvement, compliance will be maintained. If during the next review period the same issues (or new issues) are identified in the Monitor's review, this paragraph will be moved to partial compliance. (See specific recommendations in report of12/4/15)			

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	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding use of force; supervisory presence; location of recording equipment; supervision of recording equipment (batteries charged, repairs needed, etc.)			

	2. Policies and procedures regarding digitally recording incidents; training for users; instructions. 3. Review of incident reports; including exceptions in which digital recordings not made. 4. Review of investigations; review of digitally recorded incidents. 5. Review of remedial or corrective actions, if any. 6. Interview with IAB staff.
Steps taken by the County to Implement this paragraph:	NA
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation compliance must be provided for the July 2016 tour.
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.

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: 1/8/16	Partial Compliance: 5/15/15, 10/24/14	Non-Compliance: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Personnel policies and procedures regarding employee discipline; relevant portions of CBAs. 2. Employee disciplinary reports; investigations. 3. Employee disciplinary sanctions. 4. Records of hearings, including arbitration hearings, if any. 5. Documentation of terminations for cause.		
Steps taken by the County to Implement this paragraph:	The TAAP directive 15-001, dated August 1, 2015 addresses the recommendations of Report #4 regarding the formal collaboration between the Labor Management Unit and the Security and Internal Affairs Bureau.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Issues identified in Report #4 have been addressed. Information provided regarding employee discipline.		
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to		

	maintain rating of compliance.

Paragraph	III.A.5.c. (duplicate III.B.3.b.) (10) The Jail will ensure that inmates receive any required medical care following a use of force.			
Compliance Status:	Compliance: 5/15/15, 10/24/14, 3/28/14	Partial Compliance: 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:	NA			
Measures of Compliance:	1. Policies and procedures regarding medical care following a use of force, including use of digital recordings. 2. Incident reports. 3. Review of inmate medical records 4. Interview with medical personnel. 5. Lesson plans.			
Steps taken by the County to Implement this paragraph:				
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation compliance must be provided for the July 2016 tour.			
Monitors' Recommendations:	Protection from Harm: Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.			

Paragraph	III. A. 5.c. (11) Every quarter, MDCR shall review for trends and implement appropriate corrective action all uses of force that required outside emergency medical treatment; a random sampling of at least 10% of uses of force where an injury to the inmate was medically treated at the Jail; and a random sampling of at least 5% of uses of force that did not require medical treatment.			
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance: 5/15/15	Non-Compliance: 10/24/14, 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding production of reports, and corrective action plans meeting above criteria. 2. Quarterly reports, and corrective action plans. 3. Review of quarterly medical/mh QA/QI reporting.			
Steps taken by the County to Implement this paragraph:	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: Documentation compliance must be provided for the July 2016 tour.
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.

Paragraph	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: 5/15/15	Partial Compliance:	Non-Compliance: 10/24/14, 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding uses of force. 2. Semi-annual report/evaluation of uses of force/quality control. 3. Corrective action plans, if any. 4. Documentation of meetings with MDCR leadership regarding the report's findings; documentation of collaboration with medical/mh staff, if necessary.			
Steps taken by the County to Implement this paragraph:	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*:* Documentation compliance must be provided for the July 2016 tour.			
Monitor's Recommendations:	Protection from Harm: Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.			

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: Not reviewed per defendant May 2015.	Compliance: 10/24/14, 3/28/14	Partial Compliance:	Non-Compliance: 7/19/13	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour				

Measures of Compliance:	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:	
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation compliance must be provided for the July 2016 tour.
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.

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: 5/15/15	Non-Compliance: 10/24/14, 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding 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)	Documentation compliance must be provided for the July 2016 tour. See above III.A.5. (11) and IV A – C.			

Monitor's Recommendations:	• Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance. • 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:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training. 2. Lessons plans. Evidence that data and information gathered (as noted in the Settlement Agreement) is used to inform and update training lesson plans, including information from IAB investigations. Evidence that the results of random interviews used to inform update of lesson plans. 3. Training schedules. 4. Documentation of provision of updates to supervisors; sign-offs, etc. 5. Reports of random interviews. 6. Observation and interviews. 7. Report noted in III.A.5.c.(12)			
Steps taken by the County to Implement this paragraph:	See Report # 4.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation compliance must be provided for the July 2016 tour.			
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.			

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

	12. Interviews with medical and mental health staff. Medical Care: [No medical audit step unless questions/issues are referred by the Security Monitor.] Mental Health: See Protection from Harm Review of investigations as they relate to inmates with severe mental illness and in the process of detoxification. This shall include but not be limited to inmate-on-inmate assaults, deaths, and suicides.
Steps taken by the County to Implement this paragraph:	
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 Report #4. Documentation compliance must be provided for the July 2016 tour.
Monitor's Recommendations:	Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.

III. A.6. Early Warning System

Paragraph	III. A. 6. Early Warning System a. Implementation (1) MDCR will develop and implement an Early Warning System ("EWS") that will document and track correctional officers who are involved in use of force incidents and any grievances, complaints, dispositions, and corrective actions related to the inappropriate or excessive use of force. All appropriate supervisors and investigative staff shall have access to this information and monitor the occurrences. (2) At a minimum, the protocol for using the EWS shall include the following components: data storage, data retrieval, reporting, data analysis, pattern identification, supervisory assessment, supervisory intervention, documentation, and audit. (3) MDCR Jail facilities' senior management shall use information from the EWS to improve quality management practices, identify patterns and trends, and take necessary corrective action both on an individual and systemic level. (4) IA will manage and administer the EWS. IA will conduct quarterly audits of the EWS to ensure that analysis and intervention is taken according to the process described below. (5) The EWS will analyze the data according to the following criteria: i. number of incidents for each data category by individual officer and by all officers in a housing unit; ii. average level of activity for each data category by individual officer and by all officers in a housing unit; iii. identification of patterns of activity for each data category by individual officer and by all officers in a housing unit; and iv. identification of any patterns by inmate (either involvement in incidents or filing of grievances).			
Compliance Status:	Compliance: 1/8/16	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed 5/15
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures establishing and maintaining the early warning system; including criteria for thresholds and referrals. 2. Existence of a fully functioning early warning system. 3. Reports generated by the early warning system as described above. 4. Evidence of employee actions (e.g. remedial training, EAP, disciplinary actions, terminations) based on early warning system. 5. MDCR report of trends, etc. regarding use of force and employee corrective actions. 6. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.			
Steps taken by the County to Implement this paragraph:	Completion of update to directive 4-017, Early Warning and Intervention System (10/28/15); provision of reports generated by the system; one sample of employee actions; minutes of meeting (5/8/15) reflecting discussion of employees identified by the system			
Monitor's analysis of conditions to	The system will be fully implemented when the directive is finalized. I met with the SIAB commander and reviewed			

assess compliance, verification of the County's representations, and the factual basis for finding(s)	materials, and memoranda that form the basis for counseling.
Monitor's Recommendations:	1. Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance. 2. Provision of additional documentation (more recent than 5/8/15) 3. Update on any action plan (if any) from the CY 2015 analysis of the EWS.

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: 1/8/16	Partial Compliance: 5/15/15	Non-Compliance: 10/24/14, Not yet due, 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding EWS and reporting. 2. Reports on EWS (180 days and bi-annually), as specified above. 3. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)			
Monitor's Recommendations:	See recommendations III.A.6. a. (1)- (5)		

Paragraph	III. A. 6. Early Warning System c. On an annual basis, MDCR shall conduct a documented review of the EWS to ensure that it has been effective in identifying concerns regarding policy, training, or the need for discipline.		
Compliance Status:	Compliance: 1/8/16	Partial Compliance: 5/15/15	Non-Compliance: 10/24/14 not yet due; 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding annual report. 2. Production of a review of the EWS; recommendations for changes, if needed. 3. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by		

	the early warning system.
Steps taken by the County to Implement this paragraph:	
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See comments III.A.6. a. (1)- (5) There needs to be more of a narrative assessment, recommendations, action plan (if any) for this paragraph. For the July '16 tour this will be required.
Monitor's Recommendations:	1. See recommendations III.A.6. a. (1)- (5) 2. Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.

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:

<table>
<tr><td>Paragraph(s):</td><td colspan="4">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.</td></tr>
<tr><td>Compliance Status:</td><td>Compliance:</td><td>Partial Compliance: 10/14; 3/14; 7/13</td><td>Non-Compliance:</td><td>Other: Per MDCR not reviewed 5/15, 1/16</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour(s):</td><td colspan="4">The revisions to DSOP 10-022 have not been authorized.</td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><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.</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="4">MDCR has developed and implemented policy, DSOP 10-022, entitled Fire Response and Prevention Plan effective 7/2/12. A revision to that policy was reviewed and accepted by the Monitor and DOJ in February, 2015. However as of this tour the revision has not been authorized pending training. It establishes the Departmental Safety Officer position that is responsible to coordinate fire inspections among other responsibilities. The 2015 accepted draft also establishes the position of Fire Inspection Specialist who is responsible to conduct the monthly fire safety inspections and provide the reports to the Compliance and Accreditation Bureau (CAB) Captain and forwarded to the Director.
When non-conformities require immediate correction, the Facilities Maintenance Bureau (FMB) shall ensure timely repairs are made. The facility/Bureau Supervisor shall follow-up to ensure that FMB completes the repairs. The policy also establishes the position of Fire Safety/Sanitation Officer (FSSO) for each facility. The FSSO is responsible to conduct a weekly fire/safety inspection of the entire facility in accordance with the Weekly Fire Inspection Report checklist among other responsibilities. It also provides for training of officers including facility specific Fire Safety Sanitation Officers (FSSOs) for each facility

MDCR utilizes a contractor, Underwater Unlimited to flow test SCBA units; Security Fire to conduct hydro tests and</td></tr>
</table>

	recharging of all fire extinguishers, MDCR continues to provide copies of all of the monthly reports completed by CAB, along with reports demonstrating corrective actions taken when non-conformities are identified during the inspections.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR continues to maintain a facility specific inventory identifying the location of all fire extinguishers, automatic external defibrillators (AEDs), and SCBAs 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. Fire pumps are located for MWDC, TGK and WDC. For this tour MDCR provided copies of the monthly fire safety inspections and corrective action reports completed by CAB for the months of July, August and September 2015. The reports documented violations and then on an attached page showed that corrections were completed. The reports were thorough, demonstrating compliance with DSOP 10-022 and this provision. However no inspection reports from Miami Dade Fire Rescue and the City of Miami Fire Rescue inspections were provided for any housing facilities. The only report provided was for the North Dade Detention Center Self-Contained Breathing Apparatus (SCBA) inventory is complete for all facilities. SCBAs are inspected daily by the unit officer with findings documented in the applicable housing unit logbook. CAB includes an inspection of SCBAs during their monthly fire safety inspections. The SCBA annual testing for 2015 has been completed for all facilities and all units were functional. 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. Weekly, the Facility Safety/Sanitation Officer (FSSO) conducts a fire safety inspection of the entire facility that includes flow valves and a visual check of the power generator, where applicable. For this tour I did not review any weekly reports. MDCR is currently reviewing the need for the weekly FSSO inspections. Once the DSOP 10-022 review/revision is completed and authorized and as long as the monthly inspections and corrective actions completed where necessary, this provision will move to compliance.
Monitor's Recommendations:	1. Assess the need for the weekly FSSO inspections to assure justification of the frequency that you currently require. 2. Assure that CAB's reviews of the monthly inspections are documented. 3. Assure that corrective actions taken as a result of inspection non-conformities are documented and the non-conformity formally closed. 4. 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.

	5. Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.

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: 10/14; 3/14; 7/13	Partial Compliance:	Non-Compliance:	Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):	None			
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. Development of either a MDCR or facility specific policy mandating at least an annual inspection of all fire alarms and sprinkler systems. The policy needs to include assurance of installation in accordance with all applicable fire codes and require effective repairs for any deficiency found. All policies and procedure are to be reviewed and updated as necessary at least annually on a schedule. 2. Establishment and implementation of a written contract with a company licensed to conduct the inspection, and make repairs. 3. Copies of the annual inspection reports and corrective actions taken for all non-conformances.			
Steps taken by the County to Implement this paragraph:	Miami-Dade County renewed its five-year contract with Fred McGillivray Inc. of Miami, FL to inspect all fire sprinkler systems and provide maintenance for all facilities. The new contract period is 11/1/13-10/31/18. 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 4/1/14-3/31/19. 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 factual basis for finding(s)	There is no change from the previous report. Because this tour was completed in January, the 2016 inspections have yet to be completed. I will request they be provided prior to the July 2016 tour. The only change from the previous report is that the contracts were renewed for the next five years as indicated above. Prior to the next tour, provide the monitor with copies of the annual inspections for all facilities from the Miami Dade Fire Rescue or the City of Miami Fire Rescue Department (dependent upon which agency has responsibility. MDCR did provide copies of the 2015 inspections for all 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. Provide evidence of 2016 inspections of fire and sprinkler systems from Florida Fire Alarm Co., along with the Miami Dade Fire Rescue and City of Miami Dade Fire Rescue Department inspections. 2. Evidence of continued substantial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.			

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:	Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):	Revisions to DSOP 11-023 have not been authorized.			
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 was reviewed and accepted by the Monitor (5/27/15) and DOJ (8/7/15), but has not yet been authorized by MDCR. Once authorized it should eliminate the need for a separate emergency key control policy for each facility. 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. At PTDC there is a second box located in main control on the first floor, as the Shift Commander's office is on the 7th floor. The "Red Box" is accessible by breaking the glass front. Using an attached hammer. The revision to DSOP 11-023, establishes that the "red box" containing the key that access the emergency key cabinet shall be located in the Shift Commander's Office and be accessible to staff. The emergency key cabinet shall be located inside the main control booth contingent upon the design of the facility. Boot Camp facility has no control booth. TTC maintains a complete set of alternate emergency keys for Boot Camp, TGK, MWDC and PTDC. DSOP 11-023 requires that emergency keys be tested monthly in each facility to test that the keys and the lock both function. The facility/Bureau Supervisor shall review the testing reports. However, the policy does not specify the testing procedures to be followed by each facility's key control officer. Staff training on emergency keys is included in the recently revised 4-hour Fire and Life Safety Training lesson plan. However, training is not yet implemented.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	For this tour MDCR did not provide copies of the monthly inspections for emergency keys, as in prior tours. The Monitor reviewed the process and documentation at each facility. All facilities require incident reports for any missing, or broken keys. Each facility uses a different format for reporting. MDCR should develop one process for reporting, along with a written process in DSOP 11-023 as to who reviews and approves the reports, and whether CAB should receive copies. The policy should also identify what is expected in a testing program. It is important to assure that the emergency keys will in fact open all of the doors for which it is assigned. At TTC there is no process to test and document the emergency keys in locks for all buildings. At TGK keys and locks are tested quarterly. At MWDC keys are tested monthly. Emergency keys should be tested at a predetermined frequency such as quarterly to assure the emergency key(s) opens the locks to which it is assigned as well as the fact that all keys are stored in accordance with			

	the policy. For the facilities I visited on this tour when asked, employees demonstrated correctly the procedure for accessing emergency keys. DSOP 11-023 needs to specify the testing process and frequency for consistent practice. I will continue to ask officers to demonstrate the use of emergency keys on future tours. Once DSPOP Policy 11-023 is authorized and a consistent reporting format is established and implemented, this provision will be in substantial compliance.
Monitor's Recommendations:	1. Authorize the 2015 revision to MDCR Policy 11-023. 2. Provide evidence of training to the revised policy and procedure for key control officers and appropriate staff. 3. Assure that during CAB fire drills there is a requirement of a demonstration by officers in the control room and those officers accessing the emergency keys that they are capable of correctly identifying the correct key by touch and/or a testing. 4. Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.

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: 1/16; 5/15; 10/14; 3/14; 7/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour(s):	Revisions to DSOP 10-022 and DSOP 10-006 have not yet been authorized.		
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" that has an effective date of July 2, 2012 requires that the Departmental Safety Officer (DSO)"maintain records of all drills. In section IX. A -2-b the policy establishes that the DSO and/or Fire Safety Specialist (FSS) shall "conduct a quarterly fire drill on each shift, in each area of the facility as outlined in the MDCR Fire Drill Procedures. Fire drill should include evacuation of inmates except where the facility's		

	security is jeopardized. Section X states the AIB commander, DSO or designee shall ensure that fire drills are conducted and documented o the Fire Drill Report. 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. A Level IV fire drill is required twice a year. A copy of the MDCR 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)	As of this tour, the 2015 revisions to DSOP Policy 10-022 and 10-006 have not yet been authorized pending implementation of required training. The term "FSS" is proposed to change to "Fire Safety/Sanitation Officer" (FSSO). Section XI states, "All facilities shall maintain fire prevention drills and inspection schedules that list routine fire safety activities." The DSO shall coordinate fire inspections, fire drills and the annual scheduling of fire drills." The draft policy does not specify any requirement for the frequency for drills. The current practice is that each facility conducts monthly drills on each shift. Prior to this tour MDCR provided copies of fire drills for the third quarter of 2015 for review. For each facility there should be nine (9) drills completed in the quarter. I reviewed nine drill reports for Boot Camp, eight drill reports for MWDC, 10 drill reports for PTDC, seven drill reports for TGK, and eight drill reports for TTC. The only level 4 drill was conducted Boot Camp during the quarter. There were six Level one drills, 31 level two drills and four level three drills. The average drill times increased from 9 minutes to 13 minutes for all facilities. For the reports reviewed there were significantly more comments from the shift commanders (62% vs. 17%) and from the fire safety officer (42% vs. 18%). The comments need to focus on a performance assessment rather than an explanation of the drill. As before, there were only a few instances where there was evidence documented of corrective actions taken as a result of the drills. Once the annual fire safety training program is implemented, this should change. CAB maintains copies of all drill reports. There was only one example provided that demonstrated where staff at MWDC did not understand how to properly don the SCBA. It is key that the assessment of drills include evidence that necessary changes to training is forwarded to the Training Bureau where deficiencies are identified that require either remedial training to specific staff or a change to the 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. CAB needs to insist on drills that include movement of inmates to assure effective response in case of an emergency. The Monitor again suggests 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 receive the drill reports monthly, along with a summary documenting any non-conformity identified and how it was addressed. By reviewing monthly, the Monitor will have adequate time to review and provide comments and better prepare for future visits. When the 2015 DSOP10-022 and DSOP10-006 policies are authorized with minimum quarterly requirements for the frequency for fire drills at each facility in compliance with the Settlement Agreement and as long as documentation of drills is provided that demonstrate compliance, the provision will move to substantial compliance.
Monitor's Recommendations:	1. Provide me a copy of the draft revision of 10-022 prior to establishing an effective date. Make sure that all training documents reflect the revised policy. It should also be included in the "biennial training" specified in III B-6. 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. 2. MDCR needs to develop specific fire drill objectives and expectations for Fire Safety Officers, Shift Commanders, Facility Managers, Tier Officers and support staff for all drills. Assure that a drill schedule provides how the objectives and expectations will be measured, assessed, reported, reviewed on every drill on every shift. Assure that Fire Safety Officers and Shift Commanders are trained on the objectives, procedures, and expectations before the next tour. 3. Monthly provide copies of the fire drills reports for all drills conducted for all facilities on each shift 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. 5. Provide the fire drill schedule for the remainder of 2016 prior to the next tour 6. Require each facility manager to provide a written report to the DSO explaining why any required drills were not completed. 7. Provide the list of the designated fire safety/sanitation officers (FSSO). 8. Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.

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	Other: Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):	Revisions to DSOP 10-010 Chemical Control have not been authorized. Training syllabus has not been completed.			

Measures of Compliance:	Fire and Life Safety: 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". While it was accepted by the Monitor (9/21/15 and DOJ (10/6/15, it has not been authorized. As of this tour MDCR is in the final stages to send out a "Request for Proposal" to establish an automatic dilution/dispensing equipment in each housing unit for all facilities. Currently only TGK is utilizing Buckeye dilution/dispensing system for floor cleaner, Marauder cleaner, and a disinfectant. Sanitation Officers for each division have received training on chemical safety and appropriate dilution of chemicals. However, the training was based on the current authorized edition of DSOP 10-010 and not the revised draft policy. 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. Each facility manages chemical inventory and distribution of chemicals on a "Chemical Inventory/Issuance Log.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	On this tour the Monitor reviewed the chemical control inventory and distribution process with designated Fire Safety Sanitation Officers (FSSOs) at Boot Camp, TTC, TGK, MWDC, and PTDC. There continues to be differences in inventory and sign-in/out forms used in several facilities. At TTC not all chemicals were controlled and staff there was contemplating using a former chemical control form. The chemicals there are controlled once they are diluted and stored on the shelf. However, at TTC chemicals currently stored in the three milk crates also need to have a documented inventory that is consistent with the storage inventory in the previous step and also have its distribution and return (sign-in/out) documented. Also at TTC chemicals are inventoried three times per week instead of daily. I suggest that TTC implement a one for one exchange as done at other facilities and conduct an inventory at least daily; more frequently if chemicals are dispensed on more than one shift. Once MDCR implements the automatic diluting and dispensing system, there will be another change to the way chemicals are controlled. The chemical storage rooms at all facilities visited were organized, and secure. Safety Data Sheets (SDSs) were available for all chemicals stored in the respective chemical control rooms. MDCR has revised the Chemical Inventory/Issuance Log and the Secondary Chemical Inventory/Issuance Log. MDCR plans to install electronic dispensing systems for all laundry washers at each facility for personal laundry. The Monitor would like to review the revised training lesson plan and syllabus and Power Point once the automatic dispensing equipment is installed and Policy 10-010 is authorized to reflect the inventory and control procedures and

	how inmates who have access to chemicals are to be supervised This provision will move to substantial compliance once the 2015 revised draft policy is authorized and the training curriculum revised and evidence of completed training for FSSOs and inmates is provided.			
Monitor's Recommendations:	1. Complete and approve the revised Chemical Control Policy 10-010 to include the process for automatic diluting and dispensing and the requirement for training of Fire Safety Sanitation Officers (FSSOs) and the inmates who have access to chemicals. 2. Revise the chemical safety, dilution, and use training lesson plan 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 DSOP 10-010. 3. Provide evidence of training of all FSSOs for each shift, officers will supervise inmate workers using chemicals in the housing areas kitchen, and classrooms, etc. and inmate workers who have responsibility to use the chemicals. 4. Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.			
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: 10/14	Non-Compliance: 3/14; 7/13	Other: Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):	Annual training has not started.			
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. Establishment of either an MDCR or facility specific policy and procedures for competence-based biennial training for correctional staff on safe and effective use of all fire and emergency equipment. 2. Written training outline/syllabus for the training that identifies all elements for safe and effective use of all fire and emergency equipment including training time. 3. Written procedure on how MDCR will identify each officer and staff who is required to receive training, the training date, name of the officer trained competency measurement score, and trainer. 4. Verification by sign-in logs of participants, and validation of successful completion of training. 5. Observation of implementation.			
Steps taken by the County to Implement this paragraph:	MDCR has not yet authorized the 2015 revision of DSOP Policy 10-022 and 10-006 for fire safety response including proper use of fire and emergency equipment. The most recent finalized policy is dated 7/2/2012. MDCR Training Bureau developed an 8-hour class lesson plan dated 7/21/2014. One class was conducted for 28 officers in 2015. The course reviews from virtually all of the participants stated the class was excellent, rating it as 5 from a scale that ranged from 1 to 5 with 5 being excellent. MDCR decided to revise the lesson plan to a 4-hour class. At the tour MDCR provided a copy of the revised lesson plan, PowerPoint, practicum exercise and pre and post test instruments. The course was designed from the most recent draft policies. MDCR has not established a start date for the 4-hour course.			
Monitor's analysis of conditions to	On this tour MDCR staff provided a copy of the 4-hour "Fire and Life Safety Lesson Plan, revised June 9, 2015. The plan			

assess compliance, verification of the County's representations, and the factual basis for finding(s)	includes both a pre and post-test instrument consisting of 20 questions and a practicum for officers to demonstrate proficiency. MDCR has not provided a pass/fail percentage for the test or for the practicum. 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. The lesson plan, with objectives, the Power Point and practical exercise is complete and thorough as it relates to the draft policies. However, there is no established passing score for the posttest or the practicum or next steps that will occur should a participant not successfully pass. Further, as stated previous reports, MDCR should consider a process for refresher training for employees who do not proficiency on routine fire drills. The refresher training should be based upon identified shortcomings from internal fire drills; both internal and external fire safety inspections and existing fire safety laws, regulations, and standards. As the biennial training lesson plan is created, this provision is now partially compliant. To obtain "substantial compliance", MDCR will need to provide evidence of implementation for several classes showing that at least 50% successful completion for all staff on all shifts for each facility
Recommendations	1. Authorize the 2015 revision to MDCR DSOP Policies 10-022 and 10-006 that requires competency based biennial training on safe and effective use of fire and emergency equipment Include in the policy the fire and emergency equipment for which training will be provided. 2. Assure the training plan that outlines how the policy will be implemented and include a schedule for completion of the first round of refresher training. 3. Assure the Lesson Plan and curriculum is consistent with the policies and the pass/fail criteria are established for both the posttest and the practicum. 4. Provide evidence of development and implementation of the refresher-training program as established in the provision. 5. Evidence of continued partial compliance must be provided before the July '16 tour for the period 5/15/15 – 7/25/16.

III. C. Inmate Grievances

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: 5/15/15	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 1/16
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 10/14 (Not audited.) Not scheduled for review this tour.	
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 1/8/16	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. Medical Care: • Audit Step a: (Inspection) The content of medical grievance replies is responsive and meaningful. As provided for in CHS Policy J-A-11, when appropriate, CHS staff meet with patients to discuss their grievances. • Audit Step b: (Inspection) Medical and mental health grievances are responded to in writing within 20 days. • Audit Step c: (Inspection) Remedies to medical grievances are implemented. • Audit Step d: (Inspection) There is a system in place for inmates to file medical grievances without the intervention of an officer. • Audit Step e: (Inspection) When interviewed, with occasional exception, inmates report that they can file a medical grievance without the intervention of an officer. • Audit Step f: (Inspection) Review of medical and mental health grievances alleging excessive use of force shows that they are handled immediately and appropriately • Audit Step g: (Inspection) CHS staff review medical grievances on a quarterly basis to identify trends and systemic areas of concern and provide these to the Medical Monitor. • (duplicate) CONSENT018/IIIA3a(4) Audit Step b: (Inspection) Review of emergency medical grievances shows that they are handled immediately and appropriately. Mental Health: See Protection from Harm and Medical Care
Steps taken by the County to Implement this paragraph:	Protection from Harm: 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: • See Report # 4 • Documentation compliance must be provided for the July 2016 tour. Medical Care: Not audited. Mental Health: MDCR and CHS should more closely evaluate grievances from inmates on the mh caseload. Also – the absence of grievances from this population should trigger concerns.
Monitors' Recommendations:	Protection from Harm: Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance.

	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: See also comments in previous compliance reports.

III. D. Audits and Continuous Improvement

<table>
<tr><td>Paragraph
<u>Coordinate and Grenawitzke</u></td><td colspan="4">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.</td></tr>
<tr><td>Protection from Harm: Compliance Status:</td><td>Compliance:</td><td>Partial Compliance: 10/24/14</td><td>Non-Compliance: 3/28/14, 7/19/13</td><td>Other: Per MDCR not reviewed 5/15, 1/16</td></tr>
<tr><td>Fire and Life Safety: Compliance Status:</td><td>Compliance:</td><td>Partial Compliance: 10/24/14</td><td>Non-Compliance: 3/28/14, 7/19/13</td><td>Other: Per MDCR not Reviewed 1/16; 5/15</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4">Directive needs to be completed.</td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><u>Protection from Harm:</u>
1. Policies and procedures regarding self-audits.
2. Self-monitoring reports.
3. Corrective action plans, if any.
4. Evidence of implementation of corrective action plans, if any.

<u>Fire and Life Safety:</u>
1. Development and implementation of effective and consistent policies for regular audits of all facilities housing inmates. It should include audits by designated staff trained in auditing techniques and the polices within each facility and from MDCR for all fire and life safety provisions as well as cleanliness, functioning of electrical and plumbing fixtures etc.</td></tr>
</table>

	2. Inspections should result in identifying specific non-conformities to the policies and include the assigning of persons responsible for taking and documenting corrective actions including oversight to measure the effectiveness of same.
Steps taken by the County to Implement this paragraph:	Protection from Harm: 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.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: • Documentation of partial compliance must be provided for the July 2016 tour. 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.
Monitors' Recommendations:	Protection from Harm: 1. Complete and issue the directive; begin to prepare reports consistent with this paragraph. 2. Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance. 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.

Paragraph Coordinate with Dr. Ruiz	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: 1/8/16, 5/15/15, 10/24/14	Non-Compliance: 3/28/14, Not Yet Due (10/27/13)	Other:
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 10/24/14, 3/28/14	Non-Compliance: Not Yet Due(10/27/13)	Other:
Unresolved/partially resolved issues from previous tour:	Directive needs to be completed			
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>Mental Health:</u> See Protection from Harm			
Steps taken by the County to Implement this paragraph:	<u>Protection from Harm:</u> <u>Mental Health:</u> 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)	<u>Protection from Harm:</u> Quarterly reports are improving; need to complete the directive governing this provision. <u>Mental Health:</u> Psychiatry • Staffing currently consists of seven FTEs. and 109 total hours of per diem or 'pool' psychiatry time. • Per diem psychiatry time has been unpredictable and unreliable • 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. is currently covered by a nurse.			

	Recruitment for a QMHP to cover this shift will be imperative. • In addition, interviews with current SW and mental health staff indicated that they were interested in development of policy and training (directed to the policy, once developed) to ensure consistency and standardization of practice between the providers. • There are two psychologists. They primarily run group therapy and individual therapy.
Monitor's Recommendations:	<u>Protection from Harm</u>: • Complete the directive and provide the analysis and action plans (and action plan updates). • Provide a table of contents with quarterly and annual reports • Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance. <u>Fire and Life Safety</u>: Provide evidence of analysis of data along with action plans to improve conditions for all fire and life safety provisions. <u>Mental Health:</u> 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.

III. Compliance and Quality Management

Paragraph Coordinate with Grenawitzke	IV. COMPLIANCE AND QUALITY IMPROVEMENT (duplicate CONSENT IV.A) A. Within 180 days of the Effective Date, the County shall revise and develop policies, procedures, protocols, training curricula, and practices to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement. The County shall revise and develop, as necessary, other written documents such as screening tools, logs, handbooks, manuals, and forms, to effectuate the provisions of this Agreement. The County shall send any newly-adopted and revised policies and procedures to the Monitor and DOJ for review and approval as they are promulgated. MDCR shall provide initial and in-service training to all Jail staff in direct contact with inmates, with respect to newly implemented or revised policies and procedures. The County shall document employee review and training in policies and procedures.			
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, Not yet due (10/27/13)	Other: Per MDCR not reviewed 5/15, 1/16
Fire and Life Safety: Compliance Status:	Compliance:	Partial Compliance: 1/8/16; 10/24/14	Non-Compliance: Not yet due (10/27/13)	Other: Per MDCR, not Reviewed 5/15
Unresolved/partially resolved issues from previous tour:	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. Fire and Life Safety: 1. Development and implementation of a formal training plan and training matrix for affected staff 2. Course syllabus for the training that addresses all applicable provision mandated in specific policies related to fire and life safety. 3. Evidence of validation of training as well as verification of attendance 4. Results of staff interviews documenting understanding of all applicable policies and ability to carry out the provisions of the policies.			

Steps taken by the County to Implement this paragraph:	Protection from Harm: Fire and Life Safety: MDCR has provided a copy of their Fiscal Year Departmental Standard Operating Procedure Annual Review Log
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Directive needs to be completed Fire and Life Safety: Of the DSOPs for fire and life safety only DSOP 10-010 is included on the annual review log. DSOP 10-006 (Emergency Procedures Re: Evacuation), 10-022 (Fire Response and Prevention), 10-023 (Key Control) are not included.
Monitor's Recommendations:	1. Complete the directive and provide the analysis and action plans (and action plan updates). 2. Provide a table of contents with quarterly and annual reports 3. Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance. 4. Assure all fire and life safety policies are included for the annual review.

Paragraph Coordinate with Grenawitzke	IV. COMPLIANCE AND QUALITY IMPROVEMENT Duplicate Consent IV.B., III.D.1.c., III.D.1.d. B. The County shall develop and implement written Quality Improvement policies and procedures adequate to identify and address serious deficiencies in protection from harm and fire and life safety to assess and ensure compliance with the terms of this Agreement on an ongoing basis.			
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed 5/15, 1/16
Fire and Life Safety: Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not Reviewed 1/16, 5/15
Unresolved/partially resolved issues from previous tour:	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			
Steps taken by the County to	Protection from Harm:			

Implement this paragraph:	 Fire and Life Safety: 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., B. Fire and Life Safety: Develop and implement policies to address the provision.
Monitor's Recommendations:	Protection from Harm: 1. Complete the directive and provide the analysis and action plans (and action plan updates). 2. Provide a table of contents with quarterly and annual reports 3. Prior to the July 2016 tour, MDCR will be required to demonstrate on-going compliance for the previous year to maintain rating of compliance. Fire and Life Safety: Develop and implement the policies as identified in the Measures of Compliance.

Paragraph Coordinate with Grenawitzke	IV. COMPLIANCE AND QUALITY IMPROVEMENT Duplicate Consent IV.A., D. C. On an annual basis, the County shall review all policies and procedures for any changes needed to fully implement the terms of this Agreement and submit to the Monitor and DOJ for review any changed policies and procedures.		
Protection from Harm: Compliance Status:	Compliance: 1/8/16	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, Not yet due 7/19/13
Fire and Life Safety: Compliance Status:	Compliance:	Partial Compliance: 10/24/14	Non-Compliance: Not yet due 3/28/14, 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.		
Steps taken by the County to Implement this paragraph:	Protection from Harm: Annual review process in place.		

	Fire and Life Safety: See IV.A. and IV. B.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Need to document that the policies are annually reviewed. Fire and Life Safety: See IV.A. and IV. B.
Monitor's Recommendations:	Protection from Harm: Provide documentation before the July '16 tour of the annual review process for specific policies and procedures. Fire and Life Safety: Develop and implement formal policies meeting the provision.

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:	Other: Per MDCR not reviewed 5/15, 1/16
Fire and Life Safety: Compliance Status:	Compliance:	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	NA			
Measures of Compliance:	Protection from Harm: 1. Production of policies and procedure for review. 2. Production of lesson plans, training schedules, tests Fire and Life Safety: 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 B-D.
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.

Compliance Report # 5
Consent Agreement - Medical and Mental Health Care
Report of Compliance Tour, January 2016

During the course of the review, the team interviewed custody and health care leaders, middle managers, front line staff, and patients, reviewed administrative documents and medical records, and observed operations. Some medical record reviews were driven by context specific factors (e.g. death, incident report, information gleaned from interviews). These reviews provided qualitative information. Other medical record reviews were conducted on a random sample of records chosen by the Monitor from among a set of records that met criteria specified by the Monitor (i.e. date range and trigger event). These reviews provided quantitative information. A list of patient cases reviewed by the Monitors is available upon request.

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

Status[1]	Number of Provisions
Compliance	4
Partial Compliance	50
Non-Compliance	61[2]
Total	115

In preparation for future tours, the Monitors expect to be notified of any provisions to be assessed for compliance no later than 45 days before the first day of the next tour, and expect to receive the documents supporting the review no later than 30 days before the first day of the next tour. For the Medical and Mental Health monitors, we request a SINGLE transmission of documents from the County. The documents should be arranged in folders labeled with the CA provision number and Audit Step(s) the documents support. The individual documents within the folder should be clearly labeled with an informative title describing the document contents. For Mental Health, the documents requested may be *in addition* to the items already outlined as necessary for compliance in the provision.

Medical Care

The Medical Monitor conducted this review with the assistance of Catherine M. Knox, RN, MN, CCHP-RN (Ms. Knox was not on-site, but performed chart reviews electronically), and Angela Goehring, RN, MSA, CCHP.

[1] For provisions containing both a Medical and Mental Health component and a status that is not the same, status was determined as follows. If either component was compliant or partially compliant, a status of Partial Compliance was assigned.

[2] As arranged prior to the January 2016 compliance tour, the Monitors reviewed those provisions that the County informed the Monitors they wished to have reviewed. The remaining provisions were assigned a status of "Non-Compliant (Not reviewed)," meaning the County did not "earn" non-compliance or demonstrate compliance, they simply were not yet ready to have them reviewed.

In response to the Medical and Mental Health Monitors' request, prior to the tour, the County informed the Monitors of the provisions of the CA for which it was prepared to be assessed for compliance. Accordingly, the Monitors limited their reviews to those provisions. Therefore, those are the only provisions for which we report in the following sections.

In response to the Monitors' observations in May 2015 of understaffing of front-line, middle-level management, and upper-level management positions, the County added a large number of new positions to its roster. Many of those positions were filled at the time of the January 2016 tour, while recruitment continues for others. The County has also implemented some key enhancements of its electronic medical record. While both these changes in infrastructure are not necessarily directly reflected in the level of compliance achieved by the County as included in this report, these improvements are changes of critical importance, without which further progress would not be achieved.

In response to the Monitors' observations in previous compliance reports of insufficient collaboration in the drafting of MDCR and CHS policies, the County developed a procedure to address policy coordination by subjecting the policies required by the CA to the new procedure.

As a reflection of the County's progress and our experience with the provisions of this CA, the Medical Monitor will fine-tune some Audit Steps. These changes (highlighted in this document in yellow) are noted in Compliance Report #5 for information only and will not be benchmarks for compliance until the tour that results in Compliance Report #6.

Finally, the Medical Monitor was impressed by very positive unsolicited comments his team received from patients during interviews, especially with those inmates held in isolation cells. Many patients were complimentary of the nurses with whom they interact. They described nurses who engaged them in conversation, were very caring, and followed up with them if they make requests. Several patients reported an improvement in the attitude of nursing staff in the months preceding this tour. A few inmates had been incarcerated in other jurisdictions and reported that by far, the treatment in the County's jail system was better than elsewhere. The inmates held in the isolation cells provided unsolicited comments that the majority of officers treated them well.

Mental Health Care

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

As referenced above, the Mental Health Monitor was impressed with the swift hiring of staff that Correctional Health Services and Miami Dade Corrections and Rehabilitation has not only approved, but implemented. To date, mental health staffing boasts nurse practitioners at intake, has nearly doubled its psychiatrists, and filled 10 social work positions. Areas for opportunity include training these new staff to the nuances of correctional mental health so that sustainability is achieved. Particularly important topics

include intake screening, emergency treatment orders, utilization of restraint, management of difficult patients, the assessment of malingering, suicide risk assessment, and assessment of capacity.

Germaine to intake screening, triage and accurate leveling of patients was an issue that came up repeatedly throughout the tour. To the County's credit, preliminary internal reviews as early as May and June 2015 identified that the intake screening tool was too sensitive. It was assigning a disproportionate percentage of patients as high risk. The Mental Health Monitor is concerned that despite adequate consultation with Jackson Health colleagues, proper remedies to address the situation were not implemented. Rather, the issue was permitted to fester, which allowed the mental health population to swell, thus causing a multiplicity of bottlenecks downstream, including bed shortages and custody transport shortages for clinic.

Issues Common to Medical and Mental Health Care

In addition to the areas requiring more work, we will discuss three here as they affect multiple provisions of the CA in both medical and mental health care: policy, training, and quality improvement.

Policy

The County operates with two separate sets of policy, one for MDCR staff and one for CHS staff. The primary purpose of policy is to provide instruction to staff on how to do their jobs. As such, they need to be able to easily find the relevant policy and instructions and, wherever located, those instructions need to be unambiguous. We have found instances where the same activity or task is described in two policies (an MDCR policy and a CHS policy), but where the description of the activity or task is different in these locations. In response to this observation, the County has developed an adequate procedure for addressing this and has begun the process of applying this procedure to policies covered in the CA. The procedure satisfies both of our core requirements: a) that there be a single easily found place for staff to obtain a policy relevant to a question they may have, and b) if information or instructions about a task are placed in MDCR and CHS policy, that that information or instruction must be identical in both locations.

Training

Training is one of the most important activities of a health care organization to ensure patient safety. The County has begun making improvements to its training program, but it is not yet fully developed. When reviewing training for health-related activities (among MDCR and CHS employees), the Monitors will be looking for documentation that demonstrates an adequate training strategy. That documentation should address:

- What training is required initially (i.e. new-hires) as well as any necessary period/in-service training, who is required to take these trainings;

- The instructor function: who is qualified to be an instructor, who selects instructors, how instructor performance is monitored;
- Control of lesson plan (or curriculum): where/how the official lesson plan maintained, who has the authority to make changes to the curriculum;
- The content of the lesson plan: This should be detailed enough to ensure consistency across different instructors. Typically the lesson plan will indicate the length of time for the training (or parts of the training), needed instructional aids, maximum number of trainees in the session, minimum number of assistant instructors in the session, classroom configuration (e.g. minimal number of rooms, classroom layout). The lesson plan will also include actual instructional content along with instructions to the instructor on how each section of the training should be taught. The complexity, reading level, and density of instructional material should be appropriate for the intended audience. The method of instruction should be appropriate for the material being taught. So, for example, when teaching a manual skill, the instructional method cannot be limited to lecture and slides, but must include demonstration and practice.
- Assessment of learning (i.e. post-test): how the instructor determines that adequate learning has taken place. Because not all learners will learn at the same pace, the lesson plan also needs to describe how supplementary/remedial learning is managed. Though not a requirement for CA compliance, we suggest considering making some training eligible for CME/CEU credit for employees. To accomplish this, the County may need to add some other elements, such as pre-testing.

Quality Improvement (QI)

The County has made some progress in its QI program. Perhaps the most important predictor of future success in this arena is the forward thinking and dedicated attitude of top management. During the tour, the CEO of Jackson Health Systems publically verbalized his expectation that health care staff will openly describe and document errors they discover during reviews, understanding that is only through such rigorous self-examination that future errors are avoided. This corporate attitude is highly laudable, and has already begun to translate into more descriptive reviews.

There remains, however, work to be done. The County does not yet have a cohesive, all-encompassing QI program. There is a mortality and morbidity program, but it is not yet "connected" to the program for detecting Preventable Adverse Events (typically detected through a mandatory reporting system) and Near Misses (typically detected through a voluntary reporting system); to the personnel management system and the "Just Culture" approach to which JHS has ascribed; or to period reporting/"dashboarding" (some of which is prescribed in the CA). And these latter programs within CHS' realm are themselves not yet well-integrated with corresponding QI programs within MDCR. In the first recommendation of provision III.A.7.a. (CONSENT034), the Medical Monitor strongly urges the County to examine

the structure of the current mortality and morbidity reporting process – including the parts required by the CA – with an eye towards simplifying the process. This recommendation should be extended to the entire QI process. The current process – driven in part by the CA – is cumbersome and time consuming for key staff, and may contribute to some of the reporting gaps noted in this report. As noted in that recommendation, and as the County undoubtedly understands, any proposed changes that impact the CA would need to be reviewed and approved by the DOJ and the Court. However, the DOJ's lead counsel, Ms. Jansen, has already expressed support, in principle, for changes to the CA (or its interpretation) that result in a better and more sustainable system for ensuring patient safety. In fact, Ms. Jansen shared with tour participants more than once, that a successful QI program is perhaps the most powerful indicator to the DOJ that a jurisdiction is ready to "fly on its own."

Summary of Status of Compliance - Consent Agreement
Tour #5

Yellow = Collaboration - Medical (Med) and Mental Health (MH)
Purple = Collaboration with Protection from Harm
Orange = Medical Only
Green = Mental Health Only
NR = Not reviewed (see footnote 2 above)

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments:
A. MEDICAL AND MENTAL HEALTH CARE				
1. Intake Screening				
III.A.1.a.		Med; MH		
III. A. 1. b.	MH			
III. A. 1. c.			MH	
III.A.1.d.	Med		MH	
III.A.1.e.		Med; MH		
III.A.1.f.		Med; MH		
III.A.1.g.		Med; MH		
2. Health Assessments				
III. A. 2. a.			Med: NR	
III. A. 2. b.			MH: NR	
III. A. 2. c.			MH: NR	
III. A. 2. d.			MH: NR	
III.A.2.e.			Med: NR	
III.A.2.f. (Covered in (IIIA1a) and C (IIIA2e))		Med; MH		
III.A.2.g.			Med: NR; MH: NR	
3. Access to Med and Mental Health Care				
III.A.3.a.(1)			Med: NR; MH: NR	
III.A.3.a.(2)			Med: NR; MH: NR	
III.A.3.a.(3)			Med: NR; MH: NR	
III.A.3.a.(4)			Med: NR; MH: NR	
III.A.3.b.			Med: NR; MH: NR	
4. Medication Administration and Management				
III.A.4.a.			Med: NR; MH: NR	
III.A.4.b(1)			Med: NR; MH: NR	

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments:
III.A.4.b(2)			Med: NR; MH: NR	
III. A. 4. c.			MH: NR	
III. A. 4. d.			MH: NR	
IIIA.4.e.			Med: NR; MH: NR	
III.A.4.f. (Covered in (III.A.4.a.)			Med: NR; MH: NR	
5. Record Keeping				
III.A.5.a.			Med: NR; MH: NR	
III.A.5 b.			MH: NR	
III.A.5.c.(Covered in III.A.5.a.)			Med: NR; MH: NR	
III.A.5.d.			Med: NR; MH: NR	
6. Discharge Planning				
III.A.6.a.(1)		Med; MH		
III.A.6.a.(2)		MH	Med	
III.A.6.a.(3)	Med	MH		
7. Mortality and Morbidity Reviews				
III.A.7.a.		Med	MH	
III.A.7.b.			Med; MH	
III.A.7.c.			Med; MH	
B. MEDICAL CARE				
1. Acute Care and Detoxification				
III.B.1.a.			Med: NR	
III.B.1.b. (Covered in (III.B.1.a.)			Med: NR	
III.B.1.c.			Med: NR	
2. Chronic Care				
III.B.2.a.			Med: NR	
III.B.2.b. (Covered in (III.B.2.a.)			Med: NR	
3. Use of Force Care				
III.B.3.a.			Med: NR; MH	
III.B.3.b.			Med: NR	
III.B.3.c. (1) (2) (3)			Med: NR	

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments:
C. MENTAL HEALTH CARE AND SUICIDE PREVENTION				
1. Referral Process and Access to Care				

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments:
III. C. 1. a. (1) (2) (3)			MH	
III. C. 1. b.			MH: NR	
2. Mental health treatment				
III. C. 2. a.		MH		
III. C. 2. b.		MH		
III. C. 2. c.			MH	
III. C. 2. d.			MH	
III. C. 2. e. (1) (2)			MH	
III. C. 2. f.		MH		
III. C. 2. g.			MH: NR	
III. C. 2. g. (1)			MH	
III. C. 2. g. (2)			MH	
III. C. 2. g. (3)		MH		
III. C. 2. g. (4)		MH		
III. C. 2. h.		MH		
III. C. 2. i.			MH	
III. C. 2. j.		MH		
III. C. 2. k.			MH	
3. Suicide Assessment and Prevention				
III. C. 3. a. (1) (2) (3) (4) (5)			MH	
III. C. 3. b.		MH		
III. C. 3. c.			MH	
III. C. 3. d.		MH		
III. C. 3. e.			MH	
III. C. 3. f.		MH		
III. C. 3. g.		Med; MH		
III. C. 3. h.			MH	
4. Review of Disciplinary Measures				
III. C. 4. a. (1) (2) and b.		MH		
5. Mental Health Care Housing				
III. C. 5. a.		MH		
III. C. 5. b.			MH	
III. C. 5. c.		MH		
III. C. 5. d.		MH		
III. C. 5. e.			MH	

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments:
6. Custodial Segregation				
III. C. 6. a. (1a)		MH		
III. C. 6. a. (1b)		MH		
III. C. 6. a. (2)		MH		
III. C. 6. a. (3)		MH		
III. C. 6. a. (4) i		MH		
III. C. 6. a. (4) ii		MH		
III. C. 6. a. (5)		MH		
III. C. 6. a. (6)		MH		
III. C. 6. a. (7)		MH		
III. C. 6. a. (8)		MH		
III. C. 6. a. (9)		MH		
III. C. 6. a.(10)		Med; MH		
III. C. 6. a. (11)		MH		
7. Staffing and Training				
III. C. 7. a.	MH			
III. C. 7. b.	MH			
III. C. 7. c.	MH			
III. C. 7. d.		MH		
III. C. 7. e.		MH		
III. C. 7. f.		MH		
III. C. 7. g. (1)(2)(3)		MH		
III. C. 7. h.			MH	
8. Suicide prevention training				
III. C. 8. a. (1 – 9)			MH	
III. C. 8. b.			MH	
III. C. 8. c.			MH	
III. C. 8. d.		MH		
9. Risk Management				
III. C. 9. a.			MH	
III. C. 9. b. (1)(2)(3)(4)			MH	
III. C. 9. c. (1)(2)(3)(4)(5)			MH	
III. C. 9. d. (1)(2)(3)(4)(5)(6)		MH		

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments:
D. AUDITS AND CONTINUOUS IMPROVEMENT				
1. Self Audits				
III. D. 1. b.		Med	MH	
III. D. 1. c.			Med; MH	
2. Bi-annual Reports				
III. D. 2 .a. (1)(2)			Med; MH	
III. D. 2. a. (3)		MH		
III. D. 2. a. (4)			MH	
III. D. 2. a. (5)		MH		
III. D. 2. a.(6)	Med	MH		
III. D. 2. b.(Covered in III. D. 1. c.)			Med; MH	
IV. COMPLIANCE AND QUALITY IMPROVEMENT				
IV. A		Med	MH	
IV. B			Med: NR; MH: NR	
IV. C	Med	MH		

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments:
JOINT REPORTING – Settlement Agreement				
III.A.3. Stern and Ruiz				See Report A
III.A.4.d. Ruiz				See Report A
III.A.4.f. Ruiz				See Report A
III.C.1-6 Stern and Ruiz				See Report A
III.D.2. Ruiz				See Report A

Abbreviations:
MAR Medication Administration Record
PA Physician Assistant
NP Nurse Practitioner (APRN)
ML Midlevel practitioner (PA or NP)
PRN Medications prescribed "as needed"
NR Not reviewed (please see footnote 2 above)

A. MEDICAL AND MENTAL HEALTH CARE

1. Intake Screening

Paragraph Author: Stern and Ruiz	III. A. 1. a. (CONSENT001) 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; 5/15; 1/16	Non-Compliance: 3/14 (NR)
Mental Health Care: Compliance Status:	Compliance: 5/15	Partial Compliance: 3/14; 10/14; 1/16	Non-Compliance: 7/13 (NR)
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 i: (Inspection) Training records show that nurses who perform intake medical screening receive training as specified in policy. • Audit Step j: (Chart Review) The entirety of the care delivered during the intake process is appropriate. [This will be an additional audit step for the tour that will result in the production of Report #6 and was not used to assess compliance for Report #5.]		

	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: The County has been working on revisions to the relevant MDCR and CHS policies. The interview areas in Booking remain confidential. The "on deck" chairs located outside the nurse screening area have been shifted a distance to increase the confidentiality of interviews being conducted in the screening area. (While this is suboptimal, it is an improvement over the previous arrangement. These chairs should only be occupied when all other seats in Booking are full.)
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 quality of the medical record of Intake has improved, but problems remain. This will eventually be reviewed primarily under the Record Keeping section of the CA when the time comes, but it may be helpful for us to point out problems in specific parts of the medical record as they come to our attention. Some of the problems may be user-related, but the majority appears to be design problems. For example, Patient 1 was screened in Intake on 11/6/15. It appears that he may have presented initially to MDCR, been diverted to JHS, and then returned to MDCR. However, it is very difficult to ascertain what happened when. There is no progress note documenting the initial presentation to MDCR. An LPN noted at 03:45 on 11/6/15 that the patient takes medications, but no medications are listed. The difficulty to understand the course of events in this relatively simple sequence exists despite (or perhaps in part due to) posting of no less than 28 separate Medical Record documents. Intake screenings are consistently performed by RNs and within the required 24 hours. There appears to be good understanding among staff that patients with Pink Bands may not leave MDCR without medical clearance. Practice largely reflects this understanding. Officers' report, however, that unstable patients (e.g. MH Level I) occasionally are released after court hearings without medical clearance. There is still not adequate coordination between MDCR and CHS policies regarding Intake. For example, MDCR policy refers to an "initial medical/mental health screening" and a "medical/mental health screening," whereas CHS policy refers to a "pre-booking screening" and a "medical and behavioral health screening." Management of patients wearing "pink bands," high risk patients, are not addressed at all in the MDCR policy, and neither policy addresses the prohibition of custody removal of a pink banded patient from MDCR without prior medical clearance. The County has improved the employee training program for Intake Screening, but it is not yet fully developed. Several elements are still missing. For example, though the County submitted a document labeled "Lesson Plan," the document does not qualify as an actual lesson plan (see Training paragraph in the introduction to the Medical and Mental Health part of Report #5); the lesson plan refers to a hand out, but none was provided; the lesson plan submitted indicates that it is targeted to TGK and Stockade staff; no lesson plan was submitted for other facilities. The slides set submitted with the lesson plan also contains factual errors: the slide of TB testing shows Tine Testing which is outdated and probably hasn't

	been used at MDCR for years; the slide about screening for pregnancy includes elements where are not part of the nurse's screening interaction, i.e. examination of breasts. <u>Mental Health Care:</u> We reviewed numerous medical records, toured the Intake area, and spoke with front line staff and managers. The Intake and Receiving Screening policy has been updated. The following problems remain: • The intake screen still does not triage or differentiate between 'emergent' vs. 'urgent' psychiatric referrals. • Accuracy of leveling (triage) of patients at intake became an issue that was identified as early as May of 2015 and has yet to be rectified. • In multiple records reviewed, it was difficult to determine whether the social worker screening the inmate at booking had read prior mental health records (i.e., no notation is made in the record of such and the information was not utilized appropriately in medical decision-making).
Monitors' Recommendations:	<u>Medical Care:</u> 1. The system gap by which patients may be released by the Release Officer from MDCR after court appearance even if they are unstable (e.g. MH Level I) should be closed. One possible method for this is to require the processing officer to have to confirm that the patient does not require medical evaluation. A "forcing function" that would accomplish this would be adding a check-off box to the release paper work. In its response to a draft of this report, the County noted that a forcing function is already in place, citing that there is already a directive in place covering this activity. The Medical Monitor appreciates this comment and was aware of such a directive. The problem he noted was that the directive is not always followed. A "forcing function," such as adding a check-off box to release paperwork, is a tool to help ensure that the directive is always followed. 2. That patients with Pink Bands may not leave MDCR without medical clearance still needs to be incorporated into policy (and training). 3. MDCR and CHS policies must be coherent (see Policy paragraph in the introduction to the Medical and Mental Health part of Report #5). 4. The training program for staff conducting intake screenings must be fully developed (see Training paragraph in the introduction to the Medical and Mental Health part of Report #5). <u>Mental Health Care:</u> 1. Implement a method to differentiate between emergent and urgent psychiatric referrals in your system, consistent with the definitions in the CA. These referrals should be tracked. 2. Please perform validation studies of your intake screening instrument and leveling system, as required per CA Section III. C. 3. b. 3. Record review indicated that 'treatment plans' were being initiated at screening. This is not a treatment plan as defined in the CA. Please initiate treatment planning for patients on the mental health caseload with the requisite participants that is thoughtful, individual, and patient-centered.

Paragraph Author: Ruiz	III. A. 1. b. Intake Screening: CHS shall sustain its policy and procedure implemented in May 2012 in which all inmates received a mental health screening and evaluation meeting all compliance indicators of National Commission on Correctional Health Care J-E-05. This screening shall be conducted as part of the intake screening process upon admission. All inmates who screen positively shall be referred to qualified mental health professionals (psychiatrist, psychologist, psychiatric social worker, and psychiatric nurse) for further evaluation.		
Compliance Status this tour:	Compliance: 5/15; 1/16	Partial Compliance: 3/14; 10/14	Non-Compliance:
Measures of Compliance:	<u>Mental Health:</u> 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 CHS033: Mental Health Screening and Evaluation. It states: "Upon intake to MDCR, CHS staff performs a systemic and structured physical and behavioral health screening of each patient." 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 an 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)	The County has retrofitted clinical space for improved confidentiality. Mental health staff assigned to intake screening are primarily of QMHPs (social workers) and nurse practitioners on some shifts. No internal audits were provided for review. However, interviews with staff indicated that issues had been identified with properly leveling patients at screening; this was in part attributed to the sensitivity of the mental health screening instrument used.		
Monitor's Recommendations:	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. c. Medical and Mental Health Care, Intake Screening: Inmates identified as in need of constant observation, emergent and urgent mental health care shall be referred immediately to Qualified Mental Health Professionals for evaluation, when clinically indicated. The Jail shall house incoming inmates at risk of suicide in suicide-resistant housing unless and until a Qualified Mental Health Professional clears them in writing for other housing.		
Compliance Status this tour:	Compliance:	Partial Compliance: 5/15	Non-Compliance: 3/14; 10/14; 1/16
Unresolved/partially resolved issues from previous tour:	The County has yet to implement a strict definition of psychiatric emergency (vs. urgent referral vs. patient designated Level IA in triage vs. patient designated Level IA on the floor) or a way to identify such in the electronic medical record. As a result, it is nearly impossible to track a patient who suffered an emergency, his orders, and the medical care he or she received.		
Measures of Compliance:	<u>Mental Health:</u> 1. Record review of adherence to screening, assessment, and trigger events as described in Appendix A 2. Review of housing logs; 3. Review of observation logs for patients placed on suicide precaution. 4. Review of adverse events and deaths of inmates with mental health and substance misuse issues.		
Steps taken by the County to Implement this paragraph:	1. The County is in the process of updating 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)	As of 2015, the County has yet to implement a strict definition of psychiatric emergency (vs. urgent referral vs. patient designated Level IA in triage vs. patient designated Level IA on the floor) or a way to identify such in the electronic medical record. As a result, it is nearly impossible to track a patient who suffered an emergency, his orders, and the medical care he or she received. Constant observation and emergent psychiatric referrals were not documented or implemented on a consistent basis. On January 4, 2016, two patients that were designated as 'constant observation' in the TTC were not assigned a specific officer for this purpose. Rather, the Mental Health Monitor was informed that a third, untrained individual was designated for this purpose, contrary to policy and procedure.		
Monitor's Recommendations:	The Mental Health Monitor recommends the County implement definitions and systems for the following: 1) emergent psychiatric referrals 2) constant observation, not only in triage but in each medical and mental treatment area and; 3) 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	III. A. 1. d. (CONSENT004) Inmates identified as "emergency referral" for mental health or medical care shall be under constant observation by staff until they are seen by the Qualified Mental Health or Medical Professional.		
Medical Care: Compliance Status:	Compliance: 7/13; 5/15; 1/16	Partial Compliance:	Non-Compliance: 3/14 (NR); 10/14
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 5/15	Non-Compliance: 3/14 (NR); 10/14; 1/16
Measures of Compliance:	<u>Medical Care:</u> • Audit Step a: (Inspection) Interview with Intake nurses reveals that after identification of "emergency referral" in Intake, patient stays under constant observation. • Audit Step b: (Chart Review) A patient identified as having an emergency medical need is seen by a practitioner immediately. <u>Mental Health Care, as above and:</u> 1. Record review of adherence to screening, assessment, and trigger events as described in Appendix A 2. Review of housing logs; 3. Review of observation logs for patients placed on suicide precaution. 4. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	<u>Medical:</u> Not applicable <u>Mental Health Care:</u> As per CHS-033, staff identifies persons who medically or psychiatrically require urgent referrals with a pink wrist band. Patients that are returns from State mental hospitals receive 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):	<u>Medical Care:</u> 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. The Monitor's observations supported this contention. <u>Mental Health Care</u> Constant observation is not utilized as a direct 1:1. MH patients identified as requiring constant observation are placed in one of two rooms in the booking area. In that location, custody staff observes the patient every 15 minutes, and nursing staff observes 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. This is inadequate.		
Monitors' Recommendations:	<u>Medical Care:</u> None <u>Mental Health Care:</u> 1. As noted in the CA, prior to assessment by a QMHP, patients must be placed on a firm 1:1 with direct constant observation until a safe disposition can be determined. 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. Once a patient is placed on intermittent observation (every 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 patient's health care record.

Paragraph Author: Stern and Ruiz	III. A. 1. e. (CONSENT005) CHS shall obtain previous medical records to include any off-site specialty or inpatient care as determined clinically necessary by the qualified health care professionals conducting the intake screening.		
Medical Care: Compliance Status:	Compliance: 5/15	Partial Compliance: 1/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 5/14; 1/16	Non-Compliance: 7/13 (NR); 3/14 (NR)
Measures of Compliance:	Medical Care: • Audit Step a: (Chart Review) Necessary previous medical records are ordered in Intake and are in the chart (or there is evidence of reasonable effort to obtain the records). • Audit Step b: (Chart Review) Previous medical records in the chart are reviewed timely by a practitioner. • Audit Step c: (Chart Review) There is evidence that upon receipt of previous medical records (which, in the case of JHS records, is immediate), a practitioner has read the previous record and incorporated that knowledge into subsequent care. [This will be an additional audit step for the tour that will result in the production of Report #6 and was not used to assess compliance for Report #5.] Mental Health Care, as above and: 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:	Medical Care: N/A Mental Health Care: The electronic health record (EHR) contained 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):	Medical Care: Only 28/33 charts reviewed were compliant. Implicit in the need to *obtain* previous medical records is that those records need to be *read*. In the case of Patient 2 the content of the practitioner's progress note reflects that he did not review the previous records (or, for that matter, the screening nurse's note); the practitioner reported that the patient had a negative past medical history, despite a history of anemia, hypercholesterolemia, depression, and recent onset of seizures. After discussion with DOJ attorneys to confirm that this reasoning reflects the original intent of this provision, the Medical Monitor has added Audit Step c which will take effect with the next compliance review. Mental Health Care: Although many records are available from prior contacts within the Jackson system, few progress notes made reference to the content of outside medical records.		

Monitors' Recommendations:	Medical Care: None Mental Health Care: 1. To ensure that records are reviewed from contacts both within JMS and outside JMS, the County 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 and incorporate the finding into their notes / decision-making.

Paragraph Author: Stern and Ruiz	III. A. 1. f. (CONSENT006) 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; 5/15; 1/16	Non-Compliance: 3/14 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14; 10/14; 5/15; 1/16	Non-Compliance: 3/14 (NR)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Intake screening form calls for assessment of drug or alcohol use and withdrawal • Audit Step b: (Chart Review) Intake screening forms include documentation of assessment of drug or alcohol use and withdrawal • Audit Step c: (Chart Review) Patients screening positive for withdrawal or withdrawal risk referred to practitioner • Audit Step d: (Chart Review) Patients referred to practitioner for withdrawal or withdrawal risk receive further evaluation and, if necessary, placement in Detox. • Audit Step e: (Inspection) Policy 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 f: (Inspection) Training records show that nurses who perform intake assessments of drug or alcohol use and withdrawal receive training as specified in policy. Mental Health Care, as above: See Medical Care		
Steps taken by the County to Implement this paragraph:	Medical Care: The County has a policy that addresses some aspects of training. They have also developed some teaching materials for this training. Mental Health Care: See Medical Care		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: There was reasonable compliance with Audit Steps a-d and f. The main deficiency observed was that the training program is not yet fully developed (Audit Step e). Many of the general deficits are described in the Training paragraph in the introduction to the Medical and Mental Health part of Report #5. Some specific areas for improvement follow. There is no active skills-based component (demonstrating, and then observing learners doing intake). The teaching methods do not match what needs to be learned: 1) a major component of this activity is recognition of symptoms of intoxication, which would lend itself to photographs, videos, and actual encounters, but none of this is part of the training; 2) a secondary component of this activity is computer data entry, but the instructional aid is a static photocopy or screenshot of the computer, rather than live interaction with the computer; the static pictures in a slide set should only be a back-up in case the computer system is non-functional on the day of training. Some other narrower problems exist: The slides of COWS and CIWA will be illegible when projected in a classroom. Finally, the value of the strategy to include		

	training on COWS and CIWA in both this training and the Intake Screening training is elusive. Why cover the same material, in the same way, for the same audience, twice? Mental Health Care: 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. Additionally, during the tour, cases were identified of 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.
Monitors' Recommendations:	Medical Care: The training program needs to be more fully developed, consistent with the comments in the Training paragraph in the introduction to the Medical and Mental Health part of Report #5. Mental Health Care: 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	III. A. 1. g. (CONSENT007) (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; 5/15; 1/16	Non-Compliance: 7/13 (NR); 3/14 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 5/15; 1/16	Non-Compliance: 7/13 (NR); 3/14 (NR)
Measures of Compliance:	<u>Medical Care:</u> • (duplicate) CONSENT001 (IIIA1a) Audit Step h: (Inspection) Policy specifies an appropriate training strategy (e.g. who is trained, how often, qualifications of trainers, curriculum, lesson plans, teaching materials, assessment of competency) for nurses who perform intake medical screening. • (duplicate) CONSENT001 (IIIA1a) Audit Step i: (Inspection) Training records show that nurses who perform intake medical screening receive training as specified in policy. <u>Mental Health Care, as above:</u> 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	III. A. 2. a. (CONSENT008) 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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	*The measures of compliance from the Settlement Agreement and/or Consent Agreement and/or what you will use to measure compliance* • Audit Step a: (Chart Review) All detainees receive an initial health assessment within 14 days of arrival. • Audit Step b: (Chart Review) The initial health assessment is clinically adequate. This includes: a) it was conducted by an appropriate clinician, b) it is legible, c) all clinically appropriate history and physical examination was collected (either by the initial assessor or someone to whom the assessor referred the patient), d) the plan is clinically appropriate, e) the plan is executed as planned.		
Steps taken by the County to Implement this paragraph:	Not audited		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	None		
Monitor's Recommendations:	After discussion with the County, 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 the County 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 tour. These changes would affect CONSENT012/IIIA2e, CONSENT013/IIIA2f, CONSENT022/IIIA4b(2), and CONSENT008/IIIA2a.		

Paragraph Author: Ruiz	III. A. 2. b. Health Assessments: Qualified Mental Health Staff will complete all mental health assessments incorporating, at a minimum, the assessment factors described in Appendix A.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Review of policy regarding mental health evaluation and screening 2. Record review for adherence to screening, assessment and trigger events as described in Appendix A. 3. Interview of staff and inmates.		
Steps taken by the County to Implement this paragraph:	CHS Suicide Prevention policy is covered in 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)	N/A		
Monitor's Recommendations:	N/A		

Paragraph Author: Ruiz	III. A. 2. c. Health Assessments: Qualified Mental Health Professionals shall perform a mental health assessment following any adverse triggering event while an inmate remains in the MDCR Jail facilities' custody, as set forth in Appendix A.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR)
Unresolved/partially resolved issues from previous tour:	3/2014: It is recommended that the County develop and implement a policy for suicide risk assessment by QMHPs. As noted by the NCCHC[3], suicide risk assessment should be viewed as an ongoing process, as it may be necessary at any point during incarceration.		
Measures of Compliance:	<u>Mental Health:</u> 1. Review of policy regarding mental health evaluation and screening 2. Record review for adherence to trigger events, referral and assessment as described in Appendix A. 3. Interview of staff and inmates. 4. Review of all adverse events involving inmates with mental health and substance misuse issues.		
Steps taken by the County to Implement this paragraph:	CHS Suicide Prevention policy is covered in CHS-059. 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, the County is in the process of updating their CHS suicide policy and procedure.		
Monitor's Recommendations:			

[3] 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. d. Health Assessment: Qualified Mental Health Professionals, as part of the inmate's interdisciplinary treatment team (outlined in the "Risk Management" Section, *infra*), will maintain a risk profile for each inmate based on the Assessment Factors identified in Appendix A and will develop and implement interventions to minimize the risk of harm to each inmate.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR)
Unresolved/partially resolved issues from previous tour:	3/14: The County 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:	<u>Mental Health:</u> 1. Review of policy regarding mental health evaluation, risk management and documentation 2. Record review for adherence to screening, trigger events, referral and assessment as described in Appendix A. 3. Interview of staff and inmates.		
Steps taken by the County to Implement this paragraph:	Treatment plans and their implementation are outlined in CHS policy 058A.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	N/A		
Monitor's Recommendations:	N/A		

Paragraph Author: Stern	III. A. 2. e. (CONSENT012) 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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	<u>Medical Care:</u> • Audit Step a: (Chart Review) *(For simplicity, this audit step addresses 3 overlapping compliance measures simultaneously: (1) the need for patients to receive an <u>Initial Health Assessment by a practitioner within 24 hours if a chronic disease</u> is identified during intake screening (CONSENT012 (IIIA2e)); (2) the need for patients to receive an <u>Initial Health Assessment by a practitioner within 24 hours if clinically indicated</u> during intake screening (CONSENT013 (IIIA2f)); and (3) the need for patients to receive an <u>evaluation by a physician within 48 hours if a serious medical problem</u> 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:	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):	N/A		
Monitor's Recommendations:	N/A		

Paragraph Author: Stern and Ruiz	III. A. 2. f. (CONSENT013) (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; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
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: Mental Health Care: Please see Consent III. A. 1. a. for more detail.		
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: See Consent III. A. 1. a.		
Monitor's Recommendations:	Medical Care:		

	N/A Mental Health Care: N/A

Paragraph Author: Stern and Ruiz	III. A. 2. g. (CONSENT014) 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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
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: N/A Mental Health Care: 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: N/A Mental Health Care: N/A		
Monitor's Recommendations:	Medical Care: N/A Mental Health Care: N/A		

3. Access to Medical and Mental Health Care

Paragraph Author: Stern and Ruiz	III. A. 3. a. (1) (CONSENT015) 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 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance: 3/14; 10/14	Partial Compliance: 7/13	Non-Compliance: 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Health care slips on the living units are available in English, Spanish, and Creole. Mental Health Care: 1. Availability of mental health care slips in English, Spanish and Creole 2. Availability of writing implements to fill out mental health care slips 3. Evidence of culturally-sensitive policies and procedures for ADA inmates with cognitive disabilities 4. Presence and implementation of confidential collection method for mental health slips daily 5. Review of logs of sick call slips, appointments, for appropriate triage 6. Review of Mental Health grievances		
Steps taken by the County to Implement this paragraph:	Medical Care: N/A Mental Health Care: 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: N/A Mental Health Care: N/A		
Monitor's Recommendations:	Medical Care: N/A Mental Health Care: N/A		

Paragraph Author: Stern and Ruiz	II. A. 3. a. (2) (CONSENT016) 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 (NR); 3/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Interviewed COs report a confidential way for detainees with impaired communication skills to access care. Mental Health Care: 1. Interview with inmates with cognitive or physical disabilities 2. Interview with staff 3. Review of medical record to assess access to care		
Steps taken by the County to Implement this paragraph:	Medical Care: 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 and Mental Health Care: N/A		
Monitors' Recommendations:	Medical Care: N/A Mental Health Care: N/A		

Paragraph Author: Stern and Ruiz	III. A. 3. a. (3) (CONSENT017) 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 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance: 10/14	Partial Compliance: 7/13	Non-Compliance: 3/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	<u>Medical Care:</u> • 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. <u>Mental Health Care:</u> 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:	<u>Medical Care:</u> N/A <u>Mental Health Care:</u> 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):	<u>Medical Care:</u> N/A <u>Mental Health Care:</u> N/A		
Monitor's Recommendations:	<u>Medical Care:</u> N/A <u>Mental Health Care:</u> N/A		

Paragraph Author: Stern and Ruiz	III. A. 3. a. (4) (CONSENT018) 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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR)
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> N/A <u>Mental Health Care:</u> 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):	<u>Medical Care:</u> N/A <u>Mental Health Care:</u> N/A		
Monitors' Recommendations:	<u>Medical Care:</u> N/A <u>Mental Health Care:</u> N/A		

Paragraph Author: Stern and Ruiz	III. A. 3. b. (CONSENT019) 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 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health : Compliance Status:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection and Chart Review) This is an overarching requirement. It is measured primarily by MDCR's success with all other medically-related requirements in the Consent Agreement. it is also the "catch-all" for any failure a) to train staff to identify and treat serious medical needs, and b) of staff to identify or treat a serious medical need. Mental Health 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: 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: N/A Mental Health Care: N/A		
Monitors' Recommendations:	Medical Care: N/A Mental Health Care: N/A		

4. Medication Administration and Management

Paragraph Author: Stern and Ruiz	III. A. 4. a. (CONSENT020) 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 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR)
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: 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: N/A Mental Health Care: N/A
Monitors' Recommendations:	Medical Care: N/A Mental Health Care: N/A

Paragraph Author: Stern and Ruiz	III. A. 4. b. (1) (CONSENT021) Within ei months of the Effective an inmate's ent Jail, a Qualified Medical or Mental Health , 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 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR)
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: N/A Mental Health Care: 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: N/A Mental Health Care: N/A		
Monitor's Recommendations:	Medical Care: N/A Mental Health Care:		

	N/A

Paragraph Author: Stern and Ruiz	III. A. 4. b. (2) (CONSENT022) 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 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
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: N/A (See CONSENT012 (IIIA2e)) Mental Health Care: N/A (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: [See CONSENT012 (IIIA2e)] Mental Health Care: [See CONSENT012 (IIIA2e)]		

Paragraph Author: Ruiz	III. A. 4. c. Medication Administration and Management ists shall c ic medications to ensure that each inmate' ibed 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 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Policy/procedure to track, analyze data, and review Levels of Care and access to care 2. Review of records to assess psychiatrist-patient visits 3. Interview with staff and inmates		
Steps taken by the County to Implement this paragraph:	N/A		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	N/A		
Monitor's Recommendations:	N/A		

Paragraph Author: Ruiz	III. A. 4. d. Medication Administration and Management CHS shall ensure nursing staff pre-sets psychotropic medications in unit doses or bubble packs before delivery. If an inmate housed in a designated mental health special management unit refuses to take his or her psychotropic medication for more than 24 hours, the medication administering staff must provide notice to the psychiatrist. A Qualified Mental Health Professional must see the inmate within 24 hours of this notice.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Policy regarding medication administration and reporting 2. Review of Medication Administration Records 3. Review of reports to Qualified Mental Health Professionals		
Steps taken by the County to Implement this paragraph:	N/A		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	N/A		
Monitor's Recommendations:	N/A		

Paragraph Author: Stern and Ruiz	III. A. 4. e. (CONSENT025) 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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	<u>Medical Care:</u> • 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.] <u>Mental Health Care, as above and:</u> 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:	<u>Medical Care:</u> N/A <u>Mental Health Care:</u> 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):	<u>Medical Care:</u> N/A <u>Mental Health Care:</u> N/A		
Monitor's Recommendations:	<u>Medical Care:</u> N/A <u>Mental Health Care:</u> N/A		

Paragraph Author: Stern and Ruiz	III. A. 4. f. (CONSENT026) (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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR)
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: N/A Mental Health Care: 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: N/A Mental Health Care: N/A		
Monitor's Recommendations:	Medical Care: N/A Mental Health Care: N/A		

5. Record Keeping

Paragraph Author: Stern and Ruiz	III. A. 5. a. (CONSENT027) 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 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14; 10/14	Non-Compliance: 7/13; 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • Audit Step a: (Chart Review) Paper medical records are adequate. This would include, among others, the provisions of NCCHC J-H-01 and J-H-04. (This audit will sunset when an EHR is implemented.) • Audit Step b: (Chart Review) Electronic medical records (contained in one or more electronic programs) are adequate. This would include, among others, the provisions of NCCHC J-H-01 and J-H-04. Mental Health Care, as above and: 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:	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: N/A Mental Health Care: N/A		
Monitors' Recommendations:	Medical Care: Two similar issues surrounding record keeping came to the Medical Monitor's attention during this tour and are		

	described here. 1. We discovered that some nurses assign to clerical staff the task of documenting the nurses' welfare checks of patients in Isolation cells (see III. C. 6. Custodial Segregation (CONSENT088)). On its face, the documentation reads as if the welfare check was conducted by the clerical staff. While, as discussed elsewhere, this documentation is no longer necessary, it raises the issue of the EHR's lack of ability (or staff's lack of knowledge) to clearly document on behalf of another individual. 2. The EHR apparently does not have the capability (or it does, and staff are not familiar with it) to allow nurses to record a verbal/telephone order from a physician. The order must be entered by the physician personally. Thus when given a verbal order, the nurse often executes the order – for example, administration of a medication – before there is a recorded order. When reading such a record, it appears as if the nurse administered the medication without an order. Worse, the record can create confusion about whether the physician's intent was for administration of a second dose, and suggests that the second order was not followed. Thus the County needs to assure that its EHR has the capability of allowing an appropriately licensed and authorized professional to document on behalf of another person, and still making it clear who the documenter is. A third issue came to the Medical Monitor's attention during the tour. Review of nursing sick call is very difficult to accomplish from the Notes or Forms view of the EHR. To view all documentation, the reviewer must also seek out "I-View" documentation, which is imbedded in the health record and obscure. It is expected that practitioners will review nurses' notes at each visit, however, using the current tools, it would take the practitioner quite a bit of time to peruse nursing documentation. Because the structure of nurse sick call may evolve, this issue may become moot. This observation is provided for County's information and action as appropriate. <u>Mental Health Care:</u> N/A

Paragraph Author: Ruiz	III. A. 5. b. Record Keeping CHS shall implement an electronic scheduling system to provide an adequate scheduling system to ensure that mental health professionals see mentally ill inmates as clinically appropriate, in accordance with this Agreement's requirements, regardless of whether the inmate is prescribed psychotropic medications.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14; 10/14	Non-Compliance: 7/13; 5/15 (NR); 1/16 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Policy regarding scheduling and documentation 2. Review of medical and mental health records for access to care 3. Review of scheduling system 4. Review of Mental Health grievances		
Steps taken by the County to Implement this paragraph:	The County has implemented CARL, an appointment scheduler. Back-ups in scheduling to see the psychiatrist and other providers have not been analyzed.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	N/A		
Monitor's Recommendations:	N/A		

Paragraph Author: Stern and Ruiz	III. A. 5. c. (CONSENT029) (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 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14; 10/14	Non-Compliance: 5/15 (NR); 1/16 (NR)
Measures of Compliance:	<u>Medical Care:</u> • (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. <u>Mental Health Care:</u> 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:	<u>Medical Care:</u> [See CONSENT027 (IIIA5a)] <u>Mental Health Care:</u> [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):	<u>Medical Care:</u> [See CONSENT027 (IIIA5a)] <u>Mental Health Care:</u> See above		
Monitors' Recommendations:	<u>Medical Care:</u> [See CONSENT027 (IIIA5a)] <u>Mental Health Care:</u> See above		

Paragraph Author: Stern and Ruiz	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 (NR); 3/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14; 10/14	Non-Compliance: 5/15 (NR); 1/16 (NR)
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. • Audit Step g: (Inspection) There is a process in place, described in policy, by which external referrals (including specialty visits and tests) are tracked, such that delays in performance of the referral or receipt of the report are automatically announced to the appropriate authority for action. [This will be an additional audit step for the tour that will result in the production of Report #6 and was not used to assess compliance for Report #5.] <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> N/A <u>Mental Health Care:</u> N/A		
Monitors' analysis of	<u>Medical Care:</u>		

conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	During the course of the review, the Medical Monitor learned that there may not be a robust system for tracking requests for consultations to external specialists, i.e. if a referral were ordered or arranged, and fell through the cracks, this might not generate any alerts. We did not examine the system ourselves, so are not sure of the accuracy of this information. This is an aspect of the referral process that the Medical Monitor will examine when this provision is ready for review, and this concept has been added as an Audit Step. <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 Memorial Hospital in the emergency department and did not review the record in a timely manner. Other cases demonstrated that patients returning from State hospitals were not 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> N/A <u>Mental Health Care:</u> N/A

6. Discharge Planning

	III. A. 6. a. (1) (CONSENT031)		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 1/16; 10/14	Non-Compliance: 7/13 (NR); 3/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 1/16	Non-Compliance: 3/14; 5/15 (NR)
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. • Audit Step b: (Inspection) Custody staff notify medical staff at least 2 weeks prior to planned releases. • Audit Step c: (Inspection) The terms of this provision are incorporated in policy. [This will be an additional audit step for the tour that will result in the production of Report #6 and was not used to assess compliance for Report #5.] 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. Evidence of providing a bridge supply of medications of up to 7 days to inmates upon release including receipt of medication as appropriate 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: The County 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: The County hired a discharge planner and is in the process of updating its policy for Discharge Planning, CHS-049. 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: Of 44 Cerner EHRs reviewed of patients with chronic medical problems who were releasing from jail, 17 did not receive appropriate or timely referrals to community resources upon release. Mental Health Care: The current policy precludes bridge medications for a majority of the patients on the mental health caseload: those on Level IV. The policy does not necessitate review by a QMHP for patients with SMI. The draft policy also requests that the patient request the medication and that there be a known discharge date ahead of time; these prerequisites contradict the guidelines set forth in the Consent Agreement.		

Monitor's Recommendations:	<u>Medical Care</u> 1. While there is continued improvement in continuity of care that is provided by the County upon planned release of patients with chronic medical problems, more progress needs to be made. It may be helpful for the County to self-audit this activity to determine the root cause of gaps. 2. The County will also need to implement an electronic report identifying discharged patients with chronic medical problems from which the Monitor (and eventually the County itself) can test how well the system was working. 3. The policy covering this provision should be finalized. <u>Mental Health Care:</u> 1. To become compliant, the County needs to expand its discharge planning process. Once a more active component is implemented, this should be reflected in the numbers of referrals. 2. Referrals should include a confirmed appointment time with an available mental health provider and confirmed dispensing of psychotropic medication as appropriate.

Paragraph Author: Stern and Ruiz	III. A. 6. a. (2) (CONSENT032) 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 (NR); 3/14 (NR); 5/15 (NR); 1/16
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 1/16	Non-Compliance 3/14; 5/15 (NR)
Measures of Compliance:	<u>Medical Care:</u> • 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.~~ [This Audit Step is being removed; it duplicates an Audit Step in III.A.6.a.(1) (CONSENT031)] • Audit Step c: (Inspection) The terms of this provision are incorporated in policy. [This will be an additional audit step for the tour that will result in the production of Report #6 and was not used to assess compliance for Report #5.] <u>Mental Health Care, as above and:</u> 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:	<u>Medical Care:</u> The County has been working on improving its discharge planning for patients with chronic disease, including attempting to have a social worker meet with patients who have planned releases. MDCR continues to notify CHS staff of planned releases at least 2 weeks prior to release. <u>Mental Health Care:</u> The County 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 that they are interested in discharge services. The draft CHS-049 policy describes the process to follow if patients are eligible for bridge medications. It does not describe who is eligible and who is not.		
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> Of 44 Cerner EHRs reviewed of patients with chronic medical problems who were releasing from jail, 20 patients did not receive any or an adequate supply of bridge medications. It is possible that patients received their medications or medications were not needed, but this documentation did not appear in the EHR. In its response to the draft of this report, the County asked to be considered partially compliant with this provision based on "MDCR provided documentation showing the notifications were occurring on a regular basis as required by CA. Inmates are notified via the Inmate Handbook and everyone inmate is notified on their property receipts which was provided to Dr. Stern." The Medical Monitor did, in fact take both of these facts into consideration in assigning the status of non-compliance. The first, notification of CHS by MDCR, is a component of the previous provision (III. A. 6. a. (1) (CONSENT031), and is, in fact, the reason that that provision		

	was assessed as partially compliant rather than non-compliant. The second, notification via the Inmate Handbook, is a component of the next provision (III. A. 6. a. (3) (CONSENT033), and is, in fact, the reason that that provision was assessed as compliant rather than non-compliant. For the present provision, however, the sole activity the County needed to demonstrate was provision of medications upon release, something that staff failed to do 55% of the time, resulting in the assessment of non-compliance. Mental Health Care: The County provided a log entitled, 'Discharge Med Pick Up Log' (January - December 2015). The Mental Health Monitor reviewed this log. The log indicated bridge medications were ordered for a total of only 30 patients in 2015 and picked up by 67% of them. This finding indicates that when the medications are ordered, they are picked up in the majority of cases.
Monitor's Recommendations:	Medical Care: Please see recommendation in III.A.6.a.(1) (CONSENT031) above. Mental Health Care: Given that the County treats thousands of patients yearly, providing bridge medications to a mere 20 patients amounts to a pilot project. To reach compliance, efforts will need to reach a minimum of 80% of the caseload with severe mental illness.

Paragraph Author: Stern and Ruiz	III. A. 6. a. (3) (CONSENT033) Adequate discharge planning is contingent on timely notification by custody for those inmates with planned released dates. For those inmates released by court or bail with no opportunity for CHS to discuss discharge planning, bridge medication and referral assistance will be provided to those released inmates who request assistance within 24-hours of release. Information will be available in the handbook and intake admission awareness paper. CHS will follow released inmates with seriously critical illness or communicable diseases within seven days of release by notification to last previous address.		
Medical Care: Compliance Status:	Compliance: 1/16	Partial Compliance: 10/14	Non-Compliance: 7/13 (NR); 3/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 1/16	Non-Compliance: 3/14; 5/15 (NR)
Measures of Compliance:	Medical Care: • 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. • Audit Step c: (Inspection) The terms of this provision are incorporated in policy. [This will be an additional audit step for the tour that will result in the production of Report #6 and was not used to assess compliance for Report #5.] • Audit Step d: (Inspection) The County has a system for monitoring compliance with the part of this provision requiring follow-up of non-communicable disease laboratory results that are reported to the County after a patient's release. [This will be an additional audit step for the tour that will result in the production of Report #6 and was not used to assess compliance for Report #5.] Mental Health Care, as above and: 1. Policy regarding discharge planning 2. Evidence of referrals for inmates with chronic medical health problems or serious mental illness. 3. Evidence of providing a bridge supply of medications of up to 7 days to inmates upon release 4. Provision of an inmate handbook at admission indicating they may request bridge medications and community referral upon release.		
Steps taken by the County to Implement this paragraph:	Medical Care: The County has hired an Infection Control Nurse who has already begun to make significant system improvements, including streamlining the process for receiving and processing abnormal laboratory results regarding communicable diseases. The addition of this staff member is a key positive step and the County is to be commended. Mental Health Care: A discharge planning log was provided. The County could not provide confirmation of written notification of other recent discharges.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's	Medical Care: 1. It is very difficult to assess compliance with the provision requiring follow-up of non-communicable disease laboratory results that are reported to the County after a patient's release. Unless it is fixed, this difficulty, experienced by the Medical Monitor, will also be experienced by the County after the Monitors' departure, making it difficult for the County to monitor its own quality of care in the future.		

representations, and the factual basis for finding(s):	2. The discharge planners have a brochure available at booking that lists a hotline for inmates to call upon release to obtain their discharge medications. They are not allowed by security staff to provide the brochure to the patient at intake and must wait to give it to them upon release. There are a number of patients who leave directly from court or who are released prior to medical staff having opportunity to provide the brochure. <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 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.
Monitor's Recommendations:	<u>Medical Care:</u> 1. The County needs to develop a system for monitoring compliance with the part of this provision requiring follow-up of non-communicable disease laboratory results that are reported to the County after a patient's release. It should be possible to develop a software solution to this. This issue will be translated into a new audit step for compliance tour #6. <u>Mental Health Care:</u> 1. The County may consider prioritizing patient treatment need. Once patients properly triaged and leveled, an active system of discharge planning should be implemented for patients from Levels I-IV with active symptomatology and recent stabilization 2. The County 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	III. A. 7. a. (CONSENT034) 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; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13; 10/14 (NR); 5/15 (NR); 1/16
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> There has been some interim improvement in the quality and quantity of required reviews and reports conducted by health care staff. During the tour, the CEO of Jackson Health Systems publically verbalized his expectation that health care staff will openly describe and document errors they discover during reviews, understanding that is only through such rigorous self-examination that future errors are avoided. This corporate attitude is highly laudable, and has already begun to translate into more descriptive, and therefore useful, reviews.		

	Mental Health Care: The County did not provide an updated policy specific to Morbidity and Mortality review. It did send the completed reports of its mortality reviews.
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: Though improving, there remain gaps in the mortality and morbidity review process. 1. Though the policy covering mortality and morbidity reviews intends for the process to include review of mortalities, serious suicide attempts, and "incidents in which an inmate was at high risk for death" (other than suicide attempts), there is still no process for defining these latter events and funneling them into this review process. Indeed, the documentation provided to the Monitors in preparation for this compliance tour only included rubrics for the first two categories. 2. A number of the required mortality reviews (3 day Administrative Review, 30 day Administrative Review, Clinical Review, 45 day Monitor Notification, 90 day remedies status review) were not done or not provided to the Monitors, or were done late. 3. While the mortality reviews conducted by the County identified some errors, they failed to identify all the errors, including some that were significant. 4. Having identified errors, there is insufficient evidence that staff conducted Root Cause Analysis (RCA) of these errors to understand the underlying cause. At least one reason for this failure appears to be the administrative barriers to conducting a RCA within the JHS system. Understandably, RCAs are commissioned, coordinated, and conducted by JHS staff. However, such a system impedes the ability of CHS to be nimble and maintain a low threshold for conducting RCAs that in turn impedes its ability to discover and correct system errors. 5. When staff have discovered errors in the course of mortality reviews, they do implement corrective actions. However, those corrective actions are almost always limited to "momentary" fixes, such as counseling an employee, sending out an email reminder, or discussing the issue at a staff meeting. While momentary fixes are necessary, they are not sufficient. They are insufficient for a number of reasons, most importantly because they erode with time: staff forget these reminders, and staff turnover results in new employees who never received the reminders. An excellent example of this comes from the mortality review of Patient 4. Pursuant to an error discovered during a previous mortality and morbidity review, supervisory staff issued a memo to physicians on 3/26/15 regarding the need for better physician-to-physician hand-offs. During the review on Patient 4, it was discovered that one of the problems was an ineffective physician-to-physician hand-off. Thus the previous "momentary" fix was insufficient to prevent a recurrence (and repeating the same insufficient fix is unlikely to work the second time). 6. Finally, there is no evidence of implementation of any monitoring to measure the effectiveness of even the "momentary" fixes put in place. (Indeed, such monitoring would likely demonstrate the short-lived nature of the momentary fixes and trigger the County to implement more sustainable fixes.) Mental Health Care: With respect to Morbidity and Mortality Reviews, the following was identified: 1. The Mental Health Monitor did not receive reports regarding serious suicide attempts, deaths, and suicides within 45 days of each incident. 2. We learned during the review that a distinction was being made between acts of self-harm that lead to admission to the emergency department vs. admission to the hospital. The latter were being reported while the former were not. 3. Opportunities for improvement were seldom identified or documented, stating instead that clinical care was adequate.

Monitors' Recommendations:	<u>Medical Care:</u> 1. The Medical Monitor strongly urges the County to examine the structure of the mortality and morbidity reporting process with regard to the number of reviews and the required timing of the reviews – including those required by the CA – with an eye towards simplifying the process. The current process – driven in part by the CA – is cumbersome and time consuming for key staff, and may contribute to some of the reporting gaps noted in this report. Any proposed changes that impact the CA will need to be reviewed and approved by the DOJ. However, the DOJ's counsel has already expressed support, in principle, for changes to the CA (or its interpretation) that result in a better and more sustainable system for ensuring patient safety. 2. If the County does revise the review process, consideration should be given to reducing the degree to which receipt of an autopsy report drives (or, more importantly, delays) interval review. In other words, because an autopsy report and official cause of death rarely change key lessons learned about system problems, the review process should proceed with or without the autopsy report; when the autopsy report is finally received, it should be reviewed and in the rare case where it raises new issues, the mortality review should be re-opened. 3. The Medical Monitor also urges JHS to provide CHS with the support and authority to conduct RCAs "at will." 4. The County needs to apply RCA to significant errors it discovers during mortality and morbidity reviews. 5. Remediation of system errors discovered during mortality and morbidity reviews must include not only "momentary " fixes (e.g. emails, discussion at staff meetings), but also sustainable fixes that will outlive the memory and tenure of current employees. Sustainable fixes include changes to: policy, procedure, forms and notifications in the EHR, post orders, job descriptions, and training curricula. 6. If not already subject to monitoring, after making changes to systems as a result of the mortality and morbidity review process, the County should usually implement some kind of monitoring mechanism to confirm the effectiveness of the change. Depending on the nature of the error, the change, and the monitoring results, the monitoring may eventually be conducted less frequently or not at all. 7. Finally, the mortality and morbidity review system addressed in this triad of provisions needs to be more integrally incorporated into the facility's overall quality improvement policy. Currently, policy deals with these as two separate activities; they are not. <u>Mental Health Care:</u> 1. Please provide 45-day reviews in timely manner. 2. Corrective action plans should include meaningful and sustainable interventions with concrete and measurable goals and recommendations. 3. Intake screens should make note of drug history. This has been a repeated issue with respect to mental health patients and appropriate triage. 4. Medication errors should be properly addressed with pharmacy and other stakeholders.

Paragraph Author: Stern and Ruiz	III. A. 7. b. (CONSENT035) 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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13; 10/14 (NR); 5/15 (NR);1/16
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> See Comments in III.A.7.a. (CONSENT034) <u>Mental Health Care:</u> The County provided mortality and morbidity reviews. However, they were not provided along the timeline prescribed by 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):	<u>Medical Care:</u> See Comments in III.A.7.a. (CONSENT034) In its response to the draft of this report, the County requested to be considered at least partially compliant for this, and the next provision, i.e. III. A. 7. b, c (CONSENT035, 036). These two provisions, along with the preceding one (III. A. 7. a. (CONSENT034) are intimately intertwined with each other. Overall, the system of mortality and morbidity review sought by these provisions is markedly underdeveloped at this point. However, it is not totally non-existent. Thus in recognition of this fact, III. A. 7. a. (CONSENT034) was assessed as partially compliant. Given the difficulty of completely disentangling these three provisions, the choice of this provision for scoring as partial compliant, rather than one or both of the other two, may be argued. However, the Medical Monitor felt that this was the most reasonable choice, and conveys what is described in the text in these three provisions: the County has made some progress, but there is much work remaining to be done to make the morbidity and mortality review system safe. <u>Mental Health Care:</u> Many of the remedies suggested by the County in the action plans submitted suggested "improved communication" and "appropriate corrective action" would take place for deficiencies that were noted but it did not specifically state how that communication or corrective action would take place or when.		
Monitors' Recommendations:	<u>Medical Care:</u>		

	See Comments in III.A.7.a. (CONSENT034) <u>Mental Health Care:</u> 1. Provide specific, concrete action items for corrective action with measurable goals.

Paragraph Author: Stern and Ruiz	III. A. 7. c. (CONSENT036) 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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR);1/16
Measures of Compliance:	<u>Medical Care:</u> • 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. <u>Mental Health Care:</u> 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:	<u>Medical Care</u> The County conducted its first bi-annual review. (The review was conducted in the days before our tour [on December 22], after the deadline for receipt of supporting information, and the minutes of this meeting were submitted after our departure. Nonetheless, the Medical Monitor included these materials in his review.) <u>Mental Health Care:</u> Specific corrective action and goals have not been implemented in policy.		
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 conducted, the bi-annual review lacks the comprehensiveness necessary for this exercise to add value to patient safety efforts: 1. The meeting was called as a special meeting rather than as part of planned, regular business of the Quality Improvement Committee; the skeletal attendance at the meeting reflects the "special" nature of the meeting. 2. Related to the previous point, the occurrence of semi-annual review (or any kind of regular review) of progress/status of fixes that have been put into place as a result of mortality and morbidity reviews (and other quality indicators), is not yet incorporated into policy. 3. As noted in comments to an earlier provision, the mortality and morbidity process includes review of "incidents in which an inmate was at high risk for death." This category of reviews seems to have been dropped in the 180-day review. 4. The report (and policy) excludes *de jure* review of deaths that occurred after release from total confinement. This blanket exclusion is not appropriate. 5. The report ignores one death (Mr. B) that occurred within the preceding 180 days. 6. The report ignores several deaths that occurred in previous 180-day periods.		

	See additional comments in III.A.7.a. (CONSENT034). <u>Mental Health Care:</u> Specific corrective action and measurable goals have not been implemented. For example, one corrective action item described improving communication via IDTT. However, IDTT is held on an average of 11 patients per month, which is less than 1% of the mental heath population.
Monitors' Recommendations:	<u>Medical Care:</u> 1. As an extension of the Recommendation 1 in III.A.7.a. (CONSENT034), the Medical Monitor encourages the County to include the current provision (requiring 180 day reviews) in its re-evaluation of the mortality and morbidity review process. The County may discover an easier and more effective way to incorporate the intent of this provision in an integrated program. For example, if the County were to develop a robust system of tracking any open "fixes" on an ongoing basis, period reviews – including 180 day reviews – might be deemed superfluous. 2. Cases in which hospitalization or release from confinement is the result of a medical condition that occurred or worsened during confinement in MDCR, should be reviewed. 3. Policy should state, and practice should reflect, that mortality reviews are not automatically limited to patients who die within the walls of MDCR. If patients die after release from the hospital and/or confinement due to an health condition which began or worsened during confinement in MDCR, and for which the hospitalization and/or release from confinement may have resulted from care for that condition at MDCR, then that mortality or morbidity should be the subject of review under this provision. 4. Any ongoing review of the status of "fixes," such as the 180 day review, should be inclusive of all open issues on all cases, even if they occurred more than 180 days before the review. See additional comments in III.A.7.a. (CONSENT034). <u>Mental Health Care</u>: Implement specific corrective action plans and goals.

B. MEDICAL CARE

1. Acute Care and Detoxification

Paragraph Author: Stern	III. B. 1. a. (CONSENT037) 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 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) When interviewed, COs report that when a detainee orally requests health care that the detainee says cannot wait to be processed via a routine health request slip, COs immediately transmit such requests to nurses without filtering or triage, regardless of how minor the problem may appear to the CO. • Audit Step b: (Inspection) When interviewed, nurses report that when receiving calls from COs for urgent detainee health care needs, a patient assessment (in person or by phone, as appropriate) is conducted that is 1) timely, 2) performed by or under the direct supervision of an RN or practitioner, and 3) is documented. • Audit Step c: (Inspection) When interviewed, with occasional exception, detainees report that when they have a need for urgent care that cannot wait to be processed via a routine health request slip: 1) they can get attract the attention of a CO immediately, 2) their request is accepted by the CO without further screening (beyond "Do you feel this cannot be handled through a health request slip?"), 3) they are assessed by a nurse soon thereafter (NB: 1. This assessment may be done in person or telephonically, if clinically appropriate. 2. Assessment does not imply that treatment must be rendered if treatment can be reasonably deferred.) • Audit Step d: (Inspection and Chart Review) When the living unit's officer log shows that a call was made to CHS for an urgent inmate request, there is a corresponding clinical entry in the inmate's record reflecting timely and adequate triage. • Audit Step e: (Inspection) The number of grievances for barriers to urgent care is fewer than 3 per 1000 ADP/year. • Audit Step f: (Chart Review) Urgent and non-urgent episodic care is appropriate: a) the care is timely b) it is delivered by appropriately trained and licensed staff c) the content of the care is clinically appropriate. • Audit Step g: (Chart Review) Orders (other than for medications, which is addressed elsewhere) are executed timely, reviewed timely, and result in appropriate and timely clinical response. • Audit Step h: (Inspection) The number of upheld grievances for poor quality episodic care is low. • (duplicate) CONSENT018/IIIA3a(4) Audit Step b: (Inspection) Review of emergency medical grievances shows that they are handled immediately and appropriately.		
Steps taken by the County to Implement this paragraph:			

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):	Though not the object of our review during this tour, conditions related to this provision came to the Medical Monitor's attention and are shared here for the County's information and action as appropriate in anticipation of review of such conditions during a subsequent tour. We discovered discontinuity in care related to orders not being executed or followed up as planned. Many examples of this can be seen within individual cases. Patient 5 had a repeat blood sugar measured in Intake as ordered by the Intake medical practitioner. It was 464 at 19:09 on 7/10/15. The lab result was not recorded in Laboratory Results and was not communicated to the practitioner for action (nor is there any indication that a feedback loop informed the practitioner that the results were not reported him) and was not checked again until over 6 hours later. On 7/20/15 the patient had a positive skin test for tuberculosis (15 mm) (I am unable to determine if the patient had repeat symptom screening at the time that positive result was discovered.). A chest x-ray was ordered, but never took place. Despite multiple subsequent interactions with health care staff, no feedback loop informed any of them of the missing test. On 8/28/15, a practitioner ordered a return visit on 8/31/15 that did not take place. On 10/9/15 a practitioner discontinued the patient's thyroid medication and ordered a thyroid blood test for 2 weeks later that did not take place. Patient 6 was seen by the physician for high blood pressure. His blood pressure was 194/114. The physician ordered the blood pressure to be repeated in 1 hour and then daily for 5 days, neither of which took place. His blood pressure was not checked in an hour and in fact was not checked again until 3 days later. That check was the only one of the 5 daily checks that was conducted. The physician also ordered a follow-up visit for 7 days later that did not happen until 12 days later. On 8/31/15 a physician ordered a visit with Dr. Dauphin on 9/1/15 for HIV management that did not take place. A physician saw the patient on 9/9/15, again due to his high blood pressure, and ordered for nurses to continue checking the patient's blood pressure and to have the patient return to the physician's clinic 7 days later, neither of which took place. No blood pressures were checked and the patient was not returned to the physician's clinic until 11 days later.
Monitor's Recommendations:	The common theme in the examples above is that orders are not executed as planned. Now that the County has an EHR, it should implement functionality within the EHR that alerts staff (and supervisors) when ordered interventions are not completed as ordered.

Paragraph Author: Stern	III. B. 1. b. (CONSENT038) (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 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
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 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 the County 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 County's custody leadership team regarding officers' role in this process.

Paragraph Author: Stern	III. B. 1. c. (CONSENT039) 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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	*The measures of compliance from the Settlement Agreement and/or Consent Agreement and/or what you will use to measure compliance* • Audit Step a (Chart Review) Patients in withdrawal or at risk for withdrawal receive appropriate monitoring and care, including, but not limited to the provisions of NCCHC Jail Standard J-G-06 and Appendix H. In general, these provisions fall into the following items: a) monitoring and treatment is conducted pursuant to patient-specific orders from a practitioner, b) monitoring is conducted by trained staff, c) monitoring is conducted using validated instruments (e.g. COWS) if they exist, and otherwise under clear and specific orders, d) while clinical data collection may be collected by any appropriately trained staff, assessments may only be made by RNs or practitioners, e) appropriate treatment is provided.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	1. We were asked to conduct informal reviews of the detoxification program during this tour. The Medical and Mental Health Monitors toured the male and female detoxification units at TGK, spoke with patients, front line staff, and supervisors, and reviewed some medical records. Pursuant to gaps in care observed during earlier tours, the Monitors had previously indicated that detoxification services need to be under the primary direction of Medical service providers (i.e. practitioners and nurses), with Mental Health service providers serving the role of consultant, even for patients with serious behavioral dysfunction. This model ensures that the most life-threatening problem facing most detoxification patients, i.e. their physical health, is addressed by staff who are adequately trained and experienced. During the current tour, the directors of Medical and Mental Health services expressed a desire to place detoxifying patients with severe concomitant behavioral dysfunction under the primary direction of Mental Health service providers. While the Monitors believe this is a more difficult model to implement, the decision on the optimal model is up to the County. However, the Monitors will still require that the service providers – regardless of their specialty – are adequately trained and experienced to provide safe detoxification services. It is on this latter criterion that the Monitors will assess detoxification services when this provision is ready for formal review. 2. During the Medical Monitor's informal review of cases, he found a patient (Patient 3) who was identified by the screening nurse as having potential for alcohol withdrawal, but did not have any formal alcohol assessments (CIWA) until almost 4 hours later. Based on discussions with staff, the time between identification of drug or alcohol withdrawal and first formal testing is sometimes longer. The County should consider modifying its policy to encourage or require COWS/CIWA testing to be done as soon as withdrawal is suspected. In most cases, then, testing would be done by the screening nurse. Such testing is valuable in identifying and responding to changes in condition as early as possible.		

	3. Patient 3 was removed from the premises by custody staff to go to court without clearance from medical staff, despite being in an acute care medical unit and potentially being medically unstable. Elsewhere we discuss the need for changes to policy directing that patients with pink bands be medically cleared before removal from MDCR. Parallel changes should be made to policy regarding patients who are equally unstable, but are located elsewhere in MDCR.
Monitor's Recommendations:	N/A

2. Chronic Care

Paragraph Author: Stern	III. B. 2. a. (CONSENT040) 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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
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. • Audit Step b: (Chart Review) Chronic care is appropriate: a) the care is timely b) it is delivered by appropriately trained and licensed staff c) the content of care is clinically appropriate [This will be a new audit step in Report #6 and does not apply to Report #5. It will replace the current Audit Step b. This change is being made to make the audit steps of this provision more consistent with those governing acute care and also to remove the limitation to practitioners.]		
Steps taken by the County to Implement this paragraph:	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):	N/A		
Monitor's Recommendations:	N/A		

Author: Stern	III. B. 2. b. (CONSENT041) (Covered in III. B. 2. a. (CONSENT040)) 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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
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:	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):	N/A		
Monitor's Recommendations:	N/A		

3. Use of Force Care

Paragraph Author: Stern and Ruiz	III. B. 3. a. (CONSENT042) The Jail shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15-minute in-person visual observation by trained custody. Qualified Medical Staff shall perform 15-minute checks on an inmate in restraints. For any custody-ordered restraints, Qualified Medical Staff shall be notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14; 5/15 (NR); 1/16 (NR)
Mental Health: Compliance Status	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14; 5/15 (NR); 1/16
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) The clinical restraint policy states that restraints are used for the minimal amount of time clinically necessary, are observed every 15 minutes by medical and custody staff. • Audit Step b: (Inspection) The custody restraint policy states that qualified medical staff shall be notified immediately after application of restraints in order to review the health record for any contraindications or accommodations required and to initiate health monitoring. • Audit Step c: (Chart Review) For patients placed in 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. Mental Health Care, as above and: • Review of adequate care provided for patients placed in restraint, including chemical restraint or involuntary intramuscular injection. Adequate documentation shall include evidence of attempts to de-escalate the incident and attempts at lesser restrictive means of treatment. • Review of mental health care provided to patients repeatedly involved in episodes of restraint for assessment of possible co-morbid mental health conditions • Review of differentiation between custody vs. clinical restraint in patients with mental health conditions, as noted by proper utilization of a medical order before initiation		
Steps taken by the County to Implement this paragraph:	Medical Care N/A Mental Health Care: In collaboration with Ms. McCampbell, examining the extent to which the uses of force involved inmates/arrestees on the mental health caseload was difficult. Because 47% of the incidents occurred in intake, whether the inmate(s) was on the mental health caseload was undetermined in many instances. For the remaining 20 instances (53%), the precise number of involved inmates who were on the mental health caseload was hard to determine from the TAAP summary and the Response to Resistance Incident		

	Worksheet. Approximately 36 inmates were involved with these 20 uses of force. An affirmative "yes" was noted for 12 inmates, and the rest were undetermined. This is because: • When more than one inmate is involved there is no place on the form to indicate if only one, or both or all inmates are on the mental health caseload; and • There are discrepancies between the information on the TAAP summary and the RTR worksheet regarding the inmate's mental health status. Secondly, in analyzing the distribution of uses of force vis-à-vis mental health staffing, it was noted that the majority of incidents occurred outside of psychiatry working hours, i.e. before 8:00 am and after 4:30 pm Monday through Friday. While this may not be causative, it may be related.
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> N/A <u>Mental Health Care:</u> 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 in the medical record. Further, the Mental Health Monitor was informed by the County that the facility had at least three episodes in which behavioral restraint was initiated by custody and turned over to psychiatry once the provider arrived on sight during routine working hours. Please note these cases were not verified via record review. 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. She was informed by the County that no such log or list existed.
Monitor's Recommendations:	<u>Medical Care:</u> N/A <u>Mental Health Care:</u> Please update mental health correctional restraint policy consistent with national guidelines.

Paragraph Author: Stern	III. B. 3. b. (CONSENT043) 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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
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:	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):	The Protection from Harm Monitor learned that investigators are not always able to glean sufficient information from the medical reports following a Use of Force. The Medical Monitor did not review this provision during the current tour, including whether the recommendations below (which originally appeared in Report #3) have already been implemented. However, in the interest of not losing track of them in case they have not yet been implemented, they have been retained in the current report as a reminder.		
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	III. B. 3. c. (CONSENT044) 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 (NR); 3/14 (NR); 5/15 (NR); 1/16 (NR)
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. • Audit Step c: (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		
Steps taken by the County to Implement this paragraph:	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):	N/A		
Monitor's Recommendations:	The Medical Monitor did not review this provision during the current tour, including whether the recommendations below (which originally appeared in Report #3) have already been implemented. However, in the interest of not losing track of them in case they have not yet been implemented, they have been retained in the current report as a reminder. 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. The County should consider modifying policy such that the health professional's report of injury is given to someone other than the front line officer. 3. The County might consider developing a role-modeling video to train new CHS staff members on recognizing possible staff-on-inmate assaults and how to respond. 4. The County 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. a. Referral Process and Access to Care Defendants shall ensure constitutional mental health treatment and protection of inmates at risk for suicide or self-injurious behavior. Defendants' efforts to achieve this constitutionally adequate mental health treatment and protection from self harm will include the following remedial measures regarding… CHS shall develop and implement written policies and procedures governing the levels of referrals to a Qualified Mental Health Professional. Levels of referrals are based on acuteness of need and must include "emergency referrals," "urgent referrals," and "routine referrals," as follows: 1. "Emergency referrals" shall include inmates identified as at risk of harming themselves or others, and placed on constant observation. These referrals also include inmates determined as severely decompensated, or at risk of severe decompensation. A Qualified Mental Health Professional must see inmates designated "emergency referrals" within two hours, and a psychiatrist within 24 hours (or the next Business day), or sooner, if clinically indicated. 2. "Urgent referrals" shall include inmates that Qualified Mental Health Staff must see within 24 hours, and a psychiatrist within 48 hours (or two business days), or sooner, if clinically indicated. 3. "Routine referrals" shall include inmates that Qualified Mental Health Staff must see within five days, and a psychiatrist within the following 48 hours, when indicated for medication and/or diagnosis assessment, or sooner, if clinically indicated.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR)
Unresolved/partially resolved issues from previous tour	3/14: 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:	Mental Health: 1. Review of medical records for implementation of policy. 2. Review of internal audits. 3. Review of emergency, urgent and routine referral logs.		
Steps taken by the County to Implement this paragraph:	CHS and MDCR are in the process of developing an interagency policy on Suicide Prevention. This policy is based in part upon input which was provided by a consultant which was brought in by the County, Ms. Judith Cox, in 2014. It has updated definitions and added these to DSOP 12-003.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The draft policy and updated forms were reviewed. The expression of suicidal ideation is grounds for a strip search. This is ill advised and will contribute to patients non-disclosure of their feelings in order to stave off embarrassment and preserve what little dignity remains.,		
Monitor's Recommendations:	1. Complete revision of interagency Suicide Prevention policy.		

	2. Train staff to the policy. 3. Perform intermittent internal reviews (audits) of intake screening for accuracy of leveling and assessment of suicide risk. 4. Initiate adequate suicide risk assessment vs. screening.

Paragraph Author: Ruiz	III. C. 1. b. Referral Process and Access to Care 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: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
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:	<u>Mental Health Care:</u> 1. Review manual of mental health policies and procedures 2. Results of internal audits 3. Review of medical records		
Steps taken by the County to Implement this paragraph:	In 2013, CHS had written policy, CHS-033, Receiving Screening and policy CHS-039, 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

<table>
<tr><td>Paragraph
Author: Ruiz</td><td colspan="3">III. C. 2. a. Mental Health Treatment
CHS shall develop and implement a policy for the delivery of mental health services that includes a continuum of services; provides for necessary and appropriate mental health staff; includes treatment plans for inmates with serious mental illness; collects data; and contains mechanisms sufficient to measure whether CHS is providing constitutionally adequate care.</td></tr>
<tr><td>Compliance Status this tour:</td><td>Compliance:</td><td>Partial Compliance: 7/13; 1/16</td><td>Non-Compliance: 3/14;10/14 (NR); 5/15 (NR)</td></tr>
<tr><td>Measures of Compliance:</td><td colspan="3"><u>Mental Health:</u>
1. Review of manual of mental health policies and procedures
2. Level of care and provision of mental health services including medication management, group therapy and discharge planning
3. Review of mental health staffing vs. mental health population
4. Review of 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.</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="3">In 2014, the County acknowledged that it was not in compliance with this provision. In 2015, it was not reviewed per their request.

Staffing was improved in the last six months. The County is beginning to collect data related to its mental health system; it is not analyzing the data in a meaningful way or implementing change based on preliminary findings.</td></tr>
<tr><td>Monitor’s analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)</td><td colspan="3">Per the information submitted by the County, in 2015, on the mental health caseload averaged:

<table>
<tr><th></th><th>May</th><th>June</th><th>July</th><th>Sept</th><th>Nov</th><th>Average</th></tr>
<tr><td>1A</td><td>28</td><td>22</td><td>26</td><td>23</td><td>24</td><td>24.6</td></tr>
<tr><td>1B</td><td>43</td><td>48</td><td>52</td><td>46</td><td>46</td><td>47</td></tr>
<tr><td>II</td><td>131</td><td>151</td><td>140</td><td>181</td><td>184</td><td>157.4</td></tr>
<tr><td>III</td><td>323</td><td>335</td><td>368</td><td>393</td><td>377</td><td>359.2</td></tr>
<tr><td>IV</td><td>1522</td><td>1609</td><td>1632</td><td>1675</td><td>1714</td><td>1630.4</td></tr>
<tr><td>Total</td><td>2047</td><td>2165</td><td>2218</td><td>2318</td><td>2345</td><td></td></tr>
</table>

The majority of mental health staff are allocated to Level I and II patients although the bulk of the patients are located at Metro West and PTDC.

Treatment plans were not readily available in the EHR for the majority of the patients, as noted on record review.</td></tr>
<tr><td>Monitor’s Recommendations:</td><td colspan="3">CHS and MDCR are encouraged to further develop policy, collect data, analyze it and develop a robust continuous quality improvement program to self-monitor. Once it has done so, it will have turned the corner. Immediate</td></tr>
</table>

	recommendations include the following: 1. Provide new hires corrections-specific training including suicide prevention, restraint management, emergency treatment orders, assessment of malingering, as well as competency. 2. Initiate regular peer review. 3. Implement patient-centered treatment plans.

Paragraph Author: Ruiz	III. C. 2. b. Mental Health Treatment CHS shall ensure adequate and timely treatment for inmates, whose assessments reveal mental illness and/or suicidal ideation, including timely and appropriate referrals for specialty care and visits with Qualified Mental Health Professionals, as clinically appropriate.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Review of mental health policies and procedures 2. Review medical records, screenings, and referrals for concordance with Appendix A 3. CHS anticipates "100% achievement of compliance" for a minimum of 4 (four) consecutive quarters of retrospective random chart reviews. In my opinion, this target may be reduced to 90%.		
Steps taken by the County to Implement this paragraph:	The CHS policies for Behavioral Health Services are in draft form. The majority of the revisions have been implemented. Outstanding concerns include the definition of psychiatric emergency and lack of coordination of care for constant observation of high risk inmates between custody and mental health.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR/CHS Interagency policy for supervision of inmates with mental health concerns is outlined in 12-005. During this on-site tour, the Mental Health Monitor interviewed various staff and inmates. For example, she was informed that the current intake mental health screening tool assigns a majority of the patients as 'high risk.' This has created a bottle neck at Levels I, II and III with leveling and re-leveling back and forth between QMHPs and psychiatrists. 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. Two charts the Mental Health Monitor reviewed indicated a delay in access to adequate and appropriate care because patients on Level IV reported difficulty accessing their medications. Another chart the Mental Health Monitor reviewed demonstrated that an emergency treatment order was made without a face-to-face assessment and without a progress note documenting the risks, benefits, and lesser intrusive means of treatment that were tried but failed. Charts were reviewed of patients at Metro West ; these patients were appropriately screened by a QMHP and reviewed by the psychiatrist.		
Monitor's Recommendations:	1. Track psychiatry appointments and patient length of stay. 2. Adjust and redistribute staff including nurse practitioners according to acuity and need. 3. Avoid duplication of effort. 4. Utilize behavioral (non-pharmacologic) treatment options where possible.		

Paragraph Author: Ruiz	III. C. 2. c. Mental Health Treatment Each inmate on the mental health caseload will receive a written initial treatment plan at the time of evaluation, to be implemented and updated during the psychiatric appointments dictated by the Level of Care. CHS shall keep the treatment plan in the inmate's mental health and medical record.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 1. Review of manual of mental health policies and procedures 2. Results of internal audits 3. Review of medical records for presence of treatment plans and evidence of their implementation		
Steps taken by the County to Implement this paragraph:	CHS Draft Policy 058A discusses interdisciplinary treatment plans. The policy as written currently states that patients on Levels III and Level IV will not have interdisciplinary team meetings. They will require treatment plans with input from all parties, none-the-less.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The policy as it relates to interdisciplinary treatment teams and treatment plans requires minor revisions.		
Monitor's Recommendations:	1. Develop and implement policy relevant to interdisciplinary treatment teams and treatment plans. This should include the requisite participants. 2. Treatment plans should be individualized, and patient-centered. They should include concrete measurable and observable goals for each patient. 3. Progress notes/medical records of patients with severe mental illness (SMI) should reflect the individualized treatment plans.		

Paragraph Author: Ruiz	III. C. 2. d Mental Health Treatment CHS shall provide each inmate on the mental health caseload who is a Level I or Level II mental health inmate and who remains in the Jail for 30 days with a written interdisciplinary treatment plan within 30 days following evaluation. CHS shall keep the treatment plan in the inmate's mental health and medical record.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Results of internal audits 3. Review of medical records for presence of treatment plans and evidence of their implementation		
Steps taken by the County to Implement this paragraph:	MDCR/CHS Interagency Policy DSOP 12-005 discusses recognition of Inmates with Mental Illness. It does not discuss treatment plans nor does it define who from corrections or medical/mental health shall participate in the Interdisciplinary treatment team meeting.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The policy as it relates to interdisciplinary treatment teams and treatment plans is inadequate. None of the charts reviewed contained adequate or appropriate treatment plans.		
Monitor's Recommendations:	1. Develop and implement policy relevant to interdisciplinary treatment teams and treatment plans. 2. This policy should include the requisite participants and that treatment plans should be individualized, and patient-centered, as stated above.		

Paragraph Author: Ruiz	III. C. 2. e. Mental Health Treatment In the housing unit where Level I inmates are housed (9C) (or equivalent housing) for seven continuous days or longer will have an interdisciplinary plan of care within the next seven days and every 30 days thereafter. In addition, the County shall initiate documented contact and follow-up with the mental health coordinators in the State of Florida's criminal justice system to facilitate the inmate's movement through the criminal justice competency determination process and placement in an appropriate forensic mental health facility. The interdisciplinary team will: (1) Include the treating psychiatrist, a custody representative, and medical and nursing staff. Whenever clinically appropriate, the inmate should participate in the treatment plan. (2) Meet to discuss and review the inmate's treatment no less than once every 45 days for the first 90 days of care, and once every 90 days thereafter, or more frequently if clinically indicated; with the exception being inmates housed on 9C (or equivalent housing) who will have an interdisciplinary plan of care at least every 30 days.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 1. Review of manual of mental health policies and procedures 2. Results of internal audits 3. Review of medical records for presence of interdisciplinary treatment plans and evidence of their implementation for patients in 9C who have been housed for seven continuous days or longer 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:	In 2014, no CHS policy was identified that outlined the policy or procedure for referral and tracking of inmates through the criminal justice competency determination process. In 2015, 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. Draft Policy CHS-058-A indicates that CHS shall provide each patient on the Behavioral Health caseload who is a Level 1 A, Level 1 B, or Level 2 with a written **interdisciplinary treatment plan** kept in the patient's **EHR.** These treatment plans have been written for approximately 5% of the mental health caseload with severe mental illness per month.		

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As indicated above, draft policy CHS-058-A indicates that patients on Levels 1A, 1B and 2 will receive written interdisciplinary treatment plans. However, the policy states that patients on Levels 3 and 4 "will not have an IDTT meeting to discuss and review their treatment. The patient's treatment plan will be implemented and updated during appointments with the treating psychiatrist as dictated by their level of care. (See Behavioral Health Levels of Care CHS-058-B)." In addition, the majority of the charts reviewed contained no treatment plans, regardless of the level of the patient.
Monitor's Recommendations:	Please implement individualized treatment plans as per Consent Agreement.

Paragraph Author: Ruiz	III. C. 2. f. Mental Health Treatment CHS will classify inmates diagnosed with mental illness according to the level of mental health care required to appropriately treat them. Level of care classifications will include Level I, Level II, Level III, and Level IV. Levels I through IV are described in Definitions (Section II.). Level of care will be classified in two stages: Stage I and Stage II.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Review of medical records for evidence of implementation of policies 3. Review of internal audits 4. Review of mental health roster / log to be managed by Program Director of Mental Health		
Steps taken by the County to Implement this paragraph:	Psychiatric level of care and follow-up is outlined in CHS policy 058B.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Policy 058B requires revisions, as noted by interview with staff. In addition, the level system as a whole requires a review and validation, as leveling and re-leveling of patients as become problematic, as noted by both interview with staff and review of medical records.		
Monitor's Recommendations:	1. Collect baseline data 2. Validate intake screen 3. Adjust intake screen 4. Simply levels as per information gathered per baseline data and systems review 5. Perform pilot of new intake screen 6. Collect new data and repeat		

Paragraph Author: Ruiz	III. C. 2. g. Mental Health Treatment Stage I is defined as the period of time until the Mental Health Treatment Center is operational. In Stage I, group-counseling sessions targeting education and coping skills will be provided, as clinically indicated, by the treating psychiatrist. In addition, individual counseling will be provided, as clinically indicated, by the treating **psychiatrist.**		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures. 2. Results of internal audits, if any 3. Review of medical records for implementation of policies consistent with appropriate treatment in Stage I, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	N/A		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	N/A		
Monitor's Recommendations:	N/A		

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 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies consistent with appropriate treatment in Stage I, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	CHS draft policy 058-B addresses patients on Level IV. It states that these patients will have an " QMHP conduct a follow-up encounter at a frequency of no less than once every 90 days and record it in the patient's EHR."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The draft policy as written is inconsistent with the Consent Agreement. Operationally, the County is using the phrase qualified mental health provider (QMHP) as a social worker or psychologist, not a psychiatrist. As a result, corrections officers and nursing staff are prohibited from making direct referrals to psychiatry. In essence, this policy states Level IV patients will be managed by mid-level providers or social workers, every 90 days (instead of having routine visits with psychiatry every 90 days) and the psychiatrists are functionally relegated to putting out fires.		
Monitor's Recommendations:	1. Please update policy and procedure to comply with Consent Agreement. 2. Each mental health encounter should be appropriately documented in the EMR in a timely fashion.		

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 (NR); 10/14 (NR); 5/15 (NR); 1/16
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies consistent with appropriate treatment in Level III, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	CHS draft policy 058-B, recently updated and submitted December 21, 2015, states Level III patients would receive: a. Evaluation and stabilizing in the appropriate setting; b. Psychotropic medication, as clinically appropriate; c. Evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; d. Individual counseling and group counseling, at least once per month or more, as deemed clinically appropriate by the treating Psychiatrist.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The draft policy 058B **with respect to Level III** is appropriate. Review of charts related to the provision of mental health treatment of patients on Level III highlighted the following: • Average number of patients per month: 360 • Leveling and re-leveling a concern between providers. Related to this, the policy that only psychiatrists or a treatment team can decrease a Level Is not being followed. • No charts reviewed demonstrated evidence of treatment plans or interdisciplinary treatment teams. • Patients are not seen on a consistent basis by psychiatry within timelines established by referrals. It should be noted that documentation provided indicated that staffing at PTDC (where the majority of Level IIIs are currently housed) was 2.8 FTEs; therefore available psychiatry time is **not** a contributing factor.		
Monitor's Recommendations:	• Consider tracking patient care and provider appointment availability. Significant backlogs should signal issues that require problem-solving and re-shuffling/deployment of staff vs. new systems. • Please track health care grievances and mental health care sick call requests, as chart reviews indicated patients on Levels III and IV escalated due to not being able to access medication and care via 'normal' channels.		

Paragraph Author: Ruiz	III. C. 2. g. (3) Mental Health Treatment Inmates classified as requiring Level II level of care will receive: i. evaluation and stabilizi i iate setti ii. iii. private assessment with a Qualified Mental Health Professional on a daily basis for the first five days and then once every seven days for two weeks; iv. evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; and v. access to individual counseling and group counseling as deemed clinically appropriate by the treating psychiatrist.		
Compliance Status this tour:	Compliance: <date>	Partial Compliance: 7/13; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies consistent with appropriate treatment in Level II, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	CHS draft policy.058B addresses the care that will be provided to patients on Level II. It states they will receive: a. Evaluation and stabilization in a setting that provides privacy; b. Psychotropic medication, as clinically appropriate; c. Assessment with a **QMHP** on a daily basis for the first five days and then once every seven days for two weeks with additional clinical assessment as clinically indicated; d. Evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; and e. Access to individual counseling and group counseling at least once per month as deemed clinically appropriate by the treating Psychiatrist.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The draft policy as outlined above almost meets the terms of the Consent Agreement. Per the CA, Bullet C requires a 'private assessment on a daily basis.' It also specifies that additional assessment is required a minimum of once every seven days for two weeks. Finally, the CA specifies that all inmates on Levels I and II will receive an interdisciplinary treatment plan within 30 days following evaluation. Chart reviews demonstrated no interdisciplinary treatment plans. In addition, follow-up for patients stepped down from Level II to III or IV was sporadic.		
Monitor's Recommendations:	The following is suggested. As stated previously, the accuracy of triage and follow-up is key for any mental health program. Continuous quality improvement indicators which track these elements should address the following: 1. Accuracy of level at booking 2. Back-log for provider appointments for medication 3. Numbers and types of adverse events, including those that are preventable. These include send outs to the emergency department, medication errors, lapses in medication, and responses to resistance.		

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; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies consistent with appropriate treatment in Level I, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	CHS draft policy 058B outlines the provisions of care of Levels 1A and 1B. Level 1A is differentiated from 1B by the safety garment.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The draft policy as written has notable omissions from the requirements of the Consent Agreement: • Qualified Mental Health Professional in-person assessment within four (4) hours • ***Immediate*** constant observation or suicide precaution • The policy does not outline what circumstances would require constant observation vs. suicide precaution. • It is noteworthy that menstruating females are not provided safe undergarments such as paper or mesh panties. Record review demonstrated that patients on Levels 1A and 1B were being seen by psychiatry regularly. Constant observation was not observed or documented satisfactorily.		
Monitor's Recommendations:	1. Provide constant observation for those patients on Level 1A. This should be tracked. 2. Please initiate treatment teams and planning for the greater than 80% of patients. Current data indicates that less than 5% of patients are receiving treatment plans.		

Paragraph Author: Ruiz	III. C. 2. h. Mental Health Treatment ill incl ion of mental health care and transiti ic environment, collaboration with Health Treatment Center is opened. The County and CHS will consult regularly with the United States and the Monitor to formulate a more specific plan for implementation of Stage II.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16	Non-Compliance: Pending 10/14; 5/15 (NR);
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of correctional and mental health policies and procedures 2. Per CHS, Phase I of the Mental Health Treatment Center is anticipated (date TBA). 3. Review of building plans		
Steps taken by the County to Implement this paragraph:	The Response to the Consent Agreement by the County 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)	Patients on Levels I and II have been transferred to TGK. Patients on Levels III and IV are in the process of being transferred to Metro West. Outstanding issues include: 1. Cells at TGK remain in need of retrofit. 2. Office space for face to face visits 3. Group therapy space.		
Monitor's Recommendations:	Please address the issues outlined above and consider collecting data on the impact of treatment vis-à-vis response to resistance and recidivism.		

Paragraph Author: Ruiz	III. C. 2. i. Mental Health Treatment CHS will provide clinically appropriate follow-up care for inmates discharged from Level I consisting of daily clinical contact with Qualified Mental Health Staff. CHS will provide Level II level of care to inmates discharged from crisis level of care (Level I) until such time as a psychiatrist or interdisciplinary treatment team makes a clinical determination that a lower level of care is appropriate.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies including 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 draft policy 058B addresses this provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Record review demonstrated that patients were leveled ad re-leveled between II, III and IV with little to no follow-up afterwards, as per this provision of the Consent Agreement. .		
Monitor's Recommendations:	Patients that are stepped-down should receive regular follow-up as per the CA. This is particularly recommended in light of the fact that many patients with real distress may report suicidal ideation out of desperation to get medical attention. Once they realize this is followed by a restriction in privileges and clothing (the 'strip search and safety garment'), they may feel punished and 'fly into health.' Thus, patients that are depressed and anxious may be labeled malingerers.		

Paragraph Author: Ruiz	III. C. 2. j. Mental Health Treatment CHS shall ensure Level I services and acute care are available in a therapeutic environment, including access to beds in a health care setting for short-term treatment (usually less than ten days) and regular, consistent therapy and counseling, as clinically indicated.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 3/14;10/14 (NR); 5/15 (NR);
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of correctional and mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of Level I care in therapeutic environment, including evidence of immediate suicide precautions and meeting with psychiatry within 24 hours		
Steps taken by the County to Implement this paragraph:	The Pretrial Detention Center was not a therapeutic environment. In December 2014, patients were transferred from PTDC to TGK. Acute and Level I mental health care is currently provided in TGK. 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 and log-wait times for rooms on an intermittent basis.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The majority of the cells where mental health patients are being housed have been retro-fitted. This was adequate. Group treatment facilities are not available.		
Monitor's Recommendations:	Address access to adequate treatment space and recreation time for the provision of both group therapy and 1:1 therapy.		

Paragraph Author: Ruiz	III. C. 2. k. Mental Health Care and Suicide Prevention: CHS shall conduct and provide to the Monitor and DOJ a documented quarterly review of a reliable and representative sample of inmate records demonstrating alignment among screening, assessment, diagnosis, counseling, medication management, and frequency of psychiatric interventions.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 1. Review of representative sample dashboards and internal audits. 2. Review of medical records for concordance of data		
Steps taken by the County to Implement this paragraph:	2014 and 2015: The County 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)	No reliable representative sample of inmate records demonstrating alignment among screening, assessment, diagnosis, counseling, medication management, and frequency of psychiatric interventions was provided for review.		
Monitor's Recommendations:	Provide analysis of reliable representative sample of inmate records demonstrating alignment among screening, assessment, diagnosis, counseling, medication management, and frequency of psychiatric interventions was for review.		

3. Suicide Assessment and Prevention

Paragraph Author: Ruiz	III. C. 3. a. Suicide Assessment and Prevention: Defendants shall develop and implement a policy to ensure that inmates at risk of self-harm are identified, protected, and treated in a manner consistent with the Constitution. At a minimum, the policy shall: (1) Grant property and privileges to acutely mentally ill and suicidal inmates upon clinical determination by signed orders of Qualified Mental Health Staff. (2) Ensure clinical staff makes decisions i clothi i and other iven to suicidal - - (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 i li ivate suicide risk assessments of each suicidal inmate (5) Ensure that staff does not retaliate against inmates by sending them to suicide watch cells. Qualified Mental Health Staff shall be involved in a documented decision to place inmates in suicide watch cells.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 3/14	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 1. Review suicide prevention policy and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies including review of the following: - Property granted to inmates upon clinical determination of QMHS - Inmates have suicide resistant mattresses - Inmates have proper suicide resistant clothing - Quality suicide risk assessments are conducted - Staff do not retaliate against inmates by sending them to suicide watch cells		
Steps taken by the County to Implement this paragraph:	CHS and MDCR are in the process of developing an interagency policy on Suicide Prevention. It is in draft form.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Substantive comments have been provided on the draft policy. Additional terms that should be added to the glossary include suicide risk assessment and suicide risk screening.		
Monitor's Recommendations:	Work that exists in the pubic sector which may be a useful resource includes that of Lindsay Hayes.		

Paragraph Author: Ruiz	III. C. 3. b. Suicide Assessment and Prevention When inmates present symptoms of risk of suicide and self harm, a Qualified Mental Health Professional shall conduct a suicide risk screening and assessment instrument that includes the factors described in Appendix A. The suicide risk screening and assessment instrument will be validated within 180 days of the Effective Date and every 24 months thereafter.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Suicide prevention policy and procedures 2. Results of internal audits. CHS anticipates "100% compliance for a minimum of 4 (four) consecutive quarters." 3. Review of medical records for implementation of policies, in accordance with triggers found in Appendix A. 4. Review of adverse events and screening to audit against false negatives.		
Steps taken by the County to Implement this paragraph:	In 2014, the County hired a consultant to assist with its suicide prevention program. Ms. Cox's input and formal recommendations included: 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. CHS Suicide Prevention Program is covered in policy #CHS-059. 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)	The majority of the County's consultant's recommendations have been implemented. New hires will require on-going training. The Mental Health Monitor was informed by staff that although intake *screening* is occurring, comprehensive suicide risk *assessments* were not occurring. This was confirmed via record review.		
Monitor's Recommendations:	Implement suicide risk assessment.		

Paragraph Author: Ruiz	III. C. 3. c. Suicide Assessment and Prevention County shall revise its Suicide Prevention policy to implement individualized levels of observation of suicidal inmates as clinically The MDCR Jail facilities' supervisory staff shall regularly check to ensure that corrections officers implement the ordered levels of observation.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 3/14	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 1. Review of suicide prevention policies and procedures to include observations of inmates at risk of suicide at staggered checks every 15 minutes and 1:1 as clinically necessary 2. Results of internal audits and adverse events, including MDCR audits of custody observation checks 3. Review of medical records for implementation of policies		
Steps taken by the County to Implement this paragraph:	In 2014 and 2015, 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. CHS Suicide Policy 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)	As indicated above, during this tour, in two cases constant observation was not implemented as ordered. In other record reviews, insufficient documentation established that satisfactory constant observation, supervision, and mental health care was provided. For example, cases documented adverse outcomes of patients committing self-harm while reportedly on constant observation.		
Monitor's Recommendations:	Provide individualized level of observation, including constant observation as clinically indicated.		

Paragraph Author: Ruiz	III. C. 3. d. Suicide Assessment and Prevention: CHS shall sustain implementation of its Intake Procedures adopted in May 2012, which specifies when the screening and suicide risk assessment instrument will be utilized.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 3/14; 1/16	Non-Compliance: 10/14 (NR); 5/15 (NR)
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:	Mental Health: 1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies, including screening and suicide risk assessments.		
Steps taken by the County to Implement this paragraph:	CHS policies 033 and 059 speak to its procedures regarding intake and suicide prevention. CHS has also hired and placed new staff at intake.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The County has done a good job of updating CHS policy and hiring staff.		
Monitor's Recommendations:	Train staff to corrections-specific intake and suicide prevention policies and practices.		

Paragraph Author: Ruiz	III. C. 3. e. Suicide Assessment and Prevention: CHS shall ensure individualized treatment plans for suicidal inmates that include signs, symptoms, and preventive measures for suicide risk.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies and training reflecting preventive measures, signs and symptoms in individualized treatment plans.		
Steps taken by the County to Implement this paragraph:	Draft Policy CHS-058A discusses treatment plans.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The policy should address timelines that are consistent with the requirements the CA, including treatment plans for Levels 2, 3 and 4. .		
Monitor's Recommendations:	Treatment plans should include concrete and measurable, individualized treatment goals for patients. In this way, clinicians and other team members can assess whether treatment is working or should be changed.		

Paragraph Author: Ruiz	III. C. 3. f. Suicide Assessment and Prevention Cut-down tools will continue to be immediately available to all Jail staff that may be first responders to suicide attempts.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 3/14; 1/16	Non-Compliance: 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. On-site check for cut-down tool. 2. Manual of mental health policies and procedures 3. Results of internal audits or on-site inspections, if any 4. Incident reports documenting use of cut-down tool		
Steps taken by the County to Implement this paragraph:	MDCR policy 12-003 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)	Interviews with staff indicated that while cut-down tools were available, staff did not routinely know where to locate them or how to use them.		
Monitor's Recommendations:	All staff shall be trained in the use of cut down tools. Towards this end, mock drills may be helpful.		

Paragraph	III. C. 3. g. Suicide Assessment and Prevention (CONSENT068)		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 5/15; 1/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 5/15; 1/16	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) There is an emergency response bag in close proximity to all housing units. The bag contains, at a minimum, a CPR mask or bag-mask ventilator, material to control bleeding, gloves, eye protection, and a cut-down tool. [If unit officers have been trained in compression-only CPR, the Medical Monitor will accept, instead, that a CPR mask or bag-mask ventilator is brought to the scene of all emergencies by responding CHS staff. If all staff carry CPR masks, the Medical Monitor will accept this in lieu of placement of the masks in the emergency response bag.] • Audit Step b: (Inspection) There is an inventory mechanism in place to ensure that emergency response bags are where they should be, have the proper contents, and the contents are operational. [Tamper seals may be used to decrease the frequency of verification of the contents of each bag.] • Audit Step c: (Inspection) When interviewed, custodial and medical staff correctly describe the location of emergency response bags. • Audit Step d: (Inspection) Policy specifies an appropriate first aid training strategy for housing unit officers (e.g. who is trained, how often). • Audit Step e: (Inspection) An effective curriculum is used during first aid training that addresses qualifications of trainers, curriculum, assessment of competency. • Audit Step f: (Inspection) Training records show that housing unit officers receive first aid training as specified in policy. Mental Health Care: 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:	Medical Care: The Chief Nursing Officer (CNO) has ordered new emergency carts to aid in organizing emergency response supplies. The carts arrived on 1/6/16 and have not yet been put in place. The CNO has also created a form to be used at all facilities that determines the contents, including inventory par levels of each cart. The intent is to have each drawer clearly labeled for ease and speed of access, as well as a drawer space large enough to contain the Ambu bag. The emergency carts will have the oxygen, backboard, and suction attached to the cart. The inventory monitoring sheets will be used across all facilities to provide a comprehensive approach to emergency readiness. Mental Health Care: Emergency bags were available		

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> 1. There were emergency response bags located on or near all housing unit visited (at least one in each of the 4 facilities). The level of knowledge by officers of the location, content, and mechanism of resupplying these was variable; some officers knew this well, while others was not familiar with one or more of these items at all 4 facilities, for example, not knowing where the bag was kept, or not knowing where to find a cut-down tool. 2. At least one facility, the shift check list did not include the AED. Thus officers only inventoried it if they remembered (at which point they documented this, free-hand, in the unit log). (In its response to the draft of this report, the County asked for the identity of this one facility. While the identity of this facility is not a secret, and the Medical Monitor would be glad to share this information off-line, the identity of the facility is not germane to the report. The Monitor only sampled a few living units. Therefore the fact that one of the units visited used a problematic process does not mean that it is not occurring at other units. Further, even if it were just occurring at a single unit, it is the Monitors' hope that managers will recognize that this still means there is a likely a system problem, and will search for that problem, rather than looking for a "bad apple.") 3. The pads for AEDs are not part of the shift check list, but are not under inventory seal. Thus they could be missing, but not noticed until an emergency. 4. At least 2 facilities the check list was not completed every shift. 5. Officers in at least 2 facilities thought that CPR was not to be commenced until the AED so indicated (rather than beginning CPR upon determination of the absence of responsiveness and a pulse). 6. Related to items 1 and 5 above, officers and supervisors reported the absence of training consisting of simulated emergencies. 7. Most medical staff were familiar with the location and contents of the medical emergency response material, however at each of the facilities, there were times when the check lists were not completed by staff. 8. There is currently no par value for contents of emergency response bags, so, after use, staff cannot know how many of each item to replace. 9. The intended contents of the emergency response bags may not be appropriate. For example, one bag contained a soft cervical collar. This has no role in emergency care. However, a stiff collar is appropriate, but is not included. The bags also include battery operated suction machines. While these are adequate, because of their bulk and weight, they may not always be taken to emergencies, and because battery checks are not part of the check list, they may not be functional when used. Similarly, the oxygen tanks currently used are E Tanks, which are heavy. Smaller tanks may be easier to carry and therefore easily included in the equipment always taken. 10. There is still not a finalized policy governing the elements of this provision. 11. There is still not an adequate training program governing the elements of this provision. Please see the general comments on training in the Training paragraph in the introduction to the Medical and Mental Health part of Report #5. 12. In support of comment 6 above, training records for officers reveals that very little training actually takes place. <u>Mental Health Care:</u> Although emergency bags were available, not all staff knew how to utilize them.
Monitors' Recommendations:	<u>Medical Care:</u> 1. AED pads should be added to the check list, or the AED should be sealed with a plastic inventory seal. In response to a comment provided by the County to the draft of this report, it should be clarified that the Monitor is not

	recommending that the shift sergeant open the pads and spoil them, but simply assure that they are present. 2. AEDs should be part of the printed check list in each living unit log. 3. CPR, AED, First Aid, and simulation exercises need to be conducted on a frequent and regular basis. 4. The County should review the appropriateness of all equipment in the emergency response bags (see comments above for details). 5. In anticipation of shifting to the new emergency carts, the County should review the layout of all facilities (including staff-only areas, public areas, and exterior grounds) to assure that a cart can be easily brought to the scene of any emergency to which medical staff respond. The County also needs to verify that the new cart-based system will be satisfactory for responding to emergencies on the upper tier of living units (without the need to run up and down the stairs for supplies) as well as during a power outage when elevator service is not available. 6. The recommendations in the Training paragraph in the introduction to the Medical and Mental Health part of Report #5 are included here by reference. Not only does the current training program not satisfy this provision, but interviews with officers underscores the fact that the current training is not effective. <u>Mental Health Care:</u> All staff shall be trained in the use of emergency procedures. Towards this end, mock drills may be helpful.

Paragraph Author: Ruiz	III. C. 3. h. Mental Health Care and Suicide Prevention: County shall conduct and provide to the Monitor and DOJ a documented quarterly review of a reliable and representative sample of inmate records demonstrating***:*** (1) adequate suicide screening upon intake, and (2) adequate suicide screening in response to suicidal and self-harming behaviors and other suicidal ideation.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14; 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 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:	No quarterly report or review of a reliable and representative sample of inmate records was provided.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	No report available for review.		
Monitor's Recommendations:	Provide a reliable and representative review that includes a sample of inmate records for analysis and review..		

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: 7/13; 1/16	Non-Compliance: 3/14;10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of MDCR and mental health policies and procedures 2. Review of tracking mechanism reflecting inmates for whom mental health has provided opinion in disciplinary proceeding and final decision. 3. Review of medical records for inmates involved in disciplinary actions with mental health history, including possible notation or evidence of consultation with Qualified Mental Health Staff.		
Steps taken by the County to Implement this paragraph:	CHS has collaborated with MDCR and produced draft policy CHS-008A. As submitted on December 21, 2015, it is adequate.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	According to the County's Quarterly Report, 24 of 570 disciplinary sanctions were denied or 4% of the total dismissed sanctions for the 3rd Quarter of 2015. This is adequate.		
Monitor's Recommendations:	Finalize policy, train staff and implement policy.		

5. Mental Health Care Housing

Paragraph Author: Ruiz	III. C. 5. a. Mental Health Care and Suicide Prevention: The Jail shall maintain a chronic care and/or special needs unit with an appropriate therapeutic environment, for inmates who cannot function in the general population.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health Care: 1. Manual of MDCR and mental health policies and procedures 2. Review of medical records for implementation of policies, including evidence of a separate housing unit for patients with chronic care or with special needs.		
Steps taken by the County to Implement this paragraph:	CHS Policy 044A discusses procedures for patients housed in disciplinary segregation.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Patients informed the Mental Health Monitor that rounds by a mental health provider did not occur on a regular basis in administrative segregation or disciplinary confinement. Patients there receive routine medical contact twice daily only if they receive medication. The policy states that mental health rounds will occur three times per week and will be documented in the patient chart. This was not confirmed via record review or patient interview.		
Monitor's Recommendations:	Augment current policy with a provision for rounds on special management units specific to behavioral health for **all patients** at least once per week.		

Paragraph Author: Ruiz	III. C. 5. b. Mental Health Care Housing: The Jail shall remove suicide hazards from all areas housing suicidal inmates or place all suicidal inmates on constant observation.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health Care:</u> 1. On-site inspection of facility, including inspection of tie-off points that may pose risk for suicidal inmates, areas with low visibility and low supervision. 2. Manual of mental health policies and procedures 3. Review of medical records and observation logs for implementation of policies, including results of adverse events and suicides, if any.		
Steps taken by the County to Implement this paragraph:	I was informed that inmates at risk of suicide are placed on suicide precaution; this did not always include constant observation.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As discussed above, inmates and patients placed on constant observation did not receive such.		
Monitor's Recommendations:	Please implement constant observation as clinically indicated.		

Paragraph Author: Ruiz	III. C. 5. c. Mental Health Care Housing The Jail shall allow suicidal inmates to leave their cells for recreation, showers, and mental health treatment, as clinically appropriate. If inmates are unable to leave their cells to participate in these activities, a Qualified Medical or Mental Health Professional shall document the individualized clinical reason and the duration in the inmate's mental health record. The Qualified Medical or Mental Health Professional shall conduct a documented re-evaluation of this decision on a daily basis when the clinical duration is not specified.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log 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:	The County provides privileges for patients by level of care with exceptions by specific order, as detailed by specific forms which were submitted for review. Level 1 is not permitted recreation, visitation, telephone, or mail unless it is ordered.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Chart reviews did not specifically state why patients were not permitted recreation, etc. and follow-up notes did not reassess these determinations.		
Monitor's Recommendations:	Improve documentation of individualized decision-making.		

Paragraph Author: Ruiz	III. C. 5. d. Mental Health Care Housing County shall provide quarterly reports to the Monitor and the United States regarding its status in developing the Mental Health Treatment Center. The Mental Health Treatment Center will commence operations by the end of 2014. Once opened, County shall conduct and report to the United States and the Monitor quarterly reviews of the capacity of the Mental Health Treatment Center as compared to the need for beds. The Parties will work together and with any appropriate non-Parties to expand the capacity to provide mental health care to inmates, if needed.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14; 10/14; 1/16	Non-Compliance: 7/13 (NR); 5/15 (NR);
Measures of Compliance:	<u>Mental Health Care:</u> 1. Review of designed staffing matrix 2. Review of timeline of Mental Health Treatment Center. 3. Interview with appropriate parties and non-parties, including CHS, MDCR and other stakeholders 4. Review of building plans		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Mental Health Monitor toured area(s) in the Mental Health Treatment Center of TGK. These treatment and cell spaces are a vast improvement over the space in PTDC. Patients on Levels I and II have been transferred to TGK. Patients on Levels III and IV are in the process of being transferred to Metro West. Outstanding issues include: 1. A percentage of mental health designated cells at TGK remain in need of retrofit. I also recommend that cells in the detox unit receive retro fit due to risk of seizure. 2. Office space for face to face visits 3. Group therapy space.		
Monitor's Recommendations:	The Mental Health Monitor suggests seeking solutions issues outlined immediately above.		

Paragraph Author: Ruiz	III. C. 5. e. Mental Health Care Housing Any inmates with SMI who remain on 9C (or equivalent housing) for seven continuous days or longer will have an interdisciplinary plan of care, as per the Mental Health Treatment section of this Agreement (Section III.C.2.e).		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedure 2. Results of internal audits, if any 3. Review of medical records for implementation of policies, including implementation of timely screening and inter-disciplinary plans of care within seven days of placement on 9C or overflow unit		
Steps taken by the County to Implement this paragraph:	CHS draft policy 058 A discusses treatment plans. The policy as submitted on December 21, 2015 requires only minor edits.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Chart reviews demonstrated no interdisciplinary treatment plans. Additionally, staff interviews and document reviews confirmed that treatment plans are conducted for a minority of the mental health caseload.		
Monitor's Recommendations:	Initiate individualized treatment planning.		

6. Custodial Segregation

Paragraph Author: Ruiz	III. C. 6. a. (1) Custodial Segregation: The Jail and CHS shall develop and implement policies and procedures to ensure inmates in custodial segregation are housed in an appropriate environment that facilitates staff supervision, treatment, and personal safety in accordance with the following: (Part a) All locked housing decisions for inmates with SMI shall include the documented input of a Qualified Medical and/or Mental Health Staff who has conducted a face-to-face evaluation of the inmate, is familiar with the details of the inmate's available clinical history, and has considered the inmate's mental health needs and history.		
Compliance Status this tour:	Compliance: <date>	Partial Compliance: 7/13; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: 1. Manual of mental health policies and procedures 2. Results of internal audits, if an 3. Review of medical records for implementation of policies, including results of disciplinary proceedings of persons on the mental health caseload and evidence of consultation with Qualified Mental Health Staff. 4. Review of logs of compliance with initial evaluation of inmate by Medical and QMHS.		
Steps taken by the County to Implement this paragraph:	CHS has developed draft policy CHS-044. It states, "QMHP shall conduct rounds at least three times a week for all inmates with SMI, and document in the EHR. The Rounds shall assess: a. Mental health status of the inmates; b. The effect of custodial segregation on each inmate's mental health; and c. The appropriateness of continued placement in custodial segregation."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Policy as written is adequate.		
Monitor's Recommendations:	Because administrative segregation and disciplinary confinement carry such risk, general rounds by a QMHP On these units for all patients, not just those with SMI or those on medications is advisable. In addition, it is recommended that continuous quality improvement programs track response to resistance and medication adherence in patients on the mental health caseload in these units.		

Paragraph Author: Ruiz	III. C. 6. a. (1) Mental Health Care and Suicide Prevention: (Part b) If at the time of custodial segregation Qualified Medical Staff has concerns about mental health needs, the inmate will be placed with visual checks every 15 minutes until the inmate can be evaluated by Qualified Mental Health Staff.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health Care:</u> 1. Review of policy mental health policies and procedures 2. Review of medical records and observation logs for SHUs for staggered 15 minute checks 3. Review of internal audits		
Steps taken by the County to Implement this paragraph:	CHS Draft Policy 044 is appropriate as written.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Approximately 250 SMI patients were placed in custodial segregation from July through December. 32% of those were Level 1 or Level 2. The data provided indicated that patients in segregation included patients on all levels of care from Level 1A to Level IV. Inadequate information was provided to demonstrate adequate mental health input was provided prior to the housing decision for patients on Levels I and II. New mental health and medical staff have not been trained to the policy or to custody-specific procedures relative to custodial segregation.		
Monitor's Recommendations:	Demonstrate collaboration between mental health and custody for patients with SMI in long-term custodial segregation and administrative segregation. Please train new medical and mental health staff specific to risks of mental health decompensation and suicide risk in custodial segregation and administrative segregation.		

Paragraph Author: Ruiz	III. C. 6. a. (2) Custodial Segregation Prior to placement in custodial segregation for a period greater than eight hours, all inmates shall be screened by a Qualified Mental Health Staff to determine (1) whether the inmate has SMI, and (2) whether there are any acute medical or mental health contraindications to custodial segregation.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log of patients placed in custodial segregation with SMI for greater than 8 hours 3. Review of medical records, initial screening evaluations and referral for mental health service slips, including results of adverse events, if any.		
Steps taken by the County to Implement this paragraph:	CHS-044 speaks to this provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Approximately 250 SMI patients were placed in custodial segregation from July through December. 32% of those were Level 1 or Level 2. The data provided indicated that patients in segregation included patients on all levels of care from Level 1A to Level IV. Inadequate information was provided to demonstrate adequate mental health input was provided prior to the housing decision for patients on Levels I and II. New mental health and medical staff have not been trained to the policy or to custody-specific procedures relative to custodial segregation.		
Monitor's Recommendations:	Demonstrate collaboration between mental health and custody for patients with SMI in long-term custodial segregation and administrative segregation.		

Paragraph Author: Ruiz	III. C. 6. a. (3) Custodial Segregation If a Qualified Mental Health Professional finds that an inmate has SMI, that inmate shall only be placed in custodial segregation with visual checks every 15 or 30 minutes as determined by the Qualified Medical Health Professional.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log of 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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Approximately 250 SMI patients were placed in custodial segregation from July through December. 32% of those were Level 1 or Level 2. The data provided indicated that patients in segregation included patients on all levels of care from Level 1A to Level IV. Inadequate information was provided to demonstrate adequate mental health input was provided prior to the housing decision for patients on Levels I and II.		
Monitor's Recommendations:	Demonstrate collaboration between mental health and custody for patients with SMI in long-term custodial segregation and administrative segregation.		

Paragraph Author: Ruiz	III. C. 6. a. (4). i. Custodial Segregation Inmates with SMI who are not diverted or removed from custodial segregation shall be offered a heightened level of care that includes: i. Qualified Mental Health Professionals conducting rounds at least three times a week to assess the mental health status of all inmates in custodial segregation and the effect of custodial segregation on each inmate's mental health to determine whether continued placement in custodial segregation is appropriate. These rounds shall be documented and not function as a substitute for treatment.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log 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)	As stated above, interviews with inmates indicated that they received contact from medical but not from mental health while in SMU or disciplinary segregation. Due to the stressful nature of this confinement, regular rounds are recommended for all patients.		
Monitor's Recommendations:	As stated above.		

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

Paragraph Author: Ruiz	III. C. 6. a. (5) Custodial Segregation Inmates with SMI shall not be placed in custodial segregation for more than 24 hours without the written approval of the Facility Supervisor and Director of Mental Health Services or designee.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log of patient in custodial segregation with SMI 3. Review of medical chart for written approval of Facility Supervisor and Director of Mental Health Services for placement		
Steps taken by the County to Implement this paragraph:	CHS draft policy 044 speaks to inmates in custodial segregation.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	No data was provided documenting written approval of the Facility Supervisor and Director of Mental Health Services for placement of Level 1 and Level 2 patients in custodial segregation.		
Monitor's Recommendations:	To achieve compliance in the future, please document written approval of the Facility Supervisor and Director of Mental Health Services for placement of Level 1 and Level 2 patients in custodial segregation as per the CA in the HER or a log within 24 hours of placement.		

Paragraph Author: Ruiz	III. C. 6. a. (6) Custodial Segregation Inmates with serious mental illness shall not be placed into long-term custodial segregation, and inmates with serious mental illness currently subject to long-term custodial segregation shall immediately be removed from such confinement and referred for appropriate assessment and treatment.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log of 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 draft policy 044 speaks to the provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As indicated above, patients with severe mental illness were in custodial segregation. No data was provided indicating that they had been referred for appropriate assessment and treatment prior to placement.		
Monitor's Recommendations:	Provide data indicating referral for assessment and treatment prior to placement in custodial segregation.		

Paragraph Author: Ruiz	III. C. 6. a. (7) Custodial Segregation If an inmate on custodial segregation develops symptoms of SMI where such symptoms had not previously been identified or the inmate decompensates, he or she shall immediately be removed from custodial segregation and referred for appropriate assessment and treatment.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log of patients 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 draft policy 044 speaks to this provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The policy is adequate as written. Staff have not been trained to the policy. As indicated above, insufficient data was provided to assess whether patients were referred for assessment due to developing symptoms of mental illness while in custodial segregation.		
Monitor's Recommendations:	As previously mentioned, staff should be trained to corrections-specific policy and procedure. In addition, any information specific to the referral of patients for SMI during custodial segregation (and assessment by a QMHP) – in accordance with the mental health compliance steps outlined above, should be submitted, as well.		

Paragraph Author: Ruiz	III. C. 6. A. (8) Custodial Segregation If an inmate with SMI in custodial segregation suffers deterioration in his or her mental health, decompensates, engages in self-harm, or develops a heightened risk of suicide, that inmate shall immediately be referred for appropriate assessment and treatment and removed if the custodial segregation is causing the deterioration.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log of patients 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 draft policy 044 speaks to this provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The policy is adequate as written. Staff have not been trained to the policy. As indicated above, insufficient data was provided to assess whether patients were referred for assessment due to developing symptoms of mental illness while in custodial segregation.		
Monitor's Recommendations:	As previously mentioned, staff should be trained to corrections-specific policy and procedure. In addition, any information specific to the referral of patients for SMI during custodial segregation (and assessment by a QMHP) – in accordance with the mental health compliance steps outlined above, should be submitted, as well.		

Paragraph Author: Ruiz	III. C. 6. A. (9) Custodial Segregation MDCR staff will conduct documented rounds of all inmates in custodial segregation at staggered intervals at least once every half hour, to assess and document the inmate's status, using descriptive terms such as "reading," "responded appropriately to questions" or "sleeping but easily aroused."		
Compliance Status this tour:	Compliance: 7/13	Partial Compliance: 1/16	Non-Compliance: 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of MDCR and mental health policies and procedures 2. Review of log of patients in custodial segregation with SMI 3. Review of custodial segregation log checks		
Steps taken by the County to Implement this paragraph:	DSOP-12-002 Section VI A describes confinement documentation.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Review of documentation demonstrated that in approximately 50% of cases, staff conducted staggered checks and in approximately 50% of cases, staff conducted checks on regular intervals. Interviews with staff stated that new tools prompted them to conduct the checks, which may explain why the regular intervals are documented.		
Monitor's Recommendations:	Staggered checks are important to prevent adverse outcomes, as suicidal inmates will frequently time checks and make attempts between checks.		

Paragraph Author: Stern and Ruiz	III. C. 6. a. (10) Custodial Segregation (CONSENT088) Inmates in custodial segregation shall have daily opportunities to contact and receive treatment for medical and mental health concerns with Qualified Medical and Mental Health Staff in a setting that affords as much privacy as reasonable security precautions will allow.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 1/16	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<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. [This documentation can be on the custody log, as long as the custody log is subject to the same retention rules as medical records.] • 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	
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> Apparently many nursing staff and supervisors were under the impression that their welfare checks on patients in Isolation cells had to be documented on unit logs AND as a progress note in the EHR. During one of the Medical Monitor's		

	regular meetings with County leaders he informed them that, while perhaps the "perfect" way to document, individual progress notes in the EHR for each welfare check was unduly burdensome and might actually be a deterrent to performing welfare checks. So he informed the County that it would be adequate if nurses documented welfare checks on the existing custody logs, as long as those logs are subject to the same record retention rules as the medical records. As a result, the County began conversion to custody-log-only documentation of welfare checks. <u>Mental Health Care:</u> MDCR and CHS have been collaborating on office space and transport officers to provide private consultation to patients as clinically indicated.
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> 1. Interviews with patients, nurses, and officers, direct observation, and review of video recordings all revealed strong evidence that welfare checks are conducted by nurses on a regular basis on all inmates in Isolation cells, and that the welfare checks are meaningful. 2. Some nurses still document welfare checks in unit logs individual progress notes in the EHR. While admirable, it is a bit confusing as it is not consistent with documentation by other nurses. Further, some of these entries are made by a clerk, making it appear that the clerk was the person conducting the welfare checks. 3. In practice, confidentiality of protected health care information seems to be well maintained. Confidential examination areas are not relevant because patients are taken to the clinic for examination. 4. Patients statements (and corroborating information from interviews with officers) supports that patients have timely, unimpeded access to non-urgent care (communicated via written request) and urgent/emergent care (communicated via oral request to an officer). 5. Review of a small sample of patient records of patients in Isolation cells in which urgent care was requested orally (via officers) revealed that access to medical care was swift and unimpeded. 6. Review of a sample of patient records of patients in Isolation cells in which non-urgent care was requested, however, was less positive. Of 12 such requests reviewed, the patient received timely and appropriate care in only 3. For example, Patient 7 submitted a request for care on 11/7/15 which was not triaged until 11/13/15 (too long a delay), and then no nursing or other encounter occurred until the patient was seen by a practitioner on 11/20/15 (again, too long a delay). Upon that examination, the patient complained of low energy, but this complaint was not evaluated. Patient 8 submitted a request for care (chest pain and nose bleeds) on 11/9/15. This request was not triaged until 11/13 (at the outer limits of an acceptable period of time), but then no nursing or other encounter occurred until the patient saw a practitioner on 11/16/15 (too long a delay). At the conclusion of that visit, the practitioner ordered "BP monitoring" but no further blood pressures were measured again for 10 days. 7. The established training programs for officers (with regard to confidentiality) and nurses (with regard to welfare checks) fell short of adequacy in a number of ways. Please see the Training paragraph in the introduction to the Medical and Mental Health part of Report #5 for more information. 8. In addition, though not included as an Audit Step, the Monitor noted two additional problems with information the County provides to officers with regard to welfare checks. First, the training curriculum for officers contains misinformation. Question 10 in the post-test lists 5 purposes of nurse welfare checks and asks the learner if these are or are not the purpose of welfare checks. The curriculum indicates that the correct answer is yes, they are. But in fact, they are not. The purpose of welfare checks is simply to assure that the patient looks healthy and does not have any unmet health care needs. The 5 activities are important, but are not the purpose of welfare checks. In response to the draft of this report, the County posits that a) the Medical Monitor's stated purpose for welfare checks is subjective, and

	b) it is not "in alignment with local, state and national standards." With regard to the first observation, indeed, a good many of the judgments made by monitors are subjective; this does not diminish their importance in assessing patient safety. With regard to the second observation, the Monitors are not asking the County to violate other standards. However, compliance with other standards may be necessary, but not sufficient to cure the requirements of the CA. 9. Along the same lines, DSOP 12-003 has misinformation about the frequency and purpose of welfare checks. MDCR and CHS policies need to be coordinated. Please see the Policy paragraph in the introduction to the Medical and Mental Health part of Report #5 for more information. 10. In all facilities, patient Requests for Health Services forms are collected by security staff and placed in a locked box for nursing staff to gather when they make their rounds. This practice defeats the purpose of a locked box, i.e. to ensure confidentiality of health requests. <u>Mental Health Care:</u> Space and facility build limitations have made treatment space a challenge. The mental health monitor was informed that MDCR and CHS are working on this issue.
Monitors' Recommendations:	<u>Medical Care:</u> 1. Given that the County has adopted a new method for documentation of Isolation cell welfare checks (documentation in the custody log), this method should be used consistently by all nurses. 2. Training curricula for nurses and officers relevant to this provision need improvement. Please see the Training paragraph in the introduction to the Medical and Mental Health part of Report #5 for more information. 3. MDCR and/or CHS policies relevant to this provision need improvement. Please see the Policy paragraph in the introduction to the Medical and Mental Health part of Report #5. 4. Officers should not collect Requests for Health Services from patients in Isolation cells. These should be collected by health care staff. Policy and practice should be changed accordingly. <u>Mental Health Care:</u> Continue implementation of robust continuous quality improvement program for analysis of productivity, patient flow, strengths and weaknesses of current system.

Paragraph Author: Ruiz	III. C. 6. a. (11) Custodial Segregation Mental health referrals of inmates in custodial segregation will be classified, at minimum, as urgent referrals		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
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:	CHS draft policy 044 speaks to this provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The policy is adequate as written. Staff have not been trained to the policy. As indicated above, insufficient data was provided to assess whether patients were referred for assessment due to developing symptoms of mental illness while in custodial segregation.		
Monitor's Recommendations:	As previously mentioned, staff should be trained to corrections-specific policy and procedure. In addition, any information specific to the referral of patients for SMI during custodial segregation (and assessment by a QMHP) – in accordance with the mental health compliance steps outlined above, should be submitted, as well.		

7. Staff and Training

Paragraph Author: Ruiz	III. C. 7. a. Staffing and Training CHS revised its staffing plan in March 2012 to incorporate a multidisciplinary approach to care continuity and collaborative service operations. The effective approach allows for integrated services and staff to be outcomes-focused to enhance operations.		
Compliance Status this tour:	Compliance: 1/16	Partial Compliance: 3/14	Non-Compliance: 7/13; 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: 1. Review of staffing plan, average census and mental health population. 2. CHS, mental health policies and procedures		
Steps taken by the County to Implement this paragraph:	In May 2015, after receiving feedback, CHS revised its staffing plan once again. It has since hired 154 positions including seven psychiatrists and: • 17 Associate Nurse Managers; • 3 Clinical Psychologists • 44 Clinical Staff Nurses • 1 Chief Nurse Officer • 1 Director of Patient Care Services • 3 Health Services Administrator • 1 Hospital Unit Secretary • 1 Infection Control Specialist • 2 LCSWs • 2 Nurse Educators • 2 Nurse Practitioners • 10 Social Worker IIs		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Information regarding remaining vacancies was requested yet not provided. Functionally, from a psychiatric standpoint, CHS is fully staffed. It has 15.74 FTEs of psychiatry time and 3 behavioral health ARNPs. It is missing administrative psychiatric representation as represented on the staffing matrix. The staffing matrix that was submitted December 21, 2015 deploys staff in a curious manner. For example, at TGK, each psychiatrist is responsible for an average of 18-25 patients daily. However, at Metro West and PTDC, where the bulk of the patients are located, only one psychiatrist is staffed to handle the enormous caseload independently. For example, if Level 1A is intended for the imminently dangerous, psychotic and most acutely ill, those needing 1:1 and constant observation, then those numbers should be very, very small. Typically less than 10 patients, less than 10 days consecutively. One should implement treatment immediately. If the patient refuses, one should assess capacity and refer to a higher level of care as clinically indicated. The point is: few patients, few options.		
Monitor's Recommendations:	1. Re-evaluate and validate your intake screen. 2. Reassess your level system. 3. Deploy staff according to population, acuity and system need.		

Paragraph Author: Ruiz	III. C. 7. b. Staffing and Training Within 180 days of the Effective Date, and annually thereafter, CHS shall submit to the Monitor and DOJ for review and comment its detailed mental health staffing analysis and plan for all its facilities.		
Compliance Status this tour:	Compliance: 1/16	Partial Compliance: 3/14	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Review of staffing plan and matrix as it relates to current and projected average census and mental health population. 2. Review mental health policies and procedures		
Steps taken by the County to Implement this paragraph:	In May 2015, after receiving feedback, CHS revised its staffing plan once again. It hired 154 positions according to the staffing matrix provided.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Preliminary data indicates that CHS is adequately staffed from a psychiatric and behavioral health perspective. the Mental Health Monitor respectfully retains the right to amend this opinion should additional data become available.		
Monitor's Recommendations:	New hires require corrections-specific training.		

Paragraph Author: Ruiz	III. C. 7. c. Staffing and Training CHS shall staff the facility based on the staffing plan and analysis, together with any recommended revisions by the Monitor. If the staffing study and/or monitor comments indicate a need for hiring additional staff, the parties shall agree upon the timetable for the hiring of any additional staff.		
Compliance Status this tour:	Compliance: 1/16	Partial Compliance: 3/14	Non-Compliance: 7/13; 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Review of staffing plan, average census, projected census and mental health population. 2. Review of timetable for hiring, as needed		
Steps taken by the County to Implement this paragraph:	In May 2015, after receiving feedback, CHS revised its staffing plan once again. It hired 154 positions according to the staffing matrix provided.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Preliminary data indicates that CHS is adequately staffed from a psychiatric and behavioral health perspective. The Mental Health Monitor respectfully retains the right to amend this opinion should additional data become available.		
Monitor's Recommendations:	New hires require corrections-specific training.		

	III. C. 7. d. Staffing and Training Every 180 days after completion of the first staffing analysis, CHS shall conduct and provide to DOJ and the Monitor staffing analyses examining whether the level of staffing recommended by the initial staffing analysis and plan continues to be adequate to implement the requirements of this Agreement. If they do not, the parties shall re-evaluate and agree upon the timetable for the hiring of any additional staff.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14; 1/16	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR);
Measures of Compliance:	<u>Mental Health:</u> 1. Review of staffing plan, average census, projected census and mental health population. 2. Review of timetable for hiring, as needed 3. Review of applicable reports		
Steps taken by the County to Implement this paragraph:	The County did an excellent job hiring this past year. According to a staffing matrix received, many positions were both added and converted, including psychiatrists, licensed clinical social workers, nurses, medical assistants, dental assistants, associate administrators, administrative positions, and technical positions.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The staffing matrix reflected a grand total of approximately 400 budgeted full time equivalent positions added to CHS. Information was not provided regarding outstanding vacancies, although this was requested. Many of the clinical staff in the mental health positions have been hired. This includes psychiatrists, psychologists, nurse practitioners and social workers. Training specific to correctional mental health has not been provided.		
Monitor's Recommendations:	Please train all staff specific to correctional mental health issues, including suicide prevention, screening, the identification of malingering, dealing with difficult patients, utilization of seclusions and restraint, assessment of capacity, and games inmates play.		

Paragraph Author: Ruiz	III. C. 7. e. Staffing and Training The mental health staffing shall include a Board Certified/Board Eligible, licensed chief psychiatrist, whose work includes supervision of other treating psychiatrists at the Jail. In addition, a mental health program director, who is a psychologist, shall supervise the social workers and daily operations of mental health services.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 3/14; 1/16	Non-Compliance: 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Review of staffing plan 2. Review of meeting minutes 3. Interview of staff 4. MDCR and mental health policies and procedures 5. Review of timetable for hiring, as needed		
Steps taken by the County to Implement this paragraph:	The County hired Dr. Patricia Junquera as their lead psychiatrist. The staffing matrix which was submitted did not identify a chief psychiatrist.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Based on interview of staff, Dr. Junquera performs both administrative and clinical functions. In addition, the information submitted designated Dr. Razdan as the supervisor of the psychiatrists.		
Monitor's Recommendations:	Designate a chief psychiatrist whose work includes supervision of the other treating psychiatrists of the Jail.		

Paragraph Author: Ruiz	III. C. 7. f. Staffing and Training The County shall develop and implement written training protocols for mental health staff, including a pre-service and biennial in-service training on all relevant policies and procedures and the requirements of this Agreement.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Review of organizational chart and staffing matrix 2. Review of in-service training sign-in sheets 3. Review of in-service training materials 4. Interview of staff 5. County, MDCR and mental health policies and procedures		
Steps taken by the County to Implement this paragraph:	Training materials were submitted.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The training materials that were submitted were not adequate. They did not train to the new policies and procedures. They did not adequately assess pre-training skill sets and post-training proficiency of the material. Interviews of staff confirmed that they did not feel adequately trained in corrections-specific elements of their job as they relate to the provision of correctional mental health care.		
Monitor's Recommendations:	Develop and implement robust written training protocols for mental health staff including post test grades and live drills, as needed. Useful training may include management of difficult patients, games criminals play, emergency treatment orders, assessment of malingering, and substance abuse assessment/treatment.		

Paragraph Author: Ruiz	III. C. 7. g. Staffing and Training The Jail and CHS shall develop and implement written training protocols in the area of mental health for correctional officers. A Qualified Mental Health Professional shall conduct the training for corrections officers. This training should include pre-service training, annual training for officers who work in forensic (Levels 1-3) or intake units, and biennial in-service training for all other officers on relevant topics, including: (1) Training on basic mental health information (e.g., recognizing mental illness, specific problematic behaviors, additional areas of concern); (2) identification, timely referral, and proper supervision of inmates with serious mental health needs; and (3) Appropriate responses to behavior symptomatic of mental illness; and suicide prevention.		
Compliance Status this tour:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Review of organizational chart and staffing matrix 2. Review of in-service training sign-in sheets 3. Review of in-service training materials for officers in identification of specific mental health needs, as per agreement 4. Interview of staff 5. MDCR and mental health policies and procedures		
Steps taken by the County to Implement this paragraph:	In reference to training, DSOP 12-005 states, "It is imperative that good judgment be exercised when dealing with mentally ill inmates. All staff assigned to supervise mentally ill inmates, (suicidal and non-suicidal as determined by IMP/mental health staff), must have previously received in-service training or specialized training in the management and supervision of inmates with conditions of mental illness; e.g., crisis intervention, human behavior, etc. The hours of training and the training content shall be in accordance with current requirements, standards and guidelines."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The training materials that were submitted were not adequate. They did not train to the new policies and procedures. They did not adequately assess pre-training skill sets and post-training proficiency of the material. Interviews of staff confirmed that they did not feel adequately trained in corrections-specific elements of their job as they relate to the provision of correctional mental health care.		
Monitor's Recommendations:	Develop and implement robust written training protocols for mental health staff including post test grades and live drills, as needed. Useful training may include management of difficult patients, emergency treatment orders, assessment of malingering, signs and symptoms of withdrawal, signs of delirium, and substance abuse assessment/treatment.		

Paragraph Author: Ruiz	III. C. 7. h. Staffing and Training The County and CHS shall develop and implement written policies and procedures to ensure appropriate and regular communication between mental health staff and correctional officers regarding inmates with mental illness.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 3/14	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 1. Review of MDCR and mental health policies, procedures, and meeting minutes requiring regular communication and reporting between CHS and MDCR 2. Review of adverse events and grievances indicating implementation of policies Interview of CHS and MDCR staff		
Steps taken by the County to Implement this paragraph:	No policy was provided related to this provision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	No policy was provided related to this provision. .In addition, the tour was significant for the identification of several breakdowns in communication between custody and mental health. This was confirmed by interviews with both mental health staff and custody.		
Monitor's Recommendations:	Consider adding mental health to daily huddles. If timing is an issue, flexibility by other party can ameliorate this to meet in the middle.		

8. Suicide Prevention Training

Paragraph Author: Ruiz	III. C. 8. a. Suicide Prevention Training 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: 7/13; 3/14; 5/15 (NR); 1/16
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:	The County submitted suicide prevention training that consisted of a lesson plan and a 10 page power point. No pre- or post- test was submitted.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's	The suicide prevention training lesson plan and power point were inadequate.		

representations, and the factual basis for finding(s):	
Monitors' Recommendations:	Material which may be useful includes material produced by Lindsay Hayes. It is in the public domain. As previously stated, the Mental Health Monitor also recommends that CHS and MDCR implement and track Competency Based Training. This approach places emphasis on demonstrating that the participants have met the competency standard through the training program and related work, not just by time spent in training. The Mental Health 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. b. Suicide Prevention Training All correctional custodial, medical, and mental health staff shall complete training on all of the suicide prevention training curriculum topics at a minimum of eight hours for the initial training and two hours of in-service training annually for officers who work in intake, forensic (Levels 1S3), and custodial segregation units and biannually for all other officers.		
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14	Non-Compliance: 7/13; 3/14; 5/15 (NR); 1/16
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:			
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):			
Monitors' Recommendations:	Please submit a matrix including level of competency according to position and percentage of staff trained as described above in III C 8 a.		

Paragraph Author: Ruiz	III. C. 8. c. Suicide Prevention Training CHS and the County shall train correctional custodial staff in observing inmates on suicide watch and step- down unit status, one hour initially and one hour in-service annually for officers who work in intake, forensic (Levels 1S3), and custodial segregation units and biannually for all other officers.		
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14	Non-Compliance: 7/13; 3/14; 5/15 (NR); 1/16
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):	The County 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. To date, since January 2015, 297 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. d. Suicide Prevention Training CHS and the County shall ensure all correctional custodial staff are certified in cardiopulmonary resuscitation ("CPR").		
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 1/16	Non-Compliance: 7/13; 3/14; 5/15 (NR)
Measures of Compliance:	1. Review of current CPR certification of all staff.		
Steps taken by the County to Implement this paragraph:	See comments in III.C. 3. g. Suicide Assessment and Prevention.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	See comments in III.C. 3. g. Suicide Assessment and Prevention.		
Monitors' Recommendations:	Please see recommendation in III.C. 3. g. Suicide Assessment and Prevention.		

9. **Risk Management**

Paragraph Author: Ruiz	III. C. 9. a. Risk Management The County will develop, implement, and maintain a system to ensure that trends and incidents involving avoidable suicides and self-injurious behavior are identified and corrected in a timely manner. Within 90 days of the Effective Date, the County and CHS shall develop and implement a risk management system that identifies levels of risk for suicide and self-injurious behavior and results in intervention at the individual and system levels to prevent or minimize harm to inmates, as set forth by the triggers and thresholds in Appendix A.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 1. CHS has proposed implementation of Quantros Incident Reporting System. Quality / Risk Management is to meet monthly and will incorporate MDCR. 2. Review of minutes of monthly meetings, suicides, adverse events, and Quantros reports. 3. Review of morbidity and mortality reports for qualitative and systematic analysis		
Steps taken by the County to Implement this paragraph:	The County has implemented the Quantros system. This information was not provided for review. Independent audits, systematic reviews and reports that included in-depth analyses were not provided for review.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The information provided was insufficient for compliance.		
Monitor's Recommendations:	1. Please provide risk management data including evidence of analysis and a system to prevent or minimize harm to inmates. 2. In addition to the Quantros system, the Mental Health Monitor recommends continued interdisciplinary review of all inmate deaths of patients that have either been on the mental health caseload or received psychotropic medication for evidence of patterns and possible interventions at the individual and system levels to prevent or minimize harm to inmates.		

Paragraph Author: Ruiz	III. C. 9. b. Risk Management The risk management system shall include the following processes to supplement the mental health screening and assessment processes: (1) Incident reporting, data collection, and data aggregation to capture sufficient information to formulate a reliable risk assessment at the individual and system levels; (2) Identification of at-risk inmates in need of clinical or interdisciplinary assessment or treatment; (3) Identification of situations involving at-risk inmates that require review by an interdisciplinary team and/or systemic review by administrative and professional committees; and (4) Implementation of interventions that minimize and prevent harm in response to identified patterns and trends.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 1. CHS has proposed implementation of Quantros Incident Reporting System. Quality / Risk Management is to meet monthly and "will incorporate" 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:	The County has implemented the Quantros system. This information was not provided for review. Independent audits, systematic reviews and reports that included in-depth analyses were not provided for review.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The information provided was insufficient for compliance. The Mental Health Monitor did not receive information that reflected analysis of incident reporting, data collection, data aggregation or identification of at-risk inmates.		
Monitor's Recommendations:	Please provide risk management data including evidence of analysis and a system to prevent or minimize harm to inmates.		

Paragraph Author: Ruiz	III. C. 9. c. Risk Management The County shall develop and implement a Mental Health Review Committee that will review, on at least a monthly basis, data on triggering events at the individual and system levels, as set forth in Appendix A. The Mental Health Review Committee shall: (1) Require, at the individual level, that mental health assessments are performed and mental health interventions are developed and implemented; (2) Provide oversight of the implementation of mental health guidelines and support plans; (3) Analyze individual and aggregate mental health data and identify trends that present risk of harm; (4) Refer individuals to the Quality Improvement Committee for review; and (5) Prepare written annual performance assessments and present its findings to the Interdisciplinary Team regarding the following: i. Quality of nursing services regarding inmate assessments and dispositions, and 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: 7/13 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 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:	The Mental Health Review Committee meets on a regular to semi-regular basis as noted by the minutes submitted.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The information provided was insufficient for compliance. The Mental Health Monitor reviewed the minutes of the Mental Health Review Committee. The Mental Health Monitor did not receive information that reflected analysis of incident reporting, data collection, data aggregation or identification of at-risk inmates. Reporting is largely quantitative rather than qualitative. For example, minutes for November and December 2015 were not present in the package and minutes for October 2015 contained data but no discussion.		
Monitor's Recommendations:	Please provide risk management data including evidence of analysis and a system to prevent or minimize harm to inmates.		

Paragraph Author: Ruiz	III. C. 9. d. Risk Management The County shall develop and implement a Quality Improvement Committee that shall: (1) Review and determine whether the screening and suicide risk assessment tool is utilized appropriately and that documented follow-up training is provided to any staff who are not performing screening and assessment in accordance with the requirements of this Agreement; (2) Monitor all risk management activities of the facilities; (3) Review and analyze aggregate risk management data; (4) Identify individual and systemic risk management trends; (5) Make recommendations for further investigation of identified trends and for corrective action, including system changes; and (6) Monitor implementation of recommendations and corrective actions.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14; 1/16	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 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:	The Quality Improvement Committee meets regularly.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Although the Quality Improvement Committee is meeting regularly, it has not completed the majority of the tasks asked of it per the Consent Agreement. For example, issues related to the over-sensitivity of the screening tool at intake were identified as early as May 2015. However, further remedies and exploration of this was not undertaken by the QIC. In addition, although the committee is lauded for identifying individual risk management cases and discussing them, the Mental Health Monitor noted little evidence of analysis of aggregate trends.		
Monitor's Recommendations:	Please provide risk management data including evidence of analysis and a system to prevent or minimize harm to inmates.		

D. Audits and Continuous Improvement
1. Self Audit Steps

Paragraph Author: Stern and Ruiz	III.D.1.b. (CONSENT110) Qualified Medical and Mental Health Staff shall review data concerning inmate medical and mental health care to identify potential patterns or trends resulting in harm to inmates in the areas of intake, medication administration, medical record keeping, medical grievances, assessments and treatment.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16
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: The County conducts monthly quality improvement (QI) meetings, surpassing the requirements of the CA (quarterly meetings), which is laudable. Mental Health Care: The Mental Health Review Committee and Quality Improvement Committees are meeting on a regular basis.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Please see the QI paragraph in the introduction to the Medical and Mental Health part of Report #5 for general observations about QI and reporting. Some comments specific to this provision follow. 1. The County is in the process of deploying 9 audit tools. These provide interesting foundational information, but non-responsive by themselves. There is no policy that governs these forms. For example, who is responsible for deciding what is to be audited? How often? What are the thresholds for acceptable? Who can perform the audits? (For the moment it appears that top level nursing managers may be performing the audits. As the audits contain only explicit measures, i.e. measures that do not require any expertise or clinical judgment to collect, the use of some of the highest paid employees is inefficient.) All the items on the audit are explicit measures; the audits are devoid of any implicit measures. 2. Some data is missing from monthly reports. For example, the June report called for the percentage of unsubstantiated grievances, but the allocated space was blank. 3. The choice of some of the measures being followed on a monthly basis is not strategic for monitoring patient safety. For example, the County is following the trend of unsubstantiated grievances; these grievances have minimal value. It is		

much more important to follow the trend of *substantiated* grievances; these are the grievances that provide a window into systems which need improvement.

4. The County's analysis of the data that it collects on a monthly basis is superficial and often results in no remedy. For example, a problem was identified by the County in the June report: a large number of medication related-grievances for expired medications. An administrator at one facility noted that the reason was that practitioners don't like to prescribe pain medications for more than 12 days. The "analysis" stopped here. How do we know this to be true? There is no indication that the data supports that this is either the problem at the one facility reporting, no less across all facilities. Even if the supposition that the grievances result from expired pain medications is presumed to be true, no repair was proposed or implemented.
5. Another example of superficial analysis can be seen in the County's review of ER trips. Comprehensive review of ER trips is a key component of a QI system because ER trips provide a valuable window into the quality of ambulatory care prior to the trip (in other words, would better ambulatory care have avoided the emergency?). The July report, for example, states that there were 51 trips in May and 28 trip in June, and the YTD average was 41.5, "so trending downward; good indication." This is not an adequate evaluation for a number of reasons. First, a 1-month reduction is not at "trend." The numbers must be looked at over a broader time horizon to identify a trend. Second, the number of trips per 100 or 1000 inmate-days is the more appropriate metric, not the absolute number. Third, the number or rate of trips is not unimportant, but it's only a start. The most important reason for monitoring ER trips is as a barometer of the quality of care. That question can only be answered by an implicit review of the cases to see which one would have been avoidable by better antecedent ambulatory care. (There is a second cost-related reason for monitoring ER trips: to see if any of the trips were avoidable, not by preventing the problem, but by managing them differently once they developed. For example, could some of the trips have been managed by admission to the jail infirmary?)
6. When staff do conduct meaningful analyses and propose "fixes," they sometimes fail to follow-up on progress. For example, the July report mentions an effort to improve the frequency of review of previous progress notes during encounters. One of the fixes was "Will try to build something into the Electronic Health Record as an attestation or reminder that this task was or should be completed; however it is up to the clinician to actually do it." There was no further mention, though, in subsequent reports of whether the EHR had been changes and, more importantly, whether behavior had changed.
7. The focus of almost all attention in the monthly QI meetings is limited to grievances and ER trips. Missing are other key patient care processes (some of which are explicitly mentioned in the CA, such as medication administration, medical record keeping, assessments and treatment.).
8. A review of attendance at QI Committee meetings reveals that a number of members of the committee missed half the meetings. Most of the custody members missed most of the meetings, and at two meetings (June, Sept) *no one* from the custody team attended.

In its response to the draft of this report, the County requested that they be found in partial compliance, rather than non-compliance, with this provision. In recognition of the fact that the County does conduct meetings and attempts to review data regarding medical care, a rating of partial compliance is appropriate and reflected in the final report.

<u>Mental Health Care:</u>

Although the Quality Improvement Committee is meeting regularly, it has not completed the majority of the tasks asked of it per the Consent Agreement. For example, no data analysis was provided regarding medication administration, psychotropic medication management according to level. The Mental Health Monitor noted little evidence of analysis of aggregate trends or discussion of mental health grievances.

Monitor's Recommendations:	Medical Care: The County must develop a cohesive, all-encompassing QI program that ties together all the elements of QI, as described in the QI paragraph of the introduction to the Medical and Mental Health part of Report #5. Other recommendations mentioned in III.A.7.a. (CONSENT034), III.A.7.c. (CONSENT036) all apply here. The County needs to view QI – the core of patient safety – as THE role of its leaders, not an ancillary task assigned to a special committee. Mental Health Care: Please provide risk management data including evidence of analysis and a system to prevent or minimize harm to inmates.

Paragraph Author: Stern and Ruiz	III.D.1.c. (CONSENT111) 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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Medical Care:</u> • 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: Review of corrective action plans. Corrective plans shall be submitted in a timely manner and shall be qualitative; addressing causes not just symptoms of harm.		
Steps taken by the County to Implement this paragraph:	Medical Care: Please see comments in III.A.7.a. (CONSENT034), III.A.7.c. (CONSENT036), and III.D.1.b. (CONSENT110). <u>Mental Health Care:</u> Insufficient material was provided in a timely manner for a review of this provision.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care</u>: Please see comments in III.A.7.a. (CONSENT034), III.A.7.c. (CONSENT036), and III.D.1.b. (CONSENT110) as well as the QI paragraph in the introduction to the Medical and Mental Health part of Report #5. <u>Mental Health Care:</u> Corrective action plans were not provided within 30 days of each quarterly review of otherwise.		
Monitor's Recommendations:	<u>Medical Care:</u> Please see recommendations in III.A.7.a. (CONSENT034), III.A.7.c. (CONSENT036), and III.D.1.b. (CONSENT110) as well as the QI paragraph in the introduction to the Medical and Mental Health part of Report #5, which are included here by reference. <u>Mental Health Care:</u> None		

2. Bi-annual Reports

Paragraph Author: Stern and Ruiz	III.D.2.a. (CONSENT113) 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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) The Medical Monitor receives bi-annual reports of health care delivered to inmates including the volume of and reason for episodic clinic visits, chronic care clinic visits, ER transfers, and hospitalizations. Mental Health 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:	Medical Care: Please see comments in III.A.7.a. (CONSENT034), III.A.7.c. (CONSENT036), and III.D.1.b. (CONSENT110) as well as the QI paragraph in the introduction to the Medical and Mental Health part of Report #5. Mental Health Care: Insufficient data was provided to assess this provision in a timely manner. CHS and MDCR did not submit a Biannual report that contained this information as required by the Consent Agreement.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Please see comments in III.A.7.a. (CONSENT034), III.A.7.c. (CONSENT036), and III.D.1.b. (CONSENT110) as well as the QI paragraph in the introduction to the Medical and Mental Health part of Report #5. Mental Health Care: The County did not provide sufficient information to assess this provision in a timely manner.		

Monitor's Recommendations:	Medical Care: Please see recommendations in III.A.7.a. (CONSENT034), III.A.7.c. (CONSENT036), and III.D.1.b. (CONSENT110) as well as the QI paragraph in the introduction to the Medical and Mental Health part of Report #5. The Medical Monitor wants to highlight recommendation 1 in III.A.7.a. (CONSENT034) wherein the County is invited to design a comprehensive sustainable patient safety program that is consistent with the spirit, but perhaps not the letter, of provisions in the CA, such as this one. Mental Health Care: None

Paragraph Author: Ruiz	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.		
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: • The Mental Health Monitor receives bi-annual reports of health care delivered to inmates **including the volume of and reason** for episodic clinic visits, 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**.		
Steps taken by the County to Implement this paragraph:	Mental Health: The Bi-annual report reviewed all suicides and serious suicide attempts. However, it did not further discuss restraint use or inmates seen within four days of 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):	The Bi-annual report reviewed all suicides and serious suicide attempts. However, it did not further discuss restraint use or inmates seen within four days of discharge		
Monitor's Recommendations:	Provide a Bi-annual collaborative custody/health care report that meets the requirements of the Consent Agreement.		

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: I. 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 for groups; III. 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 (NR); 5/15 (NR); 1/16
Measures of Compliance:	Mental Health: • The Mental Health Monitor receives bi-annual reports of health care delivered to inmates including the volume of and reason for episodic clinic visits, evidence of timely follow-up/chronic care clinic visits, group therapy and individual therapy. • Bi-annual reports are be submitted in a timely manner and to include accurate data supportive of its conclusions.		
Steps taken by the County to Implement this paragraph:	The Bi-annual report as submitted did not satisfy any of the components of the Consent Agreement.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	The Bi-annual report as submitted did not satisfy any of the components of the Consent Agreement		
Monitor's Recommendations:	Submit a Biannual Report as requested by the Consent Agreement.		

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: 1/16	Non-Compliance: 10/14 (NR); 5/15 (NR)
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:	The County submitted a Biannual report.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	A Bi-annual report was submitted that included data on inmate disciplinary actions. It did not include information on whether QMHPs participated in the disciplinary actions.		
Monitor's Recommendations:	Submit a Biannual Report with the information detailed as requested by the Consent Agreement .		

Paragraph Author: Stern and Ruiz	III.D.2.a.(6) (CONSENT117) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following:… [6] Reportable incidents. The report will include: i. a brief summary of all reportable incidents, by type and date; ii. [Joint audit with MH] a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit; and iii. number of grievances referred to IA for investigation.		
Medical Care: Compliance Status:	Compliance: 1/16	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Medical Care:</u> • Audit Step a: (Inspection) The Medical Monitor receives bi-annual reports of inmate injuries, medical emergencies and in-custody deaths. [NB: For the purpose of this report, MDCR should include deaths which occur outside the MDCR facility (e.g. hospital) and regardless of whether or not the inmate was in custody, if the death resulted from a health status/condition that existed while the inmate was at MDCR. <u>Mental Health Care:</u> 1. Review of bi-annual reports 2. Review of incident reports 3. Review of inmate deaths, including those which died following transfer from MDCR to Jackson Healthcare		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> <u>Mental Health Care:</u> The County submitted a Biannual report that provided data on grievances.		
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 County provided this report, in compliance with the requirement of this provision. <u>Mental Health Care:</u> The Bi-annual report does separate medical grievances from mental health grievances. In addition, rates of very low grievances were not discussed or further explored. For example, Boot Camp has zero grievances. This is odd.		
Monitors' Recommendations:	<u>Medical Care:</u> Though the required report was produced, the value of such a report – as required by the CA – may be minimal. The Medical Monitor would much prefer the County developed regular internal reports, used by MDCR and CHS leaders to guide their management of the operation. The current report would be fair fodder for redesign in a comprehensive all-inclusive QI program, as described in the QI paragraph of the introduction to the Medical and Mental Health part of Report #5 and in recommendation 1 of III.A.7.a. (CONSENT034). <u>Mental Health Care:</u>		

	Pursue further analysis of data and trends.

Paragraph Author: Stern and Ruiz	III.D.2.b. (CONSENT118) (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 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR);1/16
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: (same as comments in III.D.1.c. (CONSENT111)) Mental Health Care: (same as comments in III.D.1.c. (CONSENT111))		
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: (same as comments in III.D.1.c. (CONSENT111)) Mental Health Care: (same as comments in III.D.1.c. (CONSENT111))		
Monitors' Recommendations:	Medical Care: (same as recommendations in III.D.1.c. (CONSENT111)) Mental Health Care:		

IV. COMPLIANCE AND QUALITY IMPROVEMENT

Paragraph Author: Stern and Ruiz	IV.A (CONSENT119) Within 180 days of the Effective Date, the County and CHS shall revise and develop policies, procedures, protocols, training curricula, and practices to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement. The County and CHS shall revise and develop, as necessary, other written documents such as screening tools, logs, handbooks, manuals, and forms, to effectuate the provisions of this Agreement. The County and CHS shall send any newly-adopted and revised policies and procedures to the Monitor and the United States for review and approval as they are promulgated. The County and CHS shall provide initial and in-service training to all Jail staff in direct contact with inmates, with respect to newly implemented or revised policies and procedures. The County and CHS shall document employee review and training in policies and procedures.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 1/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR);1/16
Measures of Compliance:	Medical Care: • Audit Step a: (Other) This compliance measure will be assessed by exception, i.e. failure to meet any of the 3 requirements below as they pertain to any other provision of the Consent Agreement. a) Develop/revise operational documents to implement the Consent Agreement, b) Provide initial and in-service training to relevant jail staff with respect to new/revised policies and procedures, c) Send new policies and procedures to Medical Monitor for approval. Mental Health Care: 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:	Medical Care: This is an over-arching provision; a number of other provisions fall under its umbrella, some of which are compliant or partially compliant. For example, the County has been sending new policies and procedures to the Monitors and has developed some operational documents to implement the Consent Agreement. Mental Health Care: The County is in the process of updating policy and forms.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed,	Medical Care: See above. Mental Health		

verification of the County's representations, and the factual basis for finding(s):	Because the County recently hired many staff, it needs to adequately train its staff. It is also updating policy and forms. It also needs to validate and operationalize quality improvement and data collection/analysis systems, intake and screening.
Monitor's Recommendations:	<u>Medical Care:</u> See various recommendations throughout this report. <u>Mental Health Care:</u> 1. Designate administrative leadership (i.e. a chief psychiatrist) for mental health as called for by the Consent Agreement. This would include **protected time** for administrative duties not clinical ones. 2. CHS should identify priorities in collaboration with MDCR and itemize. 3. Assign accountability. 4. Begin work including but not limited to: written directives, revision of policies, screening tools and implementing pilot projects as appropriate

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 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	<u>Medical Care:</u> • Audit Step a: (Inspection) MDCR 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>: N/A <u>Mental Health Care:</u> 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):	<u>Medical Care:</u> N/A <u>Mental Health Care:</u> N/A		

Monitors' Recommendations:	Medical Care: N/A Mental Health Care: N/A

Paragraph Author: Stern and Ruiz	IV.C (CONSENT121) On an annual basis, the County and CHS shall review all policies and procedures for any changes needed to fully implement the terms of this Agreement and submit to the Monitor and the United States for review any changed policies and procedures.		
Medical Care Compliance Status:	Compliance: 1/16	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Compliance Status:	Compliance:	Partial Compliance: 3/14; 1/16	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) There is evidence of annual review of policies and procedures for any needed changes. • (duplicate) CONSENT119 (IV.A) Audit Step a: (Other) This compliance measure will be assessed by exception, i.e. failure to meet any of the 3 requirements below as they pertain to any other provision of the Consent Agreement. c) Send new policies and procedures to Medical Monitor for approval. Mental Health Care: 1. Review of policies and procedures 2. Review of implementation of policies and procedures, as noted in Medical Care 3. Review of committee meeting minutes and/ or documentation reflecting annual review of policies and updates, as needed.		
Steps taken by the County to Implement this paragraph:	Medical Care: The County is actively reviewing policies, most of which are the subject of provisions within the CA. Mental Health Care: CHS is in the process of updating its policies.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: This is a difficult provision on which to fairly review the County's progress because most of the County's policies are subject to revision as a result of this CA, and therefore the process which this provision aims to measure is in flux. Thus while there may be some policies that are overdue for review, it may indeed be a better use of the County's resources to wait until those policies are ready for review under the Summary Action Plan – Revised than to review them prematurely, just to find that they require further revision based on input from the Monitors and DOJ. For this reason, the County is being found in compliance with this provision now. However, as we approach the sunset of the CA and the "dust settles" as most of the policies have completed the major revisions they are undergoing presently, to deem this provision in compliance, the Medical Monitor will be looking for evidence of a reliable system in place to maintain these policies going forward. Mental Health Care: The majority of CHS' policies are in draft form. They require varying levels of revisions.		
Monitor's Recommendations:	Medical Care: None Mental Health Care: To CHS' credit, it has begun the process of revising its policies. Many policies are complete or nearly complete, such as Intake Screening are complete. Other policies require revision and may benefit from a fresh start. These include the Level policy and Quality Improvement policy.		

Appendix A - Settlement Agreement					
Section	**Jul-13**	**May-14**	**Oct-14**	**May-15**	**Jan-16**
Safety and Supervision					
III.A.1.a. (1)	pc	pc	pc	nr	pc
III.A.1.a. (2)	nc	nc	pc	nr	nr
III.A.1.a. (3)	pc	pc	c	nr	nr
III.A.1.a. (4)	pc	pc	pc	c	nr
III.A.1.a. (5)	pc	pc	c	nr	nr
III.A.1.a. (6)	pc	c	c	nr	nr
III.A.1.a. (7)	pc	pc	c	nr	nr
III.A.1.a. (8)	nc	nc	pc	nr	c
III.A.1.a. (9)	pc	pc	pc	nr	c
III.A.1.a. (10)	pc	pc	pc	nr	nr
III.A.1.a. (11)	pc	pc	pc	nr	nr
Security Staffing					
III.A.2. a.	not due	pc	pc	c	nr
III.A.2. b.	nc	pc	pc	c	nr
III.A.2.c.	not due	pc	pc	c	nr
III.A.2.d.	not audited	not due	nc	not due	c
Sexual Misconduct					
III. A.3.	pc	pc	c	nr	pc
Incidents and Referrals					
III. A.4 a.	pc	pc	c	nr	nr
III.A.4. b.	nc	nc	c	nr	nr
III.A.4.c.	nc	pc	pc	nr	c
III.A.4.d.	not due	nc	pc	c	nr
III.A.4.e.	pc	pc	pc	nr	nr
III.A.4.f.	pc	pc	pc	pc	c
Use of Force by Staff					
III.A. 5 a.(1) (2) (3)	pc	pc	pc	pc	pc
III.A.5. b.(1), (2) i., ii, iii, iv, v, vi	pc	pc	pc	pc	nr
III.A. 5. c. (1)	nc	c	pc	nr	nr
III.A. 5. c. (2)	nc	pc	pc	nr	pc
III.A. 5. c. (3)	pc	pc	pc	c	nr
III.A. 5. c. (4)	pc	not audited	c	nr	nr
III.A. 5. c. (5)	pc	c	c	nr	nr
III.A. 5. c. (6)	nc	not audited	pc	c	nr
III.A. 5. c. (7)	pc	c	c	nr	nr
III.A. 5. c. (8)	nc	nc	c	nr	c
III.A. 5. c. (9)	nc	nc	pc	pc	c
III.A. 5. c. (10)	pc	c	c	c	nr
III.A. 5. c. (11)	nc	nc	nc	pc	nr

III.A. 5. c. (12)	nc	nc	nc	pc	nr
III.A. 5. c. (13)	nc	c	c	nr	nr
III.A. 5. c. (14)	nc	nc	nc	pc	nr
III.A.5. d. (1) (2) (3) (4)	pc	pc	pc	nr	nr
III.A.5. e. (1) (2)	nc	pc	pc	nr	nr
Early Warning System					
III.A.6. a. (1) (2) (3) (4) (5)	nc	nc	pc	nr	c
III.A.6.b.	nc	nc	not due	pc	c
III.A.6.c.	nc	nc	no	pc	c
Fire and Life Safety					
III.B.1.	pc	pc	pc	nr	nr
III.B.2.	c	c	c	nr	nr
III.B.3.	pc	pc	pc	nr	nr
III.B.4.	pc	pc	pc	pc	pc
III.B. 5.	nc	pc	pc	nr	nr
III.B.6	nc	nc	nc	pc	nr
Inmate Grievances					
III.C. 1.,2.,3.,4.,5.,6.	pc	pc	pc	c	nr
Audits and Continuous Improvements					
PFH III.D.1. a. b.	nc	nc	pc	nr	nr
FLS III.D.1. a. b.	nc	nc	pc	nr	nr
PFH III.D. 2.a. b.	not due	nc	pc	pc	pc
Compliance and Quality Improvement					
PFH IV. A.	not due	nc	pc	nr	nr
FLS IV. A.	not due	not audited	pc	nr	pc
PFH IV. B.	nc	nc	pc	nr	nr
FLS IV.B.	nc	nc	pc	nr	nr
PFH IV.C.	not due	nc	pc	nr	c
FLS IV. C.	not due	nc	pc	nr	pc
PFH IV. D.	pc	pc	c	nr	nr
FLS IV. D.	pc	pc	pc	nr	pc

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