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. 6

September 9, 2016

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Introduction – Compliance Report # 6
United States v. Miami-Dade County

This is the sixth 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). The Monitors also assessed the County's compliance with the Summary Action Plan (SAP) approved by the Court on May 18, 2016.

The Monitors toured the week of July 25, 2016. Prior to the tour, the monitoring team reviewed materials, and individually and collectively conferred with the parties through telephone conferences.

The draft of this report was provided to all parties on August 16, 2016, with a requested date to return comments of August 31st. All parties provided comments that were carefully considered by the Monitors as this report was finalized.

The Monitors thanks the leadership of both MDCR Interim Director Dan Junior and CHS Director Jesus Estrada. We also extend our thanks to: Mayor Carlos A. Gimenez, 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 meetings with the independent Monitors and their advice and actions.

The defendants are working diligently to overcome structural and historical barriers to achieving compliance with the three documents. The support of the Mayor and the leadership at Jackson Health System are pivotal to moving this work forward, to a successful conclusion. This report identifies several areas that require continued collaboration, and documentation of progress before the first tour of 2017.

Compliance with the Summary Action Plan

Based on the Summary Action Plan, filed with the Court on May 18, 2016, the County committed to achieve compliance by July 1, 2016 with Intake Screening (CA III.A.1.), and Risk Management (CA III.C.9.).

The findings of the Monitors are:

- Intake Screening (III. A. 1.) **Partial Compliance**
    - Of these seven provisions in this section. Five of the provisions relate to both Medical and Mental Health Care; two relate only to Mental Health care.
    - Of the five provisions related to Medical Care, the County is in compliance with one provision, and is partially compliant with four provisions.
    - Of the seven provisions evaluated by the Mental Health Monitor, the County is in compliance with one provision, partially compliant with four provisions, and non-compliant with two.

- Risk Management (III.C.9.) **Partial Compliance**
    - There are four provisions in this section. All four relate only to Mental Health Care.

Of the four provisions, three are partially compliant and one is non-compliant.

Compliance Update

The obligation of the Monitors is to assess the status of all compliance for all provisions of the Settlement Agreement and the Consent Agreement, regardless of the Department of Justice's deadlines negotiated Summary Action Plan's. In previous tours the Monitors' reviewed paragraphs of the Consent Agreement determined by the County to be "ready" for compliance assessment.[1] This tour, the Monitors, with six month's notice to the County, assessed the compliance status of all provisions of the Consent Agreement, whether or not the provision was scheduled to be in compliance according to the Summary Action Plan. As such provisions previously found to be non-compliant (by reason of not having been reviewed), were reviewed and given a compliance rating. As a result, Compliance Report # 6 reports an increase in the number of partially compliant provisions. While the Monitors recognize the work needed to move from non-compliance to partial compliance, substantial work remains to report that a provision is in compliance.

The report provides a summary update of compliance status:

Settlement Agreement - page 8
Consent Agreement – page 94

Sustaining Compliance

With all subsequent tours, the Monitors will be assessing the County's on-going compliance with provisions of both agreements.

Areas of Progress, Areas of Concern

The most notable areas of progress and concerns are:

Progress and Concern: Staffing

Both MDCR and CHS are acknowledged for their substantial efforts to hire employees. Three areas of concern for the Monitors are: deployment of CHS staff, particularly mental health providers on other than the day shift/weekdays; the need examine current procedures for escorting inmates to clinic appointments, and inmate supervision during triage/appointments with medical/mental health providers; and establishing schedules for housing units for rounds by providers (non-emergency).

[1] All paragraphs were reviewed and assessment for the Settlement Agreement in the five previous Compliance Reports.

The Monitors urge in this report that the parties revisit the deployment of CHS mental health staffing based on data describing needs for inmates on the mental health caseload, and in consultation with facility commanders. We also urge the parties to consider establishing schedules for housing units, specifically all mental health units, to better organize and anticipate the need for custodial staff to supervise and escort inmates. If providers arrive in housing units it is a challenge to assure that custodial staff are available in that unit at that time, particularly if there are staffing demands elsewhere. We also suggest that the parties examine the current protocols delineating what classification of inmates can be escorted together and/or held in waiting areas at clinics.

The Monitors will revisit these areas in the next tour, and hope that the parties will document their deliberations, as well as document any changes made as a result of their collaborative deliberations.

Concern: Mental Health Housing

The number of beds needed for acute and step-down mental health housing is increasing based on the increase of inmates found to be on the mental health caseload. We urge the County to evaluate why this is occurring (e.g. assess validity of screening instruments and associated staff training), and assure appropriate number of 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. Staff working with inmates on the mental health caseload require training, preferably the Crisis Intervention Training (CIT) developed by MDCR.

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. As noted above, this report identifies areas where collaboration is needed.

Concern – Completion of Policies/Procedures/Written Directives

As noted in prior Compliance Reports - 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.

Concern – Prison Rape Elimination Act of 2003

In Report # 4, the Monitor identified several issues regarding compliance with the provisions of the Settlement Agreement regarding compliance with the Prison Rape Elimination Act of 2003. These deficiencies resulted in the County moving out of compliance with the relevant provisions of the SA. These issues have not been addressed

in the intervening time between these two compliance tours. The County has agreed that they will seek a PREA audit prior to the first tour of 2017 and/or upon approval of the Interagency Policy on Inmate Sexual Abuse/Abuse Prevention.

Concern – Jail Bed Replacement

The Monitors were briefed concerning the County's plans to replace beds, particularly following the closure of the TTC for inmate housing. We are pleased to learn about these options and look forward to receiving more information as the process moves forward. While TTC was a concern and that closure is a positive, the County's attention should also be focused on the physical plant 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 programs. 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 increases in reported uses of force, including uses of force involving inmates on the mental health caseload, are concerning. The County is strongly urged to analyze this issue and develop some immediate plans of action.

Looking Ahead

The Monitors recognize and applaud the County, MDCR and CHS for the progress to date. Significant issues remain. The Monitors are grateful to the Mayor for his agreement to establish a compliance director/coordinator to assist with the efforts.

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)
- Summary Action Plan (approved/filed by the Federal Court May 18, 2016)
- Training and Treatment Center/Stockade (TTC)
- Turner Guilford Knight Correctional Center (TGK)

Settlement Agreement

Introduction

Compliance Report # 6 describes the efforts toward meeting the requirements in the Settlement Agreement. In this report, the Monitors assessed compliance in maintaining compliance with relevant provisions, as well as examining the County's assertions regarding moving some provisions from partial to full compliance.[2]

The provisions of the Settlement Agreement anticipated the County being into compliance within six months of signing – or late 2013. The Monitors are very concerned that the work to achieve compliance with this Settlement Agreement is now entering its fourth year. While no doubt optimistic in its estimation of 2013 compliance, the defendants are not yet in compliance for 53% of the provisions, which is the same status as the previous tour in early 2016. There are perhaps a myriad of reasons why compliance has not been achieved. The Monitors believe that there are two important accomplishments occurring during the tour, referenced below, that will focus the defendants on finally crossing the goal line.

It is important to note that while there is a decrease in the inmate population of the County's jail system (from approximately 7,000 in 2005 to 4,100 in mid-2016), the number of inmates on the mental health caseload is an astonishing 63% of that population. This poses health and safety threats to all those incarcerated and working in the system.

Notable Progress and Challenges

The Monitors acknowledge the accomplishments to date. The County has:

- Closed the 9th floor at the Pre-Trial Detention Center (PTDC) and relocated acute mental health inmates to newly renovated housing at Turner Guilford Knight (TGK).
- Moved most Level 3 and Level 4 mental health inmates to Metro West (MW). Level 4 inmates are housed by MDCR in general population.
- Continued to renovate units at TGK to meet the increases in number of inmates on the mental health caseload.
- Closed the Training and Treatment Center (TTC), formerly known as the Stockade, and relocated staff and inmates into the remaining three facilities. This is a major step as the physical plant conditions in the TTC were a barrier to achieving a constitutional level of care within the jail system.
- Acquired a 112–bed facility from the State in the western part of the County that, when renovated, may potentially be used for the juvenile population and the Boot Camp.
- Continued to meet the hiring benchmarks.

The remaining challenges for the County include:

[2] Darnley R. Hodge, Sr. assisted the monitoring for this report by touring each facility.

- Develop a long-range plan to replace PTDC, where conditions continue to deteriorate even with funds spent to maintain the physical plan.
- Address the on-going staff training needs when 63% of the inmates have been determined to be on the mental health population.
- Quickly engage in activities to reduce the increase in uses of force, 80% of which involve inmates on the mental health caseload.
- Strategize to lower the number of inmate/inmate altercations, enhancing protection from harm.
- Continue to improve the analyses of major incidents, self-critical reviews of critical incidents, uses of force, and infusing a quality assurance into everyone's daily work.
- Re-envision Metro West and return to its design of direct supervision, involving gaining staff commitment, training, and updating management and supervision with the goal of improving inmate and staff protection from harm. The physical layout of the facility is only for direct supervision, necessitating making this a priority for inmate and staff safety.
- Solidify new leadership, including new promotions for leadership and management positions in MDCR.
- Work to create a collaborative environment at the all levels between CHS and MDCR.
- Assure that the budget supports the updating of the jails' infrastructure (roofs, walls, plumbing, HVAC, etc.).
- Funding for continued staff pre-service training to meet the requirements of both agreements.

It is abundantly clear that the County has not been standing still, and working on some difficult challenges. An important area that has not made significant progress is compliance with the Settlement Agreement. The Monitors believe that this can be changed in a relatively short amount of time.

To summarize, the County

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
6	30	26	0	0	56

Additional comments regarding the specific provisions of the Settlement Agreement are provided below.

Moving Forward

Several accomplishments resulting from the July 2016 tour are important.

First, the County has agreed to fund a new position of compliance manager/director/officer who will have the responsibility to coordinate all the work in managing the compliance efforts. While not relieving CHS or MDCR of their responsibilities, this position will be accountable for the work being done on time, and being of the quality demanded by the County's leadership.

Secondly, MDCR agreed to produce a "road map" that describes the remaining tasks to be done to achieve compliance and provides the dates when the work will be concluded. MDCR wants to achieve compliance by 2017, but there is not a clear path to do that. This "road map" will be a critical factor on subsequent tours in assessing MDCR's ability to meet its own deadlines and its commitment to compliance.

The work of the Monitors was substantially hampered by the incompleteness of the materials provided ahead of the tour, and in delays in responding to questions and need for clarifications to information. It is clear to any reviewer that there was an ineffective review of materials provided by the County to attempt to document compliance. The Monitors, in an abundance of fairness to the defendants reviewed all materials, even if not timely produced nor complete. However, if materials documenting compliance were received after the tour, the documentation was acknowledged but did not result in a change in the compliance status noted at the conclusion of the on-site tour. We believe that the new compliance manager position will prevent this from occurring on subsequent tour.

Overview - Protection From Harm

Safety and Security

MDCR's implementation of the new jail management information system is behind schedule. This is important in terms of scheduling the various modules and in the validation of the classification system that relies on the data this new system is to produce.

There is a need to train all staff working with all inmates on the mental health caseload, not just those staff who are working with acute inmate. MDCR notes that CIT training is provided to all staff assigned to the Mental Health Treatment Center, Intake and Hospital. However, with 63% of inmates on the mental health caseload, the clients are not housed only in units identified as "mental health". As such more training is needed.

An action plan is needed to address inmate/inmate violence and uses of force.

Security Staffing

The County notes that the budget has been proposed for the next fiscal year to align with the most recent staffing analysis. This will include funds for overtime and for training. While not finalized by the Board of County Commissioners until September, this budget also provides for an additional class for new correctional officers, if needed in the next fiscal year, due to attrition. The closing of TTC has aided in reallocation of staff, and therefore positively impacted the budget.

As noted in the Introduction to this report, the Monitors have concerns about deployment of CHS mental health staffing, and the collaboration and coordination between CHS and custodial staff in terms of assuring inmate access to care. We will look to the parties to document their deliberations on these three matters, as well as document any changes made as a result of their collaborative deliberations. We believe with establishing schedules and better organization, the staff can be deployed more effectively.

Sexual Misconduct

There has not been a regaining of compliance with this provision since July 2015. The draft policies were provided to the Monitor immediately ahead of the tour, but were not yet reviewed. The County has committed to fund a new PREA audit.

Incidents and Referrals

Work needs to be done as described in the following report to assure that there are modifications to training that remove the formulaic, and therefore, inaccurate language in regards to use of force reporting.

Use of Force by Staff

The Monitor reviewed in depth 25 use of force incidents to assess if MDCR is engaged in sufficient self-analysis of these incidents. There were recommendations provided for all 25 incidents. The TAAP unit continues to mature. The leadership of MDCR needs to be more attuned to the work level and flow of the unit, and make staffing allocations to support the mission.

By mid-July there were more than 360 reported uses of force for the calendar year. This is a troubling increase, especially as: 80% of these incidents involve inmates on the mental health caseload; and the inmate population is down. Additionally, since 2014, 12 incidents of potentially excessive use of force have been referred to the State's Attorney's Office (SAO) for review and/or action. Pursuant to a request made on site, MDCR has provided some of the documentation regarding these allegations; which were not reviewed in preparation for this report. The Monitor will review these incidents in the coming weeks and provide any feedback to the County.

As with inmate/inmate violence, MDCR needs a robust plan of action to address this matter, including, but not limited to: re-envisioning Metro West to be the direct supervision facility it is, training on managing person with mental illness for staff working with all levels of inmates on the mental health caseload, using the information from the TAAP reviews to feedback to facility commanders to reduce opportunities to use force.

A re-assessment of investigations, in collaboration with the State's Attorney's Office is indicated. There needs to be a commonly agreed upon set of criteria about what types of cases should be sent by the MDCR's investigators to the SAO. While not a suggestion to generate more work or slow down the process, these important benchmarks needs to be put in writing, and periodically reviewed. Decisions need to be made about how inmates who witness uses of force, or inmate/inmate violence have their statements memorialized. It is not possible that in a 60-bed unit, 50 inmates were asleep or in the bathroom during an incident. The reputation and effectiveness of the internal investigative process is at stake. The role of the Miami-Dade Police Department also needs re-examination in terms of what allegations they investigate, the length of time to do that, and the referrals for prosecution.

The report contains specific recommendations regarding MDCR's legal status in initiating and conducting investigation in which criminal charges may result. The SIAB standard operating procedures also need to be completed.

Early Warning System

Evidence was not provided regarding the decisions about names that appear in the early warning system. As noted in the last compliance report, narrative information must b provided to the Monitor that describe the outcomes as to why names were removed, not removed, remedial training provided, etc.

Fire and Life Safety

The six paragraphs in the Settlement Agreement should be in compliance by this time. The Monitor urges the County to complete the work, develop and maintain the documentation that is required, and assure that compliance can be achieved at the first tour of 2017.

Inmate Grievances

The system is improving in terms of the data produced to inform jail operations. There are fewer undefined categories of findings. MDCR is working with CHS to improve CHS' responses. It would benefit the process if CHS can assign individuals to this process, so that there is collaboration and training for a specified number of staff who are accountable for the process. *See the Introduction to the Consent Agreement for identification of specific issues that need to be addressed by the parties before the first tour in 2017.*

There were some inmate complaints about the process, largely that the counselor sometimes missed their unit (or the inmate wasn't there to get a grievance form), or that the counselor sometimes didn't have forms.

The Monitor's contact information has been provided to inmates (in English, Spanish and Creole) since the January tour. Most of the fifty-seven letters received since that time were complaints about medical care, only one was about the grievance process. Our experience is that if the grievance process is not working that more letters would have been received, and that the topic would have been the grievance process.

It is strongly recommended that CHS develop a means to triage the medical grievances, which now come into CHS as all "emergency" grievances. While it is commendable that there are no barriers to inmates' medical grievances, this system stains the CHS staff. There are many models in other jails, and certainly internal systems that can be implemented to assure critical health care needs are addressed without burdening staff resources.

Audits and Continuous Improvement and Compliance and Quality Improvement

As noted in Compliance Report # 5, this is the area in which the largest significant work remains to be done. These procedures will be the measure of how well the systems can self-regulate, thus not needing Monitor oversight. MDCR has built a very robust data collection and reporting system. What is needed is the *analysis* of that data, and implementation and oversight of plans of action indicated by the *analysis*.

Next Compliance Tour

To be clear, the Monitors' expectations for the next tour include:

1. Careful review of the Compliance Reports, the recommendations and the measures of compliance contained therein.
2. Evidence of on-going compliance with paragraphs currently in compliance, including documents that cover the period since the last compliance tour;
2. Clear documentation for what paragraphs the County is claiming compliance, and the evidence of such;
3. Documentation that is more than "data dumps" – with specific highlighting of the evidence that indicates of 1., and 2., above.
4. Clear documentation of whether policies/procedures, etc. are in draft or in final.
5. Production of this information at least 30 days before the next tour (e.g. January 27, 2017) produced electronically.

In the interim, Monitor McCampbell will be discussing the use of force reviews periodically with MDCR.

If the County is in need of more specifics about what the Monitors need to evaluate compliance, the monthly conference calls provide this forum, as well as any communication the County wishes to initiate. The measures of compliance in the document also provide information.

Conclusion

As always, the Monitors extend our thanks to the MDCR and CHS leadership. We understand that the Monitors' presence is a disruption to daily operations. We appreciate the as we did our work the good humor, hospitality, professionalism, and accommodation of schedule changes made throughout the week.

The County remains in compliance with 30 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.

Settlement Agreement - Summary of Compliance
Tour the Week of July 25, 2016[3]

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		
III.A.1.a. (3)	x			
III.A.1.a. (4)	x			
III.A.1.a. (5)	x			
III.A.1.a. (6)	x			
III.A.1.a. (7)	x			
III.A.1.a. (8)	x			
III.A.1.a. (9)	x			
III.A.1.a. (10)		x		
III.A.1.a. (11)		x		
Security Staffing				
III.A.2. a.	x			
III.A.2. b.		x		
III.A.2.c.	x			
III.A.2.d.	x			A similar provision in the CA is in partial compliance. The defendants need to coordinator or this paragraph's compliance is subject to change at the next tour. See Consent III.A.2.d.
Sexual Misconduct				
III. A.3.		x		
Incident and Referrals				
III. A.4 a.	x			
III.A.4. b.	x			
III.A.4.c.	x			
III.A.4.d.	x			A similar provision in the CA is in partial compliance. The defendants need to coordinator or this paragraph's compliance is subject to change at the next tour. See Consent III.A.5.c.2. vii.

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

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
III.A.4.e.	x			
III.A.4.f.		x		
Use of Force				
III.A. 5 a.(1) (2) (3)		x		
III.A.5. b.(1), (2) i., ii, iii, iv, v, vi	x			A similar provision in the CA is in partial compliance. The defendants need to coordinator or this paragraph's compliance is subject to change at the next tour. See Consent Agreement III.B.3.
III.A. 5. c. (1)	x			
III.A. 5. c. (2)		x		See notes and also Settlement Agreement III.A.5.c.(1)
III.A. 5. c. (3)	x			
III.A. 5. c. (4)	x			
III.A. 5. c. (5)	x			A similar provision in the CA is in partial compliance. The defendants need to coordinator or this paragraph's compliance is subject to change at the next tour. See Consent Agreement III.B.3.
III.A. 5. c. (6)	x			A similar provision in the CA is in partial compliance. The defendants need to coordinator or this paragraph's compliance is subject to change at the next tour. See Consent Agreement III.B.3.
III.A. 5. c. (7)	x			
III.A. 5. c. (8)	x			
III.A. 5. c. (9)	x			
III.A. 5. c. (10)	x			A similar provision in the CA is in partial compliance. The defendants need to coordinator or this paragraph's compliance is subject to change at the next tour. See Consent Agreement III.B.3.
III.A. 5. c. (11)		x		A similar provision in the CA is in partial compliance. The defendants need to coordinator or this paragraph's compliance is subject to change at the next tour. See Consent Agreement III.B.3.
III.A. 5. c. (12)		x		A similar provision in the CA is in partial compliance. The defendants need to coordinator or this paragraph's compliance is subject to change at the next tour. See Consent Agreement III.B.3.
III.A. 5. c. (13)	x			
III.A. 5. c. (14)		x		

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
III.A.5. d. (1) (2) (3) (4)		x		
III.A.5. e. (1) (2)		x		
Early Warning System				
III.A.6. a. (1) (2) (3) (4) (5)		x		
III.A.6.b.		x		
III.A.6.c.		x		
Fire and Life Safety				
III.B.1.		x		
III.B.2.		x		
III.B.3.		x		
III.B.4.		x		
III.B. 5.		x		
III.B.6		x		
Inmate Grievances				
III.C. 1.,2.,3.,4.,5.,6.	x			A similar provision in the CA is in partial compliance. The defendants need to coordinator or this paragraph's compliance is subject to change at the next tour. See also Consent Agreement III.A.3.a.(4)
Audits and Continuous Improvements				
III.D.1. a. b.		x		
III.D. 2.a. b.		x		A similar provision in the CA is in partial compliance. The defendants need to coordinator or this paragraph's compliance is subject to change at the next tour. See also Consent Agreement III. D. 2.
Compliance and Quality Improvement				
IV. A.		x		
IV. B.		x		
IV. C.	x			
IV. D.	x			

Settlement Agreement
Findings – Tour Week of July 25, 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: 7/29/16	Partial Compliance: 3/28/14, 7/19/13, 10/24/14, 1/8/16	Non-Compliance:	Other: Per MDCR not reviewed in 5/15
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Manual of security and control-related policies, procedures, written directives and practices, consistent with Constitutional standards and contents of the Settlement Agreement. 2. Internal audits. 3. Documentation of annual review(s). 4. Schedule of review for policies, procedures, practices.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Compliance is noted with the caveat that there needs to be improvement in the analysis of data, as well as development of robust plans of action to address any identified deficiencies. See III.D. and IV. On-going compliance will be assessed at next tour.			
Monitor's Recommendations:	1. Assure that quarterly reports include meaningful analysis of the data; and if needed, plans of action are implemented, and assessed for impact on the deficiencies identified by the analysis.			

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, 7/29/16	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:	1. Update plan for validation of the classification system and timetable. 2. Discuss with DOJ is willing to accommodate another option for completion of the validation study. 3. Assure that the revised TAAP protocols include an assessment in examining inmate/inmate altercations, uses of force, and other critical incidents that inmates are correctly classified and housed in alignment with their classification.			

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: 7/29/16, 10/24/14,	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16.
Unresolved/partially resolved issues from previous tour:	None			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures requiring conduct of rounds. 2. Review of housing unit logs. 3. Review of staffing in housing units through observation and logs. 4. Interviews with inmates, employees.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Monitor raised questions about how rounds were noted, indicating the possibility that the time column was completed at the beginning of the shift, rather than when rounds conducted at irregular intervals. MDCR's quality control should have identified this issue when the materials were sent to the Monitor.			
Monitor's Recommendations:	1. MDCR's inspectional process needs to evaluate logs to assure there is compliance with this paragraph. 2. If the logs are not meeting requirements of the SA, an action plan needs to be developed. 3. Monitors will re-assess next tour.			

Paragraph	III. A. 1. Safety and Supervision: a. MDCR will take all reasonable measures to ensure that inmates are not subjected to harm or the risk of harm. While some danger is inherent in a jail setting, MDCR shall implement appropriate measures to minimize these risks, including: (4) Document all security rounds on forms or logs that do not contain pre-printed rounding times. Video surveillance may be used to supplement, but not replace, rounds by correctional officers.			
Compliance Status:	Compliance: 5/15/15, 7/29/16	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 1/16.
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures on reporting and logging. 2. Policy on use of video surveillance. 3. Review of staffing in housing units through observation and logs. 4. Interviews with inmates, employees Examination of logs.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III.A.1.a. (3)			
Monitor's Recommendations:	See III.A.1.a. (3)			

<table>
<tr><td>Paragraph</td><td colspan="4">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.</td></tr>
<tr><td>Compliance Status:</td><td>Compliance: 10/24/14, 7/29/16</td><td>Partial Compliance: 3/28/14, 7/19/13</td><td>Non-Compliance:</td><td>Other: Per MDCR not reviewed in 5/15, 1/16.</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><u>Protection from Harm:</u>
1. Re-classification screening documentation for inmates moved to maximum security housing that does not have direct supervision or video monitoring.
2. Plan to increase video surveillance and recording capacity; implementation dates; contracts; evidence of completion on required dates; plan of action if dates specified in the Settlement Agreement for completion not met.</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="4"></td></tr>
<tr><td>Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)</td><td colspan="4">Documentation provided. WDC and TTC are closed.</td></tr>
<tr><td>Monitor's Recommendations:</td><td colspan="4">Continue to demonstrate that video camera systems are working, and if cameras require repair these are quickly identified and fixed.</td></tr>
</table>

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, 7/29/16	Partial Compliance: 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures 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 was provided indicating that supervisors are initially logs, indicating their presence in the unit. MDCR asserts that there were no circumstances where staff were found not completing logs as required, thus corrective actions were not necessary. While this is laudable, it is unlikely. Emphasis on identifying any non-conforming behavior is essential through the internal inspection process.			
Monitor's Recommendations:	1. Assure that internal inspections and quality control activities identify any deficiencies, and individual correction is noted.			

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, 7/29/16	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:	<u>Protection from Harm:</u> 1. Policies and procedures regarding daily supervisory rounds in inmate housing units on all shifts. 2. Examination of logs/documentation. 3. Inmate interviews. 4. Corrective actions for any supervisory findings from rounds (examples of), if any.			
Steps taken by the County to Implement this paragraph:	Documentation of rounds conducted by staffs were provided. In some instances, the Monitor noted that the manner in which the rounds time and initials on the logs were noted, that the information could have been entered at the start, or end of the shift. The Monitor urges that the supervisors and inspection process assure that the logs and related documentation are not completed before the shift begins, or after the shift ends.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)				
Monitor's Recommendations:	1. Assure inspection of logs for the issues noted above.			

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 7/29/16	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:				
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:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR maintains data in the quarterly reports regarding recovers of contraband; what is missing is robust analysis of the data. The Monitor will evaluate the analysis before the next tour, as well as review any plans of action that result from the analysis. Evidence also provided for each facility regarding sell searches.			
Monitor's Recommendations:	1. Include analysis and action plans, as necessary, in the quarterly reports. 2. Include in subsequent documentation the evidence that the searches meet the criteria (e.g. random, regular, large scale). 3. For next tour, will be looking for evidence that MDCR is analyzing and using the data, including, but not limited to, plans of action. 4. Provide relevant document to the Monitor ahead of next tour highlighting specific compliance with this paragraph, rather than just pages of printouts.			

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, 7/29/16	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15.
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:				
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)	Without knowing the labor/management resolution regarding periodicity of transfer, MDCR provided evidence of training for officers transferring to a different facility. The caveat is that staff transferring to work with inmates on the mental health caseload require mental health training in addition to facility orientation. This is addressed elsewhere in this report.			
Monitor's Recommendations:	None at this time; provided that labor/management issues have been addressed.			

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, 7/29/16	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	Training for staff who are assigned to work with inmates on the (non-acute) mental health caseload.			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training of staff assigned to special management units. 2. Lesson plans for the 8 hours of training. 3. Evidence training was held annually; evidence those working in the units attended. 4. Documentation of knowledge gained (e.g., pre and post tests) 5. Remedial training, if any.			
Steps taken by the County to Implement this paragraph:				
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	63% of inmates in the jail system are on the mental health caseload. MDCR has provided CIT and mental health training to staff assigned to units with inmates on the acute mental health (mh) caseload. The data regarding inmate/inmate violence, and uses of force speaks to the needs to assure that all staff are trained. This observation is also made by inmates themselves. For staff working in Metro West there needs to be a return to the principles and practices of direct supervision to manage inmates (regardless of their status on the mh caseload) and insure staff/inmate safety.			
Monitors' Recommendations:	Develop and implement mental health training for all staff working with inmates on the mh caseload; provide direct supervision management training for staff assigned to Metro West.			

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, 7/29/16	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:	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:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR produces quarterly reports with data documenting inmate/inmate altercations and uses of force. What is missing is the analysis of this data, and creation and implementation of action plans. The increase in uses of force involving inmates on the mh caseload, and inmate/inmate altercations is a critical finding and concern.			
Monitor's Recommendations:	1. Analyze the data being collected. 2. 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.			

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, 7/29/16	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:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR's staffing needs are somewhat is flux as TTC was closed. The Mayor's budget proposes funding consistent with the March 2016 staffing plan (prior to TTC closing). There is funding for overtime. There is also a specific statement that if more new correctional officer classes are necessary in the next fiscal year, they will be held (page 28 of the Mayor's budget submission to the Board of County Commissioners). The concern is that funding will continued to be allocated to allow for the staff training to meet the mandates of the SA and CA.			
Monitor's Recommendations:	1. Track vacancies, overtime, and training to assure on-going compliance with the start of the next fiscal year. 2. Update the staffing analysis as the impact of closing TTC is evaluated, as well as examination of attrition and vacancies. 3. Evaluate the staffing needs based operating Metro West as direct supervision as well as the decision to post two officers to certain mh units.			

Paragraph Coordinate with Drs. Ruiz and Stern	III. A. 2. Security Staffing: b. MDCR shall ensure that the staffing plan includes staffing an adequate number of correctional officers at all times to escort inmates to and from medical and mental health care units.			
Protection from Harm: Compliance Status:	Compliance: 5/15/15	Partial Compliance: 10/24/14, 3/28/14, 7/29/16	Non-Compliance: 7/19/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:	Mental health monitor heard during the tour that there were issues regarding: escorts, coordination of provider times in housing units, lack of schedules, impact of lockdowns on provider rounds/care.			
Measures of Compliance:	Protection from Harm: 1. Staffing plan; staffing for escorts in each facility. 2. Policies and procedure for officer escorts to and from medical and mental health care units. 3. Overtime records, if any. 4. Consultation with Drs. Ruiz and Stern; interview with medical and mental health personnel 5. Review of patient scheduling deficiencies (e.g. cancelled, rescheduled appointments). Medical Care: • Audit Step a: (Inspection) This compliance measure will be assessed by exception, i.e. any 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	Production of a housing plan.			
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./ Mental Health As the number of inmates on the mental health caseload is increasing so are the demands on custody staff. This fundamental change in inmate housing needs to be recognized and accommodate in the staffing plan. See above information gathered by the mental health Monitor during this most recent tour.			
Monitors' Recommendations:	Protection from Harm/Mental Health 1. Develop schedules for housing units to assure maximum collaboration for medical/mental health providers. This includes coordinating off-unit appointments. 2. Provide these schedules to the Monitors before the next tour. 3. Develop internal measures (recordkeeping, problem identification, action plans if necessary), in addition to MAC and "mini"-MAC meetings to address this issue. For example, providing a list of staff who worked overtime is not a proof of compliance if it is not directly identified as being relevant to this particular paragraph.			

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, 7/29/16	Partial Compliance: 10/24/14; 3/28/14	Non-Compliance: Not yet due 11/27/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Completed staffing plan; discussion of recommendations by the monitor, if any. 2. Determination of the need for more hiring, if any. 3. Hiring plan, if needed, with timetable. 4. Results of hiring, if needed.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	A credible and well-developed staffing plan has been updated as of March 2016. See comments in III.A.2.a., above. There is a hiring plan.			
Monitor's Recommendations:	See III. A. 2. a.			

Paragraph	III. A. 2. Security Staffing: d. Every 180 days after completion of the first staffing analysis, MDCR shall conduct and provide to DOJ and the Monitor staffing analyses examining whether the level of staffing recommended by the initial staffing analysis and plan continues to be adequate to implement the requirements of this Agreement. If the level of staffing is inadequate, the parties shall re-evaluate and agree upon the timetable for the hiring of any additional staff.		
Compliance Status:	Compliance: 1/8/16, 7/29/16	Partial Compliance:	Not Yet Due: 5/15/15 10/24/14; 3/28/14
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	1. Report from MDCR comparing if recommended staffing is adequate to implement the requirements of this agreement. 2. Review of overtime costs; vacancies and vacancy trends. 3. Re-evaluation of hiring and hiring timetable, if needed. 4. Review/comment by the monitor of report in III.A.2.a., above.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III.A.2.a., above Will re-evaluate staffing numbers during next tour. If issues raised by the mental health Monitor are not satisfactorily addressed at next tour, this provision may be moved to partial compliance.		
Monitor's Recommendations:	See III.A.2.a., above		

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, 7/29/16	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.
Unresolved/partially resolved issues from previous tour:	Complete updated policies/procedures; schedule a PREA audit.		
Measures of Compliance:	Protection from Harm: 1. PREA policies and procedures 2. Self-audit (separate action plan to be based on MDCR's self-audit) [see http://static.nicic.gov/Library/026880.pdf] 3. Implementation of plans of action, etc., including audit based on self-audit. Medical Care/Mental Health: • 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:	Protection from Harm: Updated policies provided just before tour; and could not be evaluated before the tour. Even with the review the defendants would have remained in partial compliance as no audit has been scheduled.		
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Remains in partial compliance.		
Monitors' Recommendations:	Protection from Harm: 1. Update policies. Finalize, train staff, update PREA materials. 2. Schedule PREA audit; considering coordinating with the Monitors regarding the process for advertising, selection of a PREA auditor.		

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, 7/29/16	Partial Compliance: 3/28/14,7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	None at this time			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding notifications to managers regarding critical incidents; actions required. 2. Policies and procedures regarding reportable incidents. 3. Documentation of notification managers; checklists/incident reports. 4. Review of incident reports. 5. Review of critical incidents. 6. Interview with supervisory and management staff.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The policies and procedures are in place. Monitor reviewed use of force issues only.			
Monitor's Recommendations:	1. Assure that the MDCR inspectional process samples reporting and incidents to insure reporting is as required. 2. Provide any inspections to the Monitors ahead of the next tour.			

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, 7/29/16	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/14	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding notifications for critical incidents, including suicides and deaths. 2. Documentation of notification checklists/documentation. 3. Review of incident reports/investigations.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III.A. 4.a.			
Monitor's Recommendations:	1. Assure that the MDCR inspectional process samples reporting and incidents to insure reporting is as required. 2. Provide any inspections to the Monitors ahead of the next tour.			

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, 7/29/16	Partial Compliance: 5/15/15; 10/24/14; 3/28/14	Non-Compliance: 7/19/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures to track, analyze data, develop corrective action plans, as needed for all reportable incidents. 2. Definition of reportable incidents. 3. Review of reports, analysis, corrective action plans. 4. Review of elements in database. 5. Review of incident reports 6. Review of any external reviews/results. 7. Review of corrective action plan, if any. 8. Review of data/reports generated from the information in the system.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	While MDCR awaits the final design and implementation of the new jail management information system, reporting continues as required.		
Monitor's Recommendations:	1. Continue to use TAAP's analysis of use of force reports to inform training needs.		

Paragraph Coordinate with Dr. Ruiz See Also Consent III.A.5.c.2. vii	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, 7/29/16	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: 7/29/16	Non-compliance: 3/28/14	Other: 7/13, 10/14, 5/15 (not audited)
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding incident reports, including criteria for screening for critical incidents (see also III.A.3); 2. Documentation of referrals of grievances for investigations; outcomes. 3. Corrective actions for incidents not referred as required. 4. Review of medical and mental health policies and procedures regarding referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc. 5. Medical and mental health policies and procedure regarding review of medical grievances to screen for critical incidents. 6. Documentation of referrals to investigators by medical and/or mental health staff, if any. 7. Assure that companion CHS policies are in place, and medical providers are trained at recognizing signs and symptoms of use of force, use of excessive force, and inmate/inmate assault and sexual assault. Mental Health: 1. Policies and procedures regarding incident reports, including criteria for screening for critical incidents (see also III.A.3); 2. Documentation of referrals of grievances for investigations; outcomes. 3. Corrective actions for incidents not referred as required. 4. Review of medical and mental health policies and procedures regarding referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc. 5. Medical and mental health policies and procedure regarding review of medical grievances to screen for critical incidents. 6. Documentation of referrals to investigators by medical and/or mental health staff, if any.			
Steps taken by the County to Implement this paragraph:				
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from harm: Documentation provided by MDCR indicates that evens are reviewed. There is evidence provided of counseling to staff who failed to report as required. Evidence of grievances that were referred to SIAB was provided. **NOTE that Consent III.A.5.c.2. vii is in partial compliance. For the next tour, the medical and mental health Monitors need to find the relevant paragraphs in III.A.5. in compliance of this paragraph may be moved to**			

	partial compliance. Mental Health: Partial Compliance
Monitors' Recommendations:	Protection from Harm/Mental Health: 1. Need to coordinate with CHS to assure all inmates' medical care includes visual screening for these incidents. 2. Assure that MDCR's inspectional process assesses this requirement. 3. Provide any inspections to the Monitors ahead of the next tour. 4. Prior to next tour, continue provide evidence of specific inmate grievances referred based on the requirements of this paragraph.

Paragraph	4. Incidents and Referrals e. Correctional staff shall receive formal pre-service and biennial in-service training on proper incident reporting policies and procedures.			
Compliance Status:	Compliance: 7/29/16	Partial Compliance: 10/24/14; 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training on preparing incident reports; and notification criteria for critical incidents. 2. Lesson plans; pre-service and in-service. 3. Training schedule and attendance rosters. 4. Documentation of knowledge gained (e.g. pre and post tests) 5. Evidence of remedial training, if needed. 6. Review of incident reports.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation of partial or substantial compliance was provided for this tour. Will reevaluate compliance in first tour of 2017 based on Monitor's recommendations provided to TAAP on reviews of the sample of use of force reports.			
Monitor's Recommendations:	1. Continue to use the TAAP process to identify issues with report writing and demonstrate that these issues will be addressed in the next round of in-service training; and are addressed in the pre-service curriculum 2. Per Monitor's recommendation, consider modifications to the pre-service and in-service curriculum to eliminate the use of formulaic words in use of force reports – such as "guided inmate to the floor", "assisted the inmate to the floor", etc. as this detracts from the accuracy of the reporting. This will be evaluated by looking at use of force incident reports before the first tour in 2017. See also recommendation # 10 in TAAP Plan of Action dated 7/22/16. This plan of action needs to be broadened to evaluation of report writing initiatives.			

Paragraph	4. Incidents and Referrals f. MDCR shall continue to train all corrections officers to immediately inform a member of the Qualified Medical Staff when a serious medical need of an inmate arises.		
Protection from Harm: Compliance Status:	Compliance: 1/8/16	Partial Compliance: 7/29/16, 5/15/15, 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	1. Policies and procedures regarding training for notifications for Medical Care and mental health emergencies. 2. Lesson plans; training schedule. 3. Documentation of knowledge gained (e.g. pre and post tests) 4. Evidence of remedial training, if needed. 5. Review of incidents in which medical/mental health issues reported and not reported. 6. Minutes of meetings between security and medical/mental health.		
Steps taken by the County to Implement this paragraph:			
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	No evidence was provided of training to meet this provision. In the January 2016 report, the defendants were advised of the proofs of compliance needed for this paragraph. The materials provided for this tour are marked in "draft".		
Monitor's Recommendations:	1. Provide evidence of training on this provision. 2. Finalize documents and lesson plans.		

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: 7/29/16, 1/8/16, 5/15/15, 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force, response to resistance, including reporting and review protocols. 2. Monitor's annual evaluation of relevant data, including whether the amount and content of use of force training achieves the goal of reducing use of excessive force; review of bi-annual reports from MCDR. 3. Policies and procedures regarding decontamination; corresponding medical policies/procedures. 4. Policies and procedures on review of incident reports (see also III.A.4.a, III.A. 4.b.) by Facility Supervisor/Bureau Commander. 5. Review of reports; data.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The policies and procedures are in place; but training is needed (mental health and direct supervision management). The increase in uses of force, especially uses of force involving inmates on the mental health caseload keep this paragraph in partial compliance. There is no plan to address this critical issue. TAAP analyses of uses of force are very helpful, but continue to need to be refined (based on third review by the Monitor of use of force reports' analyses). Regarding investigations, MDCR needs to collaborate with the State's Attorney's Office to determine which uses of force the SAO wants to review.		
Monitor's Recommendations:	1. Develop facility-specific plans to address the increases in uses of force. 2. Provide training to all staff working with inmates (all levels) on the mh caseload. 3. Re-envision Metro West to its original direct supervision design. 4. Work with CHS to achieve goals of fewer uses of force.		

	5. Notify Monitor and plaintiffs of allegations of excessive force. 6. Develop memorandum of agreement with SAO regarding incidents that the SAO wants to review.

<table>
<tr><td>Paragraph
See Consent Agreement III.B.3.</td><td colspan="4">III. A. 5. Use of Force by Staff
b. Use of Restraints
(1) MDCR shall revise the “Recognizing and Supervising Mentally Ill Inmates” policy regarding restraints (DSOP 12-005) to include the following minimum requirements:
i. other than restraints for transport only, mechanical or injectable restraints of inmates with mental illness may only be used after written approval order by a Qualified Health Professional, absent exigent circumstances.
ii. four-point restraints or restraint chairs may be used only as a last resort and in response to an emergency to protect the inmate or others from imminent serious harm, and only after the Jail attempts or rules out less-intrusive and non-physical interventions.
iii. the form of restraint selected shall be the least restrictive level necessary to contain the emerging crisis/dangerous behavior.
iv. MDCR shall protect inmates from injury during the restraint application and use. Staff shall use the least physical force necessary to control and protect the inmate.
v. restraints shall never be used as punishment or for the convenience of staff. Threatening inmates with restraint or seclusion is prohibited.
vi. any standing order for an inmate’s restraint is prohibited.
(2) MDCR shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15 minute in-person visual observation by trained custodial staff. For any custody-ordered restraints, Qualified Medical Staff are notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.</td></tr>
<tr><td>Protection from Harm: Compliance Status:</td><td>Compliance: 7/29/16</td><td>Partial Compliance: 5/15/15, 10/24/14, 3/28/14, 7/19/14</td><td>Non-Compliance:</td><td>Other: Per MDCR not reviewed in 1/16</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4">1. Policies and procedures regarding recognizing and supervising inmates with mental illness; use of restraints; monitoring those in restraints and elements of this paragraph of the Settlement Agreement.
2. Corresponding medical and mental health policies/procedures. Consistency between the directives of security and medical/mental health.
3. Minutes of meetings between security and medical/mental health in which these topics are reviewed/discussed; or other documentation of collaboration, and problem-solving.
4. Review of uses of restraints; required logs.
5. Identification of employees requiring training.
6. Review of use of seclusion.
7. Lesson plans and schedule for training.
8. Maintenance of data regarding uses of force involving inmates on the mental health caseload, by facility.</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="4"></td></tr>
<tr><td>Monitors’ analysis of conditions to</td><td colspan="4">Policies and procedures are in place; documentation provided.</td></tr>
</table>

assess compliance, verification of the County's representations, and the factual basis for finding(s)	**NOTE: A similar provision in the Consent Agreement, III.B.3. is noted in partial compliance by the medical/mental health Monitors. If there is no finding of compliance with the first tour in 2017 or the CA, this provision may have a compliance change.**
Monitors' Recommendations:	1. Provide training to all staff working with all levels of inmates on the mh caseload. 2. Continue to document discussions in MAC and mini-MAC meetings.

Paragraph	III. A. 5. Use of Force by Staff a. Use of Force Reports (1) MDCR shall develop and implement a policy to ensure that staff adequately and promptly report all uses of force within 24 hours of the force.		
Compliance Status this tour:	Compliance: 7/29/16, 10/24/14, 3/28/14	Partial Compliance:	Non-Compliance: July 2013, not reviewed 5/11/15
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding reporting of uses of force; definitions; reporting formats; time requirements. 2. Review of incident reports. 3. Review of investigations into uses of force. 4. Review of remedial/corrective actions, if any.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Remains in compliance with policy.		
Monitor's Recommendations:	None at this time.		

<table>
<tr><td>Paragraph</td><td colspan="4">III.A. 5.c.
(2) MDCR shall ensure that use of force reports:
i. are written in specific terms and in narrative form to capture the details of the incident in accordance with its policies;
ii. describe, in factual terms, the type and amount of force used and precise actions taken in a particular incident, avoiding use of vague or conclusory descriptions for describing force;
iii. contain an accurate account of the events leading to the use of force incident;
iv. include a description of any weapon or instrument(s) of restraint used, and the manner in which it was used;
v. are accompanied with any inmate disciplinary report that prompted the use of force incident;
vi. state the nature and extent of injuries sustained both by the inmate and staff member
vii. contain the date and time any medical attention was actually provided;
viii. include inmate account of the incident; and
ix. note whether a use of force was videotaped, and if not, explain why it was not videotaped.</td></tr>
<tr><td>Protection from Harm: Compliance Status:</td><td>Compliance:</td><td>Partial Compliance: 7/29/16, 1/8/16, 10/24/14, 3/28/14</td><td>Non-Compliance: 7/19/13</td><td>Other: Other: Not reviewed per MDCR 5/15</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><u>Protection from Harm:</u>
1. Policies and procedures regarding use of force reports; specifications for reporting.
2. Review of incident reports.
3. Review of investigations.
4. Review of inmate disciplinary reports.
5. Review of lesson plans.
6. Review of Medical Care/mental health records regarding injuries, including any required off-site hospitalizations.
7. Review of sample of staff workers' compensation claim relating to uses of force, inmate/inmate altercations.
8. Remedial, corrective action if necessary.
9. Review of digitally recorded incidents.
10. Review of MDCR Inmate Violence Report</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="4"><u>Protection from harm</u>:
See III.A.5.c. (1)</td></tr>
<tr><td>Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)</td><td colspan="4">The work that remains to be done is:
• Evaluate the language being trained in use of force reporting which has been documented by the Monitor since 2014 ("assisted to the floor", "guided to the floor");
• Gathering statement from the inmate victim(s);
• Gathering statements from inmate witnesses;
• Use the precise times of the events (can be gained from video if needed);
• Assess the adequacy of the CHS' evaluation of inmate's injuries.
The continued maturity of the TAAP unit's analysis of reports will assist in this. The plan of action developed in</td></tr>
</table>

	response to the Monitor's December 2015 and July 2016 analysis of the incidents.
Monitors' Recommendations:	1. Refine the plan of action presented to the Monitor during the week of the tour (dated 7/22/16) to address the deficiencies and growth opportunities for TAAP reviews of uses of force. 2. See above, develop MOU with the SAO to determine other changes/modifications recommended to the information, gathering, memorialize the role of MDPD in reviewing assaults related to uses of force, inmate/inmate, staff/inmate.

Paragraph	III. A. 5.c. (3) MDCR shall require initial administrative review by the facility supervisor of use of force reports within three business days of submission. The Shift Commander/Shift Supervisor or designee shall ensure that prior to completion of his/her shift, the incident report package is completed and submitted to the Facility Supervisor/Bureau Commander or designee.			
Compliance Status:	Compliance: 7/29/16, 5/15/15	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	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)	Policy in place; no deviation from the requirements in Monitors review of a sample of use of force reports.			
Monitor's Recommendations:	1. Assure that the MDCR inspectional process samples reporting and incidents to insure reporting is as required.			

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: 7/29/16, 10/24/14	Partial Compliance: 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force reports; supervisory review of reports; time deadlines. 2. Review of MDCR Incident Report and Response to Resistance Summary, as specified above. 3. Review of memoranda with exceptions. 4. Review of investigations. 5. Remedial, corrective action if necessary 6. Review of post orders; job descriptions for Facility supervisor/Bureau Commander.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The facility commanders provide some recommendations at the conclusion of their reviews. These reviews are forwarded to TAAP. There needs to be better coordination of the actions needed, if any, based on the facility commander's review.			
Monitor's Recommendations:	1. Assure that the MDCR inspectional process samples reporting and incidents to insure reporting is as required.			

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: 7/29/16, 10/24/14, 3/28/14	Partial Compliance: 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	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:				
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The policy is in place, and the reviews are being conducted. The Monitor urges an audit of the CHS evaluation and documentation of inmate injuries related to uses of force. The Monitors identified instances where CHS documentation is sparse, and/or inadequate. Sampling reports is needed with specific attention to this, along with collaborative action plans with CHS to re-train and supervise. **NOTE: A similar provision in the Consent Agreement, III.B.3. is noted in partial compliance by the medical/mental health Monitors. If there is no finding of compliance with the first tour in 2017 or the CA, this provision may have a compliance change.**			
Monitors' Recommendations:	1. Conduct an audit of CHS medical documentation. Develop an action plan, if necessary, based on the outcome.			

Paragraph	III. A. 5.c. See (duplicate 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: 7/29/16, 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:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding criteria for referrals to IAB for use of force investigations. 2. Review of reports. 3. Review of medical and mental health policies and procedures for referrals regarding injuries consistent with excessive use of force, and other related critical incidents. 4. Documentation of referrals from medical/mental health to IAB. 5. Minutes of meeting between security and medical/mental health in which these topics are discussed/reviewed. 6. Treatment of inmates at outside hospitals. 7. PREA policies, data. 8. Review of investigations. 9. Review of remedial or corrective action plans, if any.			
Steps taken by the County to Implement this paragraph:				
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Compliance is noted here PROVIDED that MDCR develop a MOU with the State's Attorney's Office of incidents that the SAO wishes to review. If this is not accomplished by the next tour, I will revisit this. Because MDCR does not have the ability, legally, to manage criminal investigations, the SAO must be involved. There were 12 incidents referred to the SAO regarding allegations of excessive use of force, of which neither the plaintiffs nor Monitor was notified. **NOTE: A similar provision in the Consent Agreement, III.B.3. is noted in partial compliance by the medical/mental health Monitors. If there is no finding of compliance with the first tour in 2017 or the CA, this provision may have a compliance change.**			
Monitor's Recommendations:	1. MDCR collaborate with the SAO on what criteria the SAO wants to review. 2. Notify the Monitor and plaintiffs of allegations of excessive use of force when they happen.			

Paragraph	III. A. 5.c. (7) Security supervisors shall continue to ensure that photographs are taken of all involved inmates promptly following a use of force incident, to show the presence of, or lack of, injuries. The photographs will become evidence and be made part of the use of force package and used for investigatory purposes.			
Compliance Status:	Compliance: 7/29/16, 10/24/14, 3/28/14	Partial Compliance: 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding reporting, recording, photographing use of force incidents. 2. Review of job descriptions/post orders. 3. Review of training for those who may/will be photographers. 4. Review of incident reports; use of force packets. 5. Review of investigations; critique of utility of photographs. 6. Review of remedial or corrective action plans, if any. 7. Interview with IAB staff.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	I reviewed 25 use of force investigations and photos were included in all files. See previous recommendation regarding auditing CHS' documentation of injuries.			
Monitor's Recommendations:	1. Continue to self-monitor compliance via TAAP. 2. See above, audit CHS documentation. 3. Work with SAO to determine if photos are sufficient for decisions regarding prosecution and the prosecutions themselves.			

Paragraph	III.A.5.c. (8) MDCR shall ensure that a supervisor is present during all planned uses of force and that the force is videotaped.			
Compliance Status:	Compliance: 7/29, 16, 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:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force; supervisory presence; location of recording equipment; supervision of recording equipment (batteries charged, repairs needed, etc.) 2. Policies and procedures regarding digitally recording incidents; training for users; instructions. 3. Review of incident reports; including exceptions in which digital recordings not made. 4. Review of investigations; review of digitally recorded incidents. 5. Review of remedial or corrective actions, if any. 6. Interview with IAB staff.			
Steps taken by the County to Implement this paragraph:	NA			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Written documentation for a sample of planned uses of force was provided, indicating a supervisor was present. Only one of the use of force incidents submitted to the Monitor for the first five months of 2016 included a planned use of force. This use of force was critiqued for the TAAP unit by the Monitor.			
Monitor's Recommendations:	1. With materials for the first tour of 2017, provide visual evidence of at least 10% of planned uses of force, indicating that a supervisor was present.			

Paragraph See also PREA policies/procedures.	III.A.5.c. (9) Where there is evidence of staff misconduct related to inappropriate or unnecessary force against inmates, the Jail shall initiate personnel actions and systemic remedies, including an IA investigation and report. MDCR shall discipline any correctional officer with any sustained findings of the following: i. engaged in use of unnecessary or excessive force; ii. failed to report or report accurately the use of force; or iii. retaliated against an inmate or other staff member for reporting the use of excessive force; or iv. interfered with an internal investigation regarding use of force.		
Compliance Status:	Compliance: 7/29/16, 1/8/16	Partial Compliance: 5/15/15, 10/24/14	Non-Compliance: 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Protection from Harm: 1. Personnel policies and procedures regarding employee discipline; relevant portions of CBAs. 2. Employee disciplinary reports; investigations. 3. Employee disciplinary sanctions. 4. Records of hearings, including arbitration hearings, if any. 5. Documentation of terminations for cause.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III. A. c. (6) Compliance is noted here PROVIDED that MDCR develop a MOU with the State's Attorney's Office of incidents that the SAO wishes to review. If this is not accomplished by the next tour, I will revisit this. Because MDCR does not have the ability, legally, to manage criminal investigations, the SAO must be involved. There were 12 incidents referred to the SAO regarding allegations of excessive use of force, of which neither the plaintiffs nor Monitor was notified.		
Monitor's Recommendations:	1. MDCR collaborate with the SAO on what criteria the SAO wants to review. 2. Track referrals to the SAO on these cases, and outcomes.		

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: 7/29/16, 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:				
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)	There is evidence in the use of force files that inmates are receiving care; what needs to improve is CHS' documentation. See III.A.5.c. (5). **NOTE that Consent III.B.3.is in partial compliance. For the next tour, the medical and mental health Monitors need to find the relevant paragraphs in III.A.5. in compliance of this paragraph may be moved to partial compliance.**			
Monitors' Recommendations:	See recommendations in III.A.5.c. (5)			

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: 7/29/16, 5/15/15	Non-Compliance: 10/24/14, 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding production of reports, and corrective action plans meeting above criteria. 2. Quarterly reports, and corrective action plans. 3. Review of quarterly medical/mh QA/QI reporting.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Quarterly reports are done; analysis is not sufficient hence action plans are not sufficient. No documentation provided to meet the requirements of this paragraph. **NOTE that Consent III.B.3.is in partial compliance. For the next tour, the medical and mental health Monitors need to find the relevant paragraphs in III.A.5. in compliance of this paragraph may be moved to partial compliance.**			
Monitor's Recommendations:	1. Analyze the data provided in quarterly reports. 2. Develop action plans based on the data.			

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: 7/29/16	Non-Compliance: 10/24/14, 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 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:	<u>Protection from Harm</u>*:*			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Policy in place, quarterly reports completed. There is, as noted in several places in this report, insufficient analysis of the data. **NOTE that <u>Consent III.B.3.</u>is in partial compliance. For the next tour, the medical and mental health Monitors need to find the relevant paragraphs in III.A.5. in compliance of this paragraph may be moved to partial compliance.**			
Monitor's Recommendations:	1. Analyze the data in the quarterly reports. 2. Develop plans of action as needed.			

Paragraph	III.A.5.c. (13) MDCR shall maintain policies and procedures for the effective and accurate maintenance, inventory and assignment of chemical and other security equipment.			
Compliance Status: Not reviewed per defendant May 2015.	Compliance: 7/29/16, 10/24/14, 3/28/14	Partial Compliance:	Non-Compliance: 7/19/13	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures for maintenance, inventory and assignment of and other security equipment. 2. Logs and/or other documentation of inventory inspections. 3. Invoices for repair of equipment. 4. Review of incident reports. 5. Visual inspections.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Written documentation provided. Monitor did not confirm. Will schedule for next tour.			
Monitor's Recommendations:	1. Assure that the inspection process assesses compliance with this paragraph; if conducted, provide to Monitor on or before the tour.			

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: 7/29/16, 5/15/15	Non-Compliance: 10/24/14, 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding unauthorized uses of force and/or allegations of excessive force. Evaluation of uses of force involving inmates on the mental health caseload. 2. MDCR annual reporting, by facility. 3. Review of incidents. 4. Review of baseline for determining increases/decreases, and subsequent data reporting. 5. Observation and interview. 6. Review of a corrective action plans, if needed			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Uses of force are increasing; there is not a corrective action plan to address. MDCR is collecting the data. The Monitor has asked for the reports regarding the uses of force in which excessive force is alleged. These were not previously provided, and will be reviewed prior to the next tour. If this robust analysis and action plans are not in place by the next tour, this paragraph will be in non-compliance.			
Monitor's Recommendations:	1. Analyze data. 2. Develop plans of action.			

<table>
<tr><td>Paragraph</td><td colspan="4">III. A. 5. Use of Force by Staff
d. Use of Force Training
(1) Through use of force pre-service and in-service training programs for correctional officers and supervisors, MDCR shall ensure that all correctional officers have the knowledge, skills, and abilities to comply with use of force policies and procedures.
(2) At a minimum, MDCR shall provide correctional officers with pre-service and biennial in-service training in use of force, defensive tactics, and use of force policies and procedures.
(3) In addition, MDCR shall provide documented training to correctional officers and supervisors on any changes in use of force policies and procedures, as updates occur.
(4) MDCR will randomly test at least 5% of the correctional officer staff annually to determine their knowledge of the use of force policies and procedures. The testing instrument and policies shall be approved by the Monitor. The results of these assessments shall be evaluated to determine the need for changes in training practices or frequency. MDCR will document the review and conclusions and provide it to the Monitor.</td></tr>
<tr><td>Compliance Status:</td><td>Compliance:</td><td>Partial Compliance: 7/29/16, 10/24/14, 3/28/14, 7/19/13</td><td>Non-Compliance:</td><td>Other: Per MDCR not reviewed in 5/15, 1/16</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><u>Protection from Harm:</u>
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)</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="4"></td></tr>
<tr><td>Monitor’s analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)</td><td colspan="4">There was no evidence provided that MDCR is randomly testing at least 5% of correctional officer staff annually.</td></tr>
<tr><td>Monitor’s Recommendations:</td><td colspan="4">1. Provide evidence that MDCR is randomly testing at least 5% of correctional officer staff annually.
2. If the staff do not pass the random testing, provide evidence that a plan of action was developed and implemented.</td></tr>
</table>

<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: 7/29/16, 10/24/14, 3/28/14</td><td>Non-Compliance: 7/19/13</td><td>Other: Per MDCR not reviewed in 5/15, 1/16</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4">Update to SIAB standard operating procedures. Collaboration with the State’s Attorney.</td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><u>Protection from Harm:</u>
1. Policies and procedures for IAB. Recordkeeping/data reporting.
2. Review of a sample of internal investigations.
3. Evidence that IAB attempts to resolve inconsistencies between statements by staff, witnesses, subject inmate, medical and mental health staff.
4. Review of investigative logs.
5. Review of timeliness of completion of investigations.
6. Memorandum of agreement with State’s Attorney regarding referrals for prosecutions. Documentation of referrals for prosecution, if any. Acceptance and/or declination of prosecution by State’s Attorney; reasons for declinations.
7. Interviews with IAB staff.
8. Training records of investigators.
9. Interviews with prosecutors.
10. Medical/mental health policies and procedures regarding cooperation with IAB investigations, release of medical reports, input into IAB review.
11. Evidence of medical and mental health cooperation/collaboration in IAB investigations into uses of force; e.g. requests for and release of inmate medical records.
12. Interviews with medical and mental health staff.</td></tr>
</table>

	Mental Health: See Protection from Harm Review of investigations as they relate to inmates with severe mental illness and in the process of detoxification. This shall include but not be limited to inmate-on-inmate assaults, deaths, and suicides.
Steps taken by the County to Implement this paragraph:	
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Insufficient documentation provided regarding the status of SIAB's standard operating procedures. Insufficient documentation provided regarding coordination with the State's Attorney's Office on referrals. The Monitor's concerns remain about the legal authority held by MDCR to initiate/conduct investigations for which criminal charges could be an outcome. (e.g. Garrity v. Miranda). Training records for staff assigned to SIAB did not indicate the vendor/instructor for the training. Companion CHS policy remains in draft.
Monitor's Recommendations:	1. Complete update of SIAB standard operating procedures. (The document retained by the Monitor is a draft from 2013). 2. Develop a MOU with the State's Attorney regarding referrals to that office. 3. Establish the legal basis for MDCR's initiation/conduct of investigations that may/could result in criminal charges.

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 <u>analyze the data according to the following criteria:</u> i. number of incidents for each data category by individual officer and by all officers in a housing unit; ii. average level of activity for each data category by individual officer and by all officers in a housing unit; iii. identification of patterns of activity for each data category by individual officer and by all officers in a housing unit; and iv. identification of any patterns by inmate (either involvement in incidents or filing of grievances).			
Compliance Status:	Compliance: 1/8/16	Partial Compliance: 7/29/16, 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed 5/15
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures establishing and maintaining the early warning system; including criteria for thresholds and referrals. 2. Existence of a fully functioning early warning system. 3. Reports generated by the early warning system as described above. 4. Evidence of employee actions (e.g. remedial training, EAP, disciplinary actions, terminations) based on early warning system. 5. MDCR report of trends, etc. regarding use of force and employee corrective actions. 6. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of	Evidence was provided that the list are generated; but there is no evidence of why individuals had not further action. Minutes provided did not provide further information (e.g., training, counseling, discipline, etc.) In the last report – this			

the County's representations, and the factual basis for finding(s)	was the finding/recommendation: "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. Prior to the first tour of 2017 MDCR will be required to demonstrate on-going compliance for the previous year to maintain gain compliance. 2. Update on any action plan for 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: 7/29/16, 5/15/15	Non-Compliance: 10/24/14, Not yet due, 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding EWS and reporting. 2. Reports on EWS (180 days and bi-annually), as specified above. 3. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III.A.6. a. (1)- (5), above.		
Monitor's Recommendations:	See recommendations III.A.6. a. (1)- (5)		

Paragraph	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: 7/29/16, 5/15/15	Non-Compliance: 10/24/14 not yet due; 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding annual report. 2. Production of a review of the EWS; recommendations for changes, if needed. 3. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.		
Steps taken by the County to Implement this paragraph:			
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:

Paragraph(s):	**III. B. 1. Fire and Life Safety** Necessary fire and life safety equipment shall be properly maintained and inspected at least monthly. MDCR shall document these inspections.			
Compliance Status:	Compliance:	Partial Compliance: 7/29/16, 10/14; 3/14; 7/13	Non-Compliance:	Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):	The revisions to DSOP 10-022 have not been authorized.			
Measures of Compliance:	Fire and Life Safety: 1. Develop a detailed controlled document inventory of all fire and life safety equipment for each facility. The list should include but is not limited to sprinkler heads, fire alarm pull boxes, and smoke detector units, and its location for each facility 2. Establish either a MDCR or facility specific formal policy outlining the procedure and staff responsibility including accountability for the monthly inspection, repair, and or replacement of all fire and life safety equipment included in the controlled document inventory. 3. Annual master calendar for all internal and external inspection of all fire and life safety system components. 4. Completed, signed, and supervisory review of all inspection and testing reports, along with documented corrective actions taken to resolve identified non-conformances.			
Steps taken by the County to Implement this paragraph:	MDCR had originally 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 it has not been authorized. During this tour MDCR provided the Monitor with a new draft DSOP 10-022 dated 7/19/16. The new draft requires in Section X.C.1that the Fire Safety/Sanitation Officer to inspect the portable fire extinguishers, fire alarm systems, generators, SCBA tanks and masks bi-weekly rather than monthly as required in the Settlement Agreement. Monthly, the FSSO is required to document that fire protection equipment, e.g. fire extinguishers are tagged with effective inspection dates and fully charged. The inspections are to be recorded on the "Monthly Comprehensive Fire Safety/Sanitation Inspection Report and submitted to the Certification and Accreditation Bureau (CAB). In turn CAB is required to conduct monthly follow-up to ensure that the Facility Maintenance Bureau repairs violations documented on the Monthly Comprehensive Fire Safety Sanitation Inspection Report. The policy also establishes the position of Fire Safety/Sanitation Officer (FSSO) for each facility. The FSSO is responsible to conduct a bi-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			

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR has not fully implemented the 2015 draft. The new 2016 draft has not been reviewed by the Monitor. Prior to the tour MDCR provided copies of the monthly "Fire Inspection Report" for January and March, 2016 for Boot Camp, MDWC, PTDC, TGK, and TTC (recently closed) MDCR provided an undated inventory of fire and life safety equipment showing by facility the location of fire extinguishers, sprinklers, smoke detectors, strobes, pull stations, heat sensors, and shut off valves. The Monitor noted previously that Boot Camp and MWDC are not equipped with sprinklers and PTDC do not have fire pumps. MDCR also provided a copy of the SCBA inventory by facility. The inventory noted the month and date of the checks for conducted in March, 2016. Subsequent to the tour MDCR provided copies of the Monthly Fire Inspection Reports for April, May and June, 2016. Staff reported they did not complete the February Fire Inspection because the Miami Fire Department's annual inspection was conducted that month. MDCR also provided examples of SCBA inspections. The material submitted following the tour was not assessed for this report. In reviewing the monthly Fire Inspection Reports submitted prior to the tour, the reports identified violations and included photographs where applicable, but did not indicate that the violations found were actually corrected. As reported in the previous report, attached corrections were shown on inspection reports attachments for the reports reviewed prior to the January tour (July, August, and September, 2015 reports). For this tour MDCR provided copies of the monthly fire safety inspections and corrective action reports completed by 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 supposed to be inspected bi-weekly by each facility's FSSO in accordance with the draft policy. The monthly Fire Safety Report demonstrates at least monthly checks to assure they are serviced, tagged and free of obstruction. It may be beneficial to note of the inspection form that the pressure gauge is showing green demonstrating it is fully pressurized.
Monitor's Recommendations:	1. Provide the Monitor with a marked up copy of the 2016 draft identifying the changes from the 2015 edition. 2. Assure that DSOP Policy 10-022 is formally adopted and implemented. Make sure the draft policy provides evidence that CAB actually completes the monthly follow-up of the Fire Inspection Reports. 3. Assure the monthly Fire Inspection Reports document that corrective actions were actually completed. 4. Assure that the monthly Fire Inspection Report includes evidence that the pressure gauges for all extinguishers were verified as functioning 5. Date the fire and life safety inventory. Document in DSOP 10-022 the frequency and responsibility for maintaining it.

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: 7/29/16	Non-Compliance:	Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):	None			
Measures of Compliance:	Fire and Life Safety: 1. 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)	MDCR requested this provision not be assessed during the May, 2015 and the January, 2016 tour. Prior to the tour no documentation was provided demonstrating compliance with the provision even though the Monitor specifically requested in the January, 2016 report that they be provided prior to the July, 2016 tour. As a result, this provision reverts to partial compliance, only because existing contract mentioned above are still in effect. The Monitor acknowledges receipt of the documentation on 8/4/16. However it was not reviewed for this report.			
Monitor's Recommendations:	1. Provide evidence of compliance with the provision prior to the February, 2017 tour in order for this provision to move back into compliance. This includes evidence of a signed contract and completion of the inspections.			

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: 7/29/16; 10/14; 3/14; 7/13	Non-Compliance:	Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):	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 still not been authorized by MDCR. When 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 maintains a "Red Box" containing the key to access the emergency key cabinet or drawer that is accessed by breaking the glass panel. 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 and the emergency keys are on the first floor. 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 except for Boot Camp as it has no control booth. There the emergency keys are located in the shift commander's office. TGK maintains a complete set of alternate emergency keys for Boot Camp, MWDC and PTDC. DSOP 11-023 requires that emergency keys be tested monthly in each facility to assure 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 the second consecutive tour MDCR did not provide copies of the monthly inspections for emergency keys, as in prior tours. Prior to the tour MDCR provided a copy of the key control lesson plan and PowerPoint slides. Emergency key training is included in the key control training. However, upon questioning there is no opportunity in training for trainees to practice how to correctly identify emergency keys by touch. MDCR also provided score sheets for 29 employees. However MDCR did provide any written criteria to identify the staff or the positions that are required to be trained. Identifying the criteria for staff needing training should be a first priority. According to MDCR staff the only training scheduled to be provided was one class on March and no other classes have been scheduled. Subsequent to the tour MDCR stated that they are developing a list needing training and they expect that the training will be completed by			

	September, 2016. The Monitor will reassess this provision during the subsequent tour. The Monitor again reviewed the process and documentation at TGK, PTDC, and MWDC. MDCR requires incident reports be completed 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 maintain copies. The policy should also identify what is expected to be included in a testing program to assure that the emergency keys will in fact open all of the doors for which it is assigned. At TGK keys and locks are tested quarterly. At MWDC keys are tested monthly. Emergency keys should be tested at least quarterly. The Monitor expected MDCR to provide evidence of emergency key testing. That will be reviewed on the next tour. During this tour when asked, employees at PTDC, TGK, and MWDC correctly demonstrated the procedure for accessing emergency keys. DSOP 11-023 needs to specify the testing process and frequency for consistent practice. Once DSPOP Policy 11-023 is authorized and a consistent testing and reporting format is established and implemented, this provision may 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 designated staff. 3. Assure that during CAB fire drills there is a requirement of a demonstration by officers expected to use the emergency keys that they are capable of correctly identifying the correct key by touch and/or a testing. 4. Provide evidence of emergency key testing for each facility.

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: 7/29/16; 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. 5.		
Steps taken by the County to Implement this paragraph:	Existing 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. The2016 draft of DSOP 10-022 also specifies four levels of drill. It states that the monthly facility fire drills are to be either a level one or two with no requirement for how many of each. The draft also states one fire drill on each shift be completed per quarter. However, there is no requirement as to what level drill is expected. 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. If any non-conformances are identified during the drill, it is considered a "failed drill.". 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, neither the 2015 or 2016 revisions to DSOP Policy 10-022 nor 10-006 has been authorized pending implementation of required training. MDCR provided copies of each facility's Post Order or SOP for fire safety. The draft policy requires each facility to conduct a monthly drill on each shift. The CAB conducts one facility fire drill on each shift per quarter. The policy is not clear if the CAB quarterly drill is in lieu of one monthly facility drill or in addition to it. The current practice is that each facility conducts monthly drills on each shift. Prior to this tour MDCR provided a copy of the fire drill schedule for 2016, along with copies of the monthly fire drill reports for the first quarter of 2016 for review. Each facility had three drills in the quarter except for TGK that had two drill completed. MDCR confirmed that a third drill was conducted, but was not provided. MDCR did not provide any CAB quarterly fire drill reports. In a six month review period the Monitor expected to see a minimum of two quarterly fire drills reports for each shift conducted by CAB. six months of drill reports. The average drill times for the reports submitted fell from 13 minutes to 9 minutes for all facilities. Comments about drill performance continue to improve. Fire Safety Officer comments increased from 42% to 78%. The Monitor stressed at each facility the importance of critical and effective assessments. When assessments are reviewed by CAB, they can identify where changes may need to be made in policies and procedures and improvements in officer training. 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. 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 the Monitor with the changes made in the 2016 version of DSOP 10-022. Once training is completed establish the effective date. 2. Assure all training documents reflect the revised policy. Fire drill performance should be included in the "biennial training". 3. MDCR should 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. 4. Provide the Monitor with copies of the quarterly drill reports, along with the review and analysis and document any corrective actions taken.

	6. Provide the fire drill schedule for the remainder of 2017 prior to the next tour 7. Provide the list of the designated fire safety/sanitation officers (FSSO), along with evidence of fire safety and evacuation training...

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: 7/29/16; 10/14; 3/14	Non-Compliance: 7/13	Other: Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):	Revisions to DSOP 10-010 Chemical Control have not been authorized. Training syllabus has not been completed.			
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. Establishment of either a MDCR or facility specific documented policy outlining the procedures including staff responsibility and accountability for the control of all chemicals in the jail including cleaning, maintenance, pest control, food service and flammables. This includes procedures for chemical spill response and cleanup and personal protective equipment including but not limited to gloves, eye, and skin protection. 2. Establishment of either a MDCR or facility documented specific policy outlining the safe and effective use of chemicals including training requirements and supervision of inmates who have access to them. 3. Evidence of effective implementation of the policies and procedures. 4. Each facility shall maintain spill kits in their designated chemical supply areas that are replaced as necessary. 5. Observations by the monitor.			
Steps taken by the County to Implement this paragraph:	MDCR developed DSOP 10-010 entitled "Chemical Control". While it was accepted by the Monitor (9/21/15) and DOJ (10/6/15), it has not been given an effective date. MDCR stated that they intend to install automatic dilution/dispensing equipment to all facilities. Currently only TGK is utilizing an automatic dispensing system (Buckeye). FSSOs 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 lesson plan and PowerPoint slides addressed chemical safety and dilutions, but does not include the process of how officers in the housing units that have automatic dispensing systems will be trained. Housing unit officers currently fill labeled working containers used by the inmates for cleaning. Staff supervising the inmates also needs to 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)	The Monitor reviewed the chemical control inventory and distribution process with designated Fire Safety Sanitation Officers (FSSOs) at TGK, MWDC, and PTDC. At each facility the FSSOs were completing the chemical inventory correctly. The chemical storage rooms were well organized and secure. Safety Data Sheets (SDSs) were available for all chemicals stored in the respective chemical control rooms. Assure the SDS notebooks are organized in a way that staff can quickly access a data sheet in case of an emergency. Chemical data sheet for chemicals no longer stored can be eliminated and a Master list maintained at MDCR headquarters. MDCR plans to install electronic dispensing systems for all laundry washers at each facility for personal laundry. At TGK where each housing unit has its own automatic dispensing equipment, the Monitor identified working			

	containers that did not have the chemical inside that was specified on the label. Upon questioning, the officer stated she had not been trained on using the dispensing equipment. MDCR needs to assure that when the automatic dispensing equipment is installed at each facility, all staff responsible for diluting and filling labeled working containers are trained in the process and the importance of supervising inmates when they use chemicals. The training needs to be documented. The Monitor would like to review the revised training lesson plan, syllabus and Power Point once the automatic dispensing equipment is installed and Policy 10-010 is revised to reflect the new equipment procedure including 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 draft policy is revised and the training curriculum modified as necessary and evidence of completed training for FSSOs and housing unit officers is provided.
Monitor's Recommendations:	1. Revise the current draft of Chemical Control Policy 10-010 to include the process for automatic diluting and dispensing and the requirement for training of all officers who have responsibility for dispensing and handling chemicals and supervising inmates who have access to chemicals. 2. Revise the chemical safety, dilution, and use training lesson plan for Fire Safety Sanitation Officers (FSSOs), 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 shifts to which they are assigned, 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.

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: 7/29/16; 10/14	Non-Compliance: 3/14; 7/13	Other: Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour(s):	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 provided a copy of the 2016 DSOP Policy 10-022 apparently to replace the 2015 revision provided at the previous tour. DSOP Policy10-006 for fire safety response including proper use of fire and emergency equipment has also not been authorized. MDCR provided a copy of the 4-hour class lesson plan revised 6/9/15, along with the course syllabus and the pre and post testing instruments. MDCR provided copies of sign-in sheets for two classes held in May, 2015. Subsequent to the tour MDCR provided a spreadsheet showing over 400 officer who were trained from May, 2015-July, 2016. That documentation will be reviewed prior to the next tour. 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.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The training sign-in sheets provided were from May, 2015. No evidence of training completed in 2016 was provided until after the tour. MDCR did not provide any schedule for classes to be held this year. 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. Provide a schedule of classes that demonstrate how all staff will receive the training and that all staff will be trained before May, 2017 3. Assure the Lesson Plan and curriculum is consistent with the current revision of DSOP 10-022 and 10-006policies and the pass/fail criteria are established for both the posttest and the practicum.

III. C. Inmate Grievances

Paragraph Coordinate with Drs. Ruiz and Stern See also Consent Agreement III.A.3.a.(4)	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: 7/29/16, 5/15/15	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 1/16
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16	Non-Compliance: 10/14 (Not audited.) Not scheduled for review this tour.	
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 7/29/16, 1/8/16	Non-Compliance: 3/28/14, 10/14 (Not audited.)	
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding inmate grievances per the specifications above. 2. Updated inmate handbook. 3. Review of grievance forms (Creole, English, Spanish) 4. Review of procedures for LEP inmates, and illiterate inmates. 5. Review of a sample of grievances. 6. Observation of grievances boxes and processing of grievances. 7. Interview with inmates. 8. Evidence of referral of grievances alleging use of force; sexual assault.			

	9. Quarterly tracking/data reporting; recommendations, if needed. 10. Documentation of collaboration between security and medical/mental health regarding inmate grievances. 11. Quarterly report of trends, by facility; corrective action plans, if any. <u>Medical Care</u>: • 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. <u>Mental Health:</u> See Protection from Harm and Medical Care
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> There is no substantial change from the last monitoring report. This paragraph remains in compliance. However during the next tour, the coordination/collaboration with CHS will be reviewed. See below. **NOTE that <u>Consent Agreement III.A.3.</u>is in partial compliance. For the next tour, the medical and mental health Monitors need to find the relevant paragraphs in III.A.5. in compliance of this paragraph may be moved to partial compliance.** <u>Medical Care:</u> See Consent Agreement III.A.3. <u>Mental Health:</u> See Consent Agreement III.A.3.
Monitors' Recommendations:	1. Coordinate CHS and MDCR policies. 2. Provide documentation that the responses to grievances are coordinated. 3. CHS should consider assigning staff to handle inmate medically related grievances to assure better collaboration with MDCR.

III. D. Audits and Continuous Improvement

Paragraph Coordinate and Grenawitzke	III. D. Self Audits 1. Self Audits MDCR shall undertake measures on its own initiative to address inmates' constitutional rights or the risk of constitutional violations. The Agreement is designed to encourage MDCR Jail facilities to self-monitor and to take corrective action to ensure compliance with constitutional mandates in addition to the review and assessment of technical provisions of the Agreement. a. On at least a quarterly basis, command staff shall review data concerning inmate safety and security to identify and address potential patterns or trends resulting in harm to inmates in the areas of supervision, staffing, incident reporting, referrals, investigations, classification, and grievances. The review shall include the following information: (1) documented or known injuries requiring more than basic first aid; (2) injuries involving fractures or head trauma; (3) injuries of suspicious nature (including black eyes, injuries to the mouth, injuries to the genitals, etc.); (4) injuries that require treatment at outside hospitals; (5) self-injurious behavior, including suicide and suicide attempts; (6) inmate assaults; an (7) allegations of employee negligence or misconduct. b. MDCR shall develop and implement corrective action plans within 60 days of each quarterly review, including changes to policy and changes to and additional training.			
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance: 7/29/16, 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed 5/15, 1/16
Fire and Life Safety: Compliance Status:	Compliance:	Partial Compliance: 7/29/16, 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not Reviewed 1/16; 5/15
Unresolved/partially resolved issues from previous tour:	Directive needs to be completed.			
Measures of Compliance:	Protection from Harm: 1. Policies and procedures regarding self-audits. 2. Self-monitoring reports. 3. Corrective action plans, if any. 4. Evidence of implementation of corrective action plans, if any. Fire and Life Safety: 1. Development and implementation of effective and consistent policies for regular audits of all facilities housing inmates. It should include audits by designated staff trained in auditing techniques and the polices within each facility and from MDCR for all fire and life safety provisions as well as cleanliness, functioning of electrical and plumbing fixtures etc.			

	2. Inspections should result in identifying specific non-conformities to the policies and include the assigning of persons responsible for taking and documenting corrective actions including oversight to measure the effectiveness of same.
Steps taken by the County to Implement this paragraph:	Steps taken by County 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. As mentioned earlier in the report MDCR developed a 2016 revision to DSOP 10-022. The Monitor requested MDCR to provide a mark-up showing the proposed changes.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: • Complete the policies. Begin documenting data collection and analysis. Fire and Life Safety: MDCR provided copies of monthly fire safety inspections conducted by the Fire Safety Sanitation Officers (FSSOs) from January through March, 2016 for review prior to the tour. Evidence was not provided demonstrating that corrective actions had been completed for non-conformances identified as had been provided for past tours. A self-audit process, if properly implemented should verify whether staff are or are not following the policies and whether training is adequate.
Monitors' Recommendations:	Protection from Harm: 1. Complete and issue the directive; begin to prepare reports consistent with this paragraph. Fire and Life Safety: 1. Complete the revision to DSOP 10-022. 2. Develop and implement a plan to train MDCR officers who are responsible for conducting internal audits and reporting. 3. 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: 7/29/16, 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: 7/29/16, 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:	Protection from Harm: 1. Policies and procedures regarding self-audits. 2. Bi-Annual Reports. 3. Corrective action plans, if needed. 4. Evidence of implementation of corrective action plans, if any. Fire and Life Safety: Same as the measures of compliance as Protection from Harm Mental Health: See Protection from Harm
Steps taken by the County to Implement this paragraph:	Protection from Harm: Mental Health: Bi-annual reports related to medical, mental health and suicide prevention started in October 2013; communication since that time has greatly improved with both MDCR and CHS. A medical and mental health-staffing grid was submitted. However, this grid did not include an assessment of current vacancies. Recent submissions have not included adequate analyses on inmate-violence as it related to patients with mental health issues, nor has it included adequate analysis of factors related to self-injurious behavior and suicide prevention.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Quarterly reporting continues to improve; analysis of the data is required. Then action plans can be developed. Mental Health: Psychiatry • Staffing currently consists of seven FTEs. and 109 total hours of per diem or 'pool' psychiatry time. • Per diem psychiatry time has been unpredictable and unreliable • 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:	Protection from Harm: • Complete the directive and provide the analysis and action plans (and action plan updates). • Provide a table of contents with quarterly and annual reports Fire and Life Safety: Provide evidence of analysis of data along with action plans to improve conditions for all fire and life safety provisions. Mental Health: Reportable incidents should include severe adverse medical events involving patients with mental health issues and substance use issues. It is imperative that the County tracks these issues, analyze systemic problems and implement plans to correct them.

IV. Compliance and Quality Management

Paragraph Coordinate with Grenawitzke	IV. COMPLIANCE AND QUALITY IMPROVEMENT (duplicate 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: 7/29/16, 10/24/14	Non-Compliance: 3/28/14, Not yet due (10/27/13)	Other: Per MDCR not reviewed 5/15, 1/16
Fire and Life Safety: Compliance Status:	Compliance:	Partial Compliance: 7/29/16; 1/8/16; 10/24/14	Non-Compliance: Not yet due (10/27/13)	Other: Per MDCR, not Reviewed 5/15
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	Protection from harm: 1. Policies and procedures regarding compliance and quality improvement. 2. Schedule for production, revision, etc. of written directives, logs, screening tools, handbooks, manuals, forms, etc. 3. Schedule for pre-service and in-service training. 4. Evidence of notification to employees regarding newly-adopted and/or revised policies and procedures. 5. Provision of newly-adopted and/or revised policies and procedures to the Monitor for review and approval. 6. Lesson plans. 7. Evidence training completed and knowledge gained (e.g. pre and post tests). 8. Observation. 9. Staff interviews. Fire and Life Safety: 1. Development and implementation of a formal training plan and training matrix for affected staff 2. Course syllabus for the training that addresses all applicable provision mandated in specific policies related to fire and life safety. 3. Evidence of validation of training as well as verification of attendance 4. Results of staff interviews documenting understanding of all applicable policies and ability to carry out the provisions of the policies.			

Steps taken by the County to Implement this paragraph:	Protection from Harm: Fire and Life Safety: MDCR continues to provide drafts of policies and copies of training plans. However, training for staff to date is inconsistent with starts and stops for fire safety, key control, and chemical control. MDCR first needs to formally identify all the staff that are required to take specific training and then provide the Monitor with the evidence demonstrating completion.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Directives and lesson plans needs to be completed Fire and Life Safety: Implement the training required consistent with current policies so that the draft policies can be finalized. As stated above, identify the specific staff needing specific training; develop a realistic training schedule that assures the correct staff receive the specific training they need.
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. Assure all fire and life safety policies are included for the annual review. 4. Develop and implement a realistic training schedule of classes to assure that staff is trained in accordance with the policies they are expected to implement.

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: 7/29/16, 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed 5/15, 1/16
Fire and Life Safety: Compliance Status:	Compliance:	Partial Compliance: 7/29/16, 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not Reviewed 1/16, 5/15
Unresolved/partially resolved issues from previous tour:	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 Implement this paragraph:	Protection from Harm: Materials not provided by MDCR indicating compliance. Fire and Life Safety: Materials not provided by MDCR indicating compliance.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: 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: 7/29/16, 1/8/16	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, Not yet due 7/19/13
Fire and Life Safety: Compliance Status:	Compliance: 7/29/16	Partial Compliance: 10/24/14	Non-Compliance: Not yet due 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	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: 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: Annual review process in place; documentation provided. Fire and Life Safety: See IV.A. and IV. B.		
Monitor's Recommendations:	Protection from Harm: None at this time. 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: 7/29/16, 10/24/14	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed 5/15, 1/16
Fire and Life Safety: Compliance Status:	Compliance: 7/29/16	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	NA			
Measures of Compliance:	Protection from Harm: 1. Production of policies and procedure for review. 2. Production of lesson plans, training schedules, tests Fire and Life Safety: 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: 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:			

	None at this time. <u>Fire and Life Safety:</u> Development of policies and review process, along with a training component to assure training to changed policies is completed before making the policies effective. As recommended in the Fire and Life Safety provisions, provide me with drafts of the revised policies identified above. Provide a copy of DSOP 4-018 for review.

Compliance Report # 6
Consent Agreement - Medical and Mental Health Care
Report of Compliance Tour of July 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, letters received by the Monitor between visits). 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:

Consent Agreement – Status of Compliance[4]

Report #	Compliance	Partial Compliance	Non-Compliance	Not Applicable/Not Due/Other	Total Paragraphs
1	1	56	40	22	119
2	0	38	73	8	119
3	2	19	98	0	119
4	6	35	75	0	116[5]
5	4	50	61	0	115
6	7	82[6]	26	0	115

In preparation for future tours, the Monitors expect receive the documents supporting compliance 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.

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

[5] Joint reporting paragraphs removed.

[6] This number includes provisions for which either the medical or mental monitor found partial compliance and also includes provisions that either the medical or mental health monitor found in either partial or **non**-compliance.

County's Compliance with the Summary Action Plan

Based on the Summary Action Plan, filed with the Court on May 18, 2016, the County committed to achieve compliance by July 1, 2016 with Intake Screening (CA III.A.1.), and Risk Management (CA III.C.9.).

The findings of the Monitors are:

- Intake Screening (III. A. 1.) **Partial Compliance**
    - Of these seven provisions in this section. Five of the provisions relate to both Medical and Mental Health Care; two relate only to Mental Health care.
    - Of the five provisions related to Medical Care, the County is in compliance with one provision, and is partially compliant with four provisions.
    - Of the seven provisions evaluated by the Mental Health Monitor, the County is in compliance with one provision, partially compliant with four provisions, and non-compliant with two.

- Risk Management (III.C.9.) **Partial Compliance**
    - There are four provisions in this section. All four relate only to Mental Health Care.
    - Of the four provisions, three are partially compliant and one is non-compliant.

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.

The Medical Monitor's team received a number of unsolicited positive comments from patients in both general population as well as some in isolation cells, some offering that they've noticed a change in the quality of care in the past 18 months, and especially the past 6 months.

Indeed, based on the Medical Monitor's observations, conditions continue to improve. However, many large problems remain, and progress towards satisfaction of the provisions of the CA is much slower than required by its terms. The Medical Monitor highlights five topics which affect multiple provisions.

Electronic Health Record (EHR)

The County uses an EHR for health care documentation. An EHR has the potential for improving care. The current EHR currently in use does provide some benefits. However, it still has numerous dysfunctions which make medical management more difficult, if not, at times, dangerous. CHS staff is aware of many of these dysfunctions and had made software modifications. Unfortunately, many problems remain. Examples are:

- Many progress notes contain unclear/nonsensical entries generated automatically by the EHR software.
- Many progress notes contain entries equally unclear/nonsensical, which, while produced by the user, are prompted or facilitated by the design of the EHR. For example, many physician progress notes contain entries for the Review of Systems that state "Negative except as noted in HPI." Such an entry denotes that the physician personally explored the particular organ system with the patient, sometimes with numerous questions (e.g. Endocrine System), and received negative responses to each question. However, it is highly likely that in at least some of these cases, no such questioning took place.
- The EHR contains documents that, according to the EHR, were produced and given to the patient when in fact, they were not. A frequent example of this are discharge and education documents filed at the completion of each MDCR admission.
- The labeling of documents in the EHR are either wrong or unhelpful. Progress notes entered by CHS physicians are sometimes erroneously labeled as having been produced by the providers in the ED or Booking. Scanned documents are particularly susceptible to mislabeling.
- Scanned documents are also subject to numerous other errors including: filed on the wrong date or wrong time (most scanned documents are labeled as having been generated at midnight, regardless of when they were actually generated); mislabeled; filed multiple times.
- Many entries are missing the credential of the author.
- Nurse progress notes from episodic care clinic encounters are filed in a different location and manner than other progress notes, making it very difficult for a user to not only read such notes, but also to read these along with other progress notes in chronological order.

Model of Care

The vast majority of medical care delivered at MDCR is delivered to address non-urgent episodic needs and treat chronic diseases. The County's current model for addressing these needs is a largely bifurcated one in which nurses initially handle the former driven by patient-generated paper requests, and practitioners (physicians, physician assistants, and nurse practitioners) handle the latter. Based on the Medical Monitor's observations, the system, as a whole, does not work well: it is ineffective and inefficient. Nurses are faced with evaluating myriad complex and potentially serious medical issues on which they must spend much more time than a practitioner would to investigate, and for which they usually (wisely) refer the patient on to a practitioner anyhow. Occasionally they miss the significance of the situation and (unwisely) manage the patient independently. The paper-based request system is cumbersome, resulting in lost papers, time spent trying to find them, and challenges coordinating (between custody and medical staff) inmate movement. One of the most striking aspects of nurse clinic as it currently operates is the extreme inefficiency of the process. In the clinics observed by the Monitor, nurses rarely managed to see more than 2 patients per hour. This is a particularly low rate, given that most of the visits were avoidable or added little or no value (because the nurse could not provide

definitive care and had to refer the patient to someone else). The following case illustrates several of these (and other) problems.

> A patient had his tooth pulled on 7/23/16. The dentist intended for him to get pain medication, but this never happened. So the patient submitted a Sick Call Request (SCR) form the next day. Instead of sending him directly to the dentist, staff triaged him to see a medical nurse on 7/26/16. By this point he had been without medications and in pain for 3 days (the nurse recognized this and provided him medication immediately). The nurse then scheduled the patient for two more visits. The second visit – the one likely to provide the patient with definitive care - was to see the dentist. However the nurse also scheduled the patient to see a medical practitioner. She did this because she did not know how soon the patient would be seen by the dentist. Thus this patient will have had 3 clinic visits (and custody staff will have had to escort him 3 times) when only one visit was necessary (and arguably even that visit was avoidable).

For chronic care, the issues that need to be addressed are usually routine (e.g. reviewing the patient's medication usage and response to therapy since the last visit, ordering enough medications until the next visit, scheduling a timely return visit). This does not happen flawlessly at MDCR. Additionally, mental health practitioners are not part of the in-clinic team, either in non-urgent episodic care clinic or chronic care clinic, as is the recommended model for primary care nationally.

While inefficient care (i.e. wasting money) is technically beyond the scope of the CA, to the extent that such inefficiency draws staff and money away from operations where these resources are needed to ensure patient safety, it is not.

Thus, due to the direct and indirect risks to patient safety posed by the current system, the Medical Monitor encourages the County to carefully examine its current model for delivery of non-urgent episodic care and chronic care, and find ways to improve delivery. Principles to consider during this review are: a) assuring that the right tasks are being assigned to the most appropriate professional. Non-urgent episodic care is among the most complex tasks in the medical unit, so consideration should be given to assigning more of this workload to the most highly trained disciplines (i.e. practitioners). Chronic care has many tasks which are well defined by national guidelines and thus lend themselves to clear protocols. Chronic care also involves careful adherence to procedures such as making sure the patient has a follow-up appointment in an appropriate interval and making sure the patient has an adequate supply of medication to last until that appointment. Finally, chronic care involves assessing the patient's adherence to treatment and lifestyle modification regimens, understanding the psychosocial impact of the disease on the patient, and providing the patient with education about dealing with their disease. All these are clinical functions perfectly suited to RNs. So consideration should be given to increasing the role of nurses in these activities; b) integrating medical, mental health, and dental disciplines into coordinated patient care; c) off-loading simpler tasks to less highly trained personnel. A large part of the RNs' time in clinic is spent searching for paperwork, searching for patients, retrieving supplies, rooming patients, and measuring vital signs, all tasks which could be

performed by non-licensed (less expensive) staff; d) integrating the clinic workload with custody needs. The most important factor determining the flow of patients through the clinic is custody. Thus any model design changes should be based on custody input. There are models of access to non-urgent episodic care that may give greater information to custody staff earlier, allowing custody staff to proactively plan patient flow. For example, replacing SCRs with living unit sign up sheets would give custody staff several hours lead to plan which inmates to move and when.

Refusals of Care and No-Shows

The Medical Monitor found a large number of patient refusals. These refusals fell into 3 categories: refusals of medications, refusals of interventions (e.g. measurement of vital signs, blood sugar, or detoxification progress using COWS/CIWA), and refusals of clinic visits. He also found a large number of no-shows, predominantly with regard to medications only. These refusals and no-shows present risks to the patient. First, it cannot be guaranteed that all events recorded as "refusals" are indeed refusals. This is especially true with medication administration where "refusals" may actually reflect that the patient did not appear at pill line because he/she did not know medications were prescribed, was asleep, or was somehow intimidated into not taking medications. Second, patients may not appear for medications or clinic visits because they are too ill (possibly as a consequence of the very disease that is being treated). Third, they may not have the capacity to refuse. This may affect their ability to refuse medications or clinic visits, but is especially relevant when patients refuse vital signs, blood sugar measurements and monitoring of detoxification (COWS/CIWA) when it can be argued that their condition (e.g. high blood sugar, high fever, intoxication, or withdrawal) clouds their ability to make a clear and informed decision. The refusal problem at MDCR is further complicated by the fact that many refusals are managed by LPNs who, by nature of their training and licensure, in most cases, do not have the ability to assess the patient's decision-making capacity and fully inform the patient of the *specific* risks of refusal and alternatives.

For these reasons, the Medical Monitor recommends that the County modify its policies and procedures with regard to refusals of medical and dental care incorporating the following principles.

1. "No-show", it and of itself, should not be an acceptable explanation for failure to administer a medication. Data collection/documentation should be amended o determine the cause. Possible acceptable reasons for non-administration of medication should be limited to:
   a. patient refused (see below);
   b. medication withheld in accordance with parameters given by the ordering clinician (e.g. "hold clonidine for systolic blood pressure less than 110")
   c. medication withheld in accordance with accepted nursing practice due to the patient's condition (e.g. patient states he have been vomiting and is not likely to retain the pill), in which case the nurse would notify a supervisor

d. medication could not be administered because the patient is at another location (e.g. court, transferred), in which case the nurse would follow policy to ensure that the dose is administered later (e.g. try again with the patient returns from court, verify with the new facility that the medication is being administered, etc.).

2. All refusals must be made in-person by the inmate to a licensed health care professional. The policy, and appropriate training for medical providers, should anticipate that there are times when a patient may refuse to present in person, and should provide guidance as to how to handle these situations.

3. Excess (non-value added) paperwork that distracts from patient care should be reduced. For example, it may be sufficient for the pill line nurse to simply record a refusal in the MAR rather than executing a refusal form. This would be less disruptive of pill line, reducing the chances for medication errors, and speed up pill line, thus reducing delays in administration of medications for other patients.

4. The policy should specify how pill line nurses should respond to refusals based on the medication or medication category and the number of missed doses. This algorithm should either be very simple, and/or be incorporated into medication administration software such that as soon as the pill line nurse documents the refusal, the software prompts the nurse with instructions on how to respond (e.g. accept the refusal, notify an RN immediately, notify an RN within X hours, notify a practitioner, etc.).

5. By definition almost any ordered monitoring, testing, medication, or treatment in an inpatient medical setting should be considered medically necessary. Therefore any refusals of these ordered interventions should be viewed as potentially dangerous and should trigger a clinical cascade designed by the County that results in either acceptance of the intervention, or involvement of the attending physician or delegate.

6. The unique skills of RNs in assessing patient behavior, concerns, and condition, should be leveraged to play a key role in addressing certain medical and dental refusals.

In summary, it is assumed that medical practitioners only order medications and other interventions because they are medically necessary. Failure to execute these orders, therefore, put patient safety at risk. Thus when a medically necessary intervention is not provided as ordered, there should be evidence that the County did everything in its power to provide it. When it is not provided because of patient refusal, that refusal should be an *informed* refusal. If the patient is unable to provide informed refusal, the County should take other reasonable clinical steps to ensure the patient's welfare. **Quality Improvement**

In the course of business, the County is discovering health care delivery processes that need to be fixed. Right now some of these processes come to light as the result of our

external monitoring. However, even after the Monitors are gone, the quality improvement "antennae" that the County raises will continue to bring many broken processes to the County's attention by a variety of mechanisms (e.g. death reviews, other adverse event reviews, voluntary error reporting system, analysis of dashboard data, peer review, managerial review, etc.). Fixing all those broken processes can be daunting; for example, the County's 10-day review of a recent death revealed 17 areas for improvement (not all necessarily causally related to the death). More importantly, given the time and resources it takes to fix system errors (in any organization), failure to prioritize which problems to fix first can result in prolonged risks to patient safety.

Thus as it designs its approach to quality improvement, the County should develop a robust system for inventorying, prioritizing, monitoring the progress of, and, as needed, reprioritizing all its quality improvement efforts. The quality improvement process should also include a mechanism for instituting new performance measures to assure that system changes that are implemented in fact accomplish what they were intended to accomplish.

Jackson Health System (JHS) Support of CHS

JHS is the home of tremendous expertise in operating all the aspects of health care delivery. As such it is a source of expertise and support to the operation CHS. At the same time, as a subunit of JHS, JHS has a responsibility to maintain reasonable control over CHS. At this point, for legal and patient safety reasons, CHS is under considerable pressure to make changes and make them quickly. These changes fall in a number of domains, including staff training, personnel management, IT, equipment procurement, to name a few. It is critically important that JHS find the path that provides the maximal support to CHS while allowing their CHS leaders the maximal reasonable empowerment to move nimbly.

Mental Health Care

The Mental Health Monitor conducted this review with the assistance of Adam Chidekel, PhD. His assistance was appreciated.

Specific to the timeline outlined in the Summary Action Plan, the Mental Health Monitor focused its review on two areas of care: Intake Screening and Risk Management. Intake Screening is important because identification of patients with possible suicide risk, major mental health concerns and risk for detoxification should occur at intake. It is here where appropriate triage is indispensible. Bottlenecks and missteps early on cause ripple effects down the line, as we saw throughout the tour. Similarly, Risk Management is crucial, as it serves as the pulse of your system. Measuring it regularly, or not at all, can give you a wealth of information.

Intake Screening and Possible Over-Referral

Intake screening is occurring. Mental health screening is occurring. On average, the nurses at booking refer three out of five or 60-70% of patients to the mental health caseload. This number is quite high, even for correctional populations. Average jails may have 40% of the

female patients on the mental health caseload and up to 25% of the men on the mental health caseload. Miami Dade's mental health caseload is much higher than the typical average.

Given the high number of referrals, it is not surprising that backlogs are occurring to see psychiatry and to get medications started. Average wait times run over by 4.5 hours for outliers. What is the impact of this?

As higher and higher number of patients wait for beds, higher and higher numbers of patients are referred to mental health Levels III and IV, the lower acuity levels of care. At these levels, the patients go to Metro West, see the psychiatrist less frequently, and are placed in dormitory-style housing. These levels of care are associated with more inmate on inmate fights, transfers to the emergency department, fractures, lacerations, and contusions. For example, I interviewed one inmate I will call Jose. Jose was admitted several months ago with "anxiety." He stated that his anxiety was viewed as a weakness by the other inmates. [Inmates on this level are also mixed in with general population inmates.] One night at Metro West, he was jumped by four inmates and he sustained a fracture of his right arm. He is awaiting surgery.

Another example of a treatable condition that is going under-managed or under-treated included alcohol withdrawal and risk for seizure. The number one diagnosis at the jail was Alcohol Dependence.

Risk Management

Risk management and continuous quality improvement have been tracking response to resistance as it relates to the mental health population. It recognized an uptick in response to resistance as early as January 2016. However, no intervention was implemented nor discussed in the meeting minutes. Similarly, while on site, areas of concern included hoarding of medication and risks of overdose (which has previously been identified at Metro West in contraband sweeps). Steps to address or mitigate this, such as referring patients who have been caught hoarding medication to the psychiatrist, were not identified. A more proactive approach is encouraged.

Inmate Grievances

The Monitors urge the parties re-visit the procedures related to grievances filed by inmates relating to medical, mental health and dental care. As noted in this report:

- The content of the grievances was not provided to the Monitors, nor were an analysis of the trends or issues related to common themes of the grievances. Staff indicated that many grievances concerned timely access to medications.
- It is noteworthy that with a mental health caseload of more than 63% of the inmate population, mental health grievances should be more than eight in number (the ones the mental health Monitor was provided to review) and should represent intake as well as other levels of care, including Levels I-IV and

detox. If this is the reality, a review of why there are so few grievances need to be examined.

- The County needs to shorten the time between a request for care and delivery of *definitive* care. Triaging to the person who can deliver that definitive care would help accomplish that goal. However, there are other models of care that can accomplish the same outcome, but with fewer steps (please see Model of Care in the introduction to this section of the report).
- Emergency grievances must be addressed *as soon as they are received*. While the current assignment of all health grievances to the "emergency" category is not harmful, it may not be the best use of CHS staff resources. Thus the Medical Monitor recommends that the County consider creating two categories of health related grievances: routine and emergency, allowing the patient to chose the appropriate category.
- The County needs to identify and address the source of the apparent delay between submission by the inmate and receipt in CHS of medical grievances. A real delay (i.e. due to County procedures) is unacceptable, so if the County determines that the delay is real, it needs to eliminate it. If the delay is only an apparent one (i.e. due to inmate filing the grievance and/or MDCR processing it to medical), it is best practice for the County to eliminate the error, or, at a minimum, memorialize its investigation, data, and analysis that demonstrates that the delay is only an apparent delay

The Settlement Agreement addresses inmate grievances in Section III.C. This section has been in compliance since Compliance Report #4. If the coordination among the parties, as well as the changes described above is not addressed before the first tour of 2017, the status of compliance with the companion provision in the Settlement Agreement may be amended. Particularly the analysis of the grievances, trend analysis, and plans of action, if necessary will be examined.

DRAFT Summary of Status of Compliance - Consent Agreement
Tour #6

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

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

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

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

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments:
III. C. 5. d.		MH		
III. C. 5. e.		MH		
6. Custodial Segregation				
III. C. 6. a. (1a)		MH		
III. C. 6. a. (1b)		MH		
III. C. 6. a. (2)		MH		
III. C. 6. a. (3)		MH		
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; MH		
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

A. MEDICAL AND MENTAL HEALTH CARE

1. Intake Screening

Paragraph Author: Stern and Ruiz	III. A. 1. a. Qualified Medical Staff shall sustain implementation of the County Pre-Booking policy, revised May 2012, and the County Intake Procedures, adopted May 2012, which require, inter alia, staff to conduct intake screenings in a confidential setting as soon as possible upon inmates' admission to the Jail, before being transferred from the intake area, and no later than 24 hours after admission. Qualified Nursing Staff shall sustain implementation of the Jail and CHS' Intake Procedures, implemented May 2012, and the Mental Health Screening and Evaluation form, revised May 2012, which require, inter alia, staff to identify and record observable and non-observable medical and mental health needs, and seek the inmate's cooperation to provide information.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 5/15; 1/16; 7/29/16	Non-Compliance: 3/14 (NR)
Mental Health Care: Compliance Status:	Compliance: 5/15	Partial Compliance: 3/14; 10/14; 1/16; 7/29/16	Non-Compliance: 7/13 (NR)
Measures of Compliance:	<u>Medical Care:</u> • 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. <u>Mental Health Care, as above and:</u> 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 made significant progress on designing, and has almost completed, a training curriculum for Intake nurses. Mental Health Care: The County has made progress on improving inmate triage and flow through the Law Enforcement Officer (LEO) lobby. Patients are being interviewed and screened for mental health issues.
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: Some problems still remain in the intake process. One nurse was observed prompting patients with the negative response to question ("You don't have any problem with X, do you?"). The nurse also assumed the response to closely related questions would be the same (so filled them in without actually asking the additional questions). Other nurses did not have sufficient expertise in conducting the mental status examination portion of the intake screening (for example, marking "mood" as "unable to determine," but "affect" as "consistent with mood." About 20% of the time, staff entered an estimated weight for patients (despite the presence of a scale in the Pre-Booking area). While *occasionally* newly arrested patients may not be cooperative with weighing, even when this happens, an actual weight should be measured during Screening or the next clinic encounter; this does not happen. Medications that patients were taking in the community are not uniformly restarted. For example, one admitted patient had been taking a medication for hemophilia prior to incarceration. This medication was not restarted for weeks. Mental Health Care: The tool being utilized for mental health and suicide screening refers approximately 60-70% of the population for additional mental health evaluation. The County maintains that the intake mental health screening tool has been validated. This is a high level of mental health referrals relative to other jails. The following may be helpful: 1. The suicide screening instrument from New York has been utilized in several jails and has a lower rate of a referral, typically 17-25%. It is available via the State of New York Commission of Correction, Office of Mental Health. Data relevant to the number or percentage of emergent vs. urgent and routine referrals was requested verbally and in writing on several occasions both prior to the July 2016 tour and on site. This data was not received. This information is relevant both to the Consent Agreement and specific to patient care and safety for several reasons. Primary among them is that emergent referrals are to be placed on constant observation by nature of their acuity and risk of acute decompensation, harm to selves or others. The fact that despite that we have repeatedly requested this information but it has not been available or is not being tracked remains a concern.
Monitors' Recommendations:	Medical Care: 1.The County needs to complete its Intake Training curriculum and begin the training process. 2. If not already being done, nurse should periodically be observed by supervisors as they intake screenings. 3. The County should incorporate many or most of these audit steps into its own, on-going quality improvement/monitoring

	process. <u>Mental Health Care:</u> 1. Implement a method to differentiate between emergent and urgent psychiatric referrals in your electronic health record system, consistent with the definitions in the CA. This information, as well as the reason for all emergent send-outs to the hospital on the mental health caseload, 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.

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; 7/29/16	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: "Nurses conducting Medical and Behavioral Health Screening or **QMPs** conducting a health assessment refer patients for Behavioral Health evaluation when clinically indicated." 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 QMHPs (social workers) and nurse practitioners. No internal audits per se were provided for review from CHS. As referenced above, although no internal audits were performed, interviews with staff indicate that screening is occurring and that inmates are not only being referred but they are being over-referred. Data from custody indicated that wait times between medical stations (at intake) demonstrated a total average delay of 15 hours (or 4.5 hours above the allotted time) to see mental health / psychiatry. Outstanding issues include timeliness to see a psychiatrist, bed placement, and the overall number of mental health referrals.		
Monitor's Recommendations:	1. Train all medical and mental health staff on intake procedure and process. 2. Consider revise and validate mental and suicide screening procedures at intake. 3. Complete self-audits of accuracy of level and triage system for mental health care. Please ensure adequate access to appropriate 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; 7/29/16
Unresolved/partially resolved issues from previous tour:	The County has yet to <u>implement</u> 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 emergent mental health care, use of restraint, constant observation and suicide prevention. 2. Interagency Policy 003 "Inmate Suicide Prevention and Response Plan" was received for commentary and review August 4, 2016, after the onsite tour.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As of 2016, 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 or her orders, and the medical care he or she received. Constant observation and emergent psychiatric referrals were not documented or implemented on a consistent basis. Documentation that demonstrated constant observation was requested on several occasions yet was not provided or not available.		
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. Constant observation should be noted in the medical record by a psychiatric order and; 3. assign/triage care as needed. I recommend review of all adverse events related to inmates with mental health and/or and substance use issues for qualitative analysis and corrective action. This will be discussed further under Use of Force and Risk Management.		

Paragraph Author: Stern and Ruiz	III. A. 1. d. Inmates identified as "emergency referral" for mental health or medical care shall be under constant observation by staff until they are seen by the Qualified Mental Health or Medical Professional.		
Medical Care: Compliance Status:	Compliance: 7/13; 5/15; 1/16	Partial Compliance: 7/29/16	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; 7/29/16
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Interview with Intake nurses reveals that after identification of "emergency referral" in Intake, patient stays under constant observation. • Audit Step b: (Chart Review) A patient identified as having an emergency medical need is seen by a practitioner immediately. Mental Health Care, as above and: 1. Record review of adherence to screening, assessment, and trigger events as described in Appendix A 2. Review of housing logs; 3. Review of observation logs for patients placed on suicide precaution. 4. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	Medical: Not applicable Mental Health Care: As per CHS-033, "Emergency Behavioral Health Referrals. The patient receives a pink band and CHS staff will inform MDCR sworn staff to place the patient under constant observation until they are seen by a **QMHP** within 2 hours."		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: 2 of 24 intakes reviewed had pink bands applied for medical reasons, but were not managed within 4 hours; both were patients who were referred for detoxification. Mental Health Care Documentation demonstrating that emergent referrals and constant observation had been provided to a sample of patients was requested. This information was not provided.		
Monitors' Recommendations:	Medical Care: 1. The County should analyze the reason patients are not seen within the 4 hour time frame. If due to lack of awareness of the time, the County should consider software solutions, such as alerts to supervisory staff when patients are approaching the time limit. If due to inadequate staffing, solutions may include additional staffing, or initial "quick" evaluations by the practitioner (thereby "stopping the clock") to determine if the patient is stable and is able to wait beyond the 4 hour time limit. Mental Health Care: 1. Constant observation, one: one observation, emergency referrals, and urgent referrals should be orders that are placed in		

	the electronic health record. 2. As noted in the CA, prior to assessment by a QMHP, patients must be placed on a 1:1 with direct constant observation until a safe disposition can be determined. In the absence of such an order, they should be placed on the highest level of observation (constant, one-on-one) until further evaluation by a MH professional and placement. 3. 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. 4. 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. CHS shall obtain previous medical records to include any off-site specialty or inpatient care as determined clinically necessary by the qualified health care professionals conducting the intake screening.		
Medical Care: Compliance Status:	Compliance: 5/15	Partial Compliance: 1/16; 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 5/14; 1/16; 7/29/16	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. 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: Review of medical records revealed instances in which previous patient history was not adequately addressed. For example, a patient presented with a history of hypertension, but the nurse did not determine the previous medications nor refer the patient to a practitioner. In another case, the nurse did order old records for a patient with cirrhosis, and referred him for follow-up the next day with a practitioner, but that appointment never materialized, so the records were never reviewed. 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: 1. The County should incorporate these audit steps into its own, on-going quality monitoring process and then address any resultant deficiencies. Mental Health Care: 1. Practitioners should review available medical records and incorporate the finding into their notes and decision-making. This is particularly pertinent to whether the inmate has a prior history of mental illness or suicidal behavior.		

Paragraph Author: Stern and Ruiz	III. A. 1. f. CHS shall sustain implementation of the intake screening form and mental health screening and evaluation form revised in May 2012, which assesses drug or alcohol use and withdrawal. New admissions determined to be in withdrawal or at risk for withdrawal shall be referred immediately to the practitioner for further evaluation and placement in Detox.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 5/15; 1/16; 7/29/16	Non-Compliance: 3/14 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14; 10/14; 5/15; 1/16; 7/29/16	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 / behavioral issues in the setting of substance abuse, intoxication, or withdrawal.
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. (Covered in III.A.1.a.) CHS shall ensure that all Qualified Nursing Staff performing intake screenings receive comprehensive training concerning the policies, procedures, and practices for the screening and referral processes.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 5/15; 1/16; 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 5/15; 1/16; 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR)
Measures of Compliance:	Medical Care: • (duplicate III.A.1.a.) 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 III.A.1.a.) Audit Step i: (Inspection) Training records show that nurses who perform intake medical screening receive training as specified in policy. Mental Health Care, as above: See Medical Care		
Steps taken by the County to Implement this paragraph:	See III.A.1.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):	See III.A.1.a.		
Monitor's Recommendations:	See III.A.1.a.		

2. Health Assessments

Paragraph Author: Stern	III. A. 2. a. Qualified Medical Staff shall sustain implementation of CHS Policy J-E-04 (Initial Health assessment), revised May 2012, which requires, inter alia, staff to use standard diagnostic tools to administer preventive care to inmates within 14 days of entering the program. [NB: This requirement is not about diagnostic tools or prevention – it is about the entirety of the health assessment. It was driven by detainees not getting, or getting inadequate initial health assessments. /MS]		
Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16
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:	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 County is not currently routinely conducting Health Assessments.		
Monitor's Recommendations:	The County needs to conduct Health Assessments in compliance with this provision of the CA. The Medical Monitor recommends that if these are conducted during the Intake process, that the patient return several days later for a review of at least the history obtained during Intake. The rationale for this is that some patients do not always provide complete and accurate histories when they first arrive in a jail, due to a combination of lack of trust, anxiety, and mind-altering conditions.		

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); 7/29/16
Measures of Compliance:	Mental Health: 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:	Interagency Policy 003 "Inmate Suicide Prevention and Response Plan was received on August 4, 2016, after the on site tour. As alluded to above, screening is occurring and issues have been identified in terms of over-referral. Preliminary review indicated that mental health assessments for Level III and Level IV inmates are delayed.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As discussed above, data reviewed indicated the mental health screenings lead to 60-70% of the population being referred to mental health assessment. Utilizing a corrections census of 4129 for July 6, 2016, this would indicate that approximately 2683 would have been on the mental health caseload. CHS clinical volume statistics demonstrated that 2051 appointments confirmed, indicating they have a 76% show rate (if these extrapolated numbers are accurate). The same data indicated hundreds (over 2000) of appointments were cancelled and rescheduled.		
Monitor's Recommendations:	Please provide data with timely analysis and explanation of findings. A corrective action plan to provide adequate access to care should be implemented.		

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); 7/29/16
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[7], 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:	Please see commentary III. A. 2. b.		
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:	Please see commentary III.A. 2. b.		

[7] 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, 7/29/16	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. It was reviewed by all monitors and the approved in its final form on August 4, 2016.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Interdisciplinary Treatment Team policy has been finalized.		
Monitor's Recommendations:	1. It is recommended that all medical, mental health and custody staff be trained to the policy and that the provisions of Appendix A be reviewed. 2. Training should include a pre and post test to assess that each participant understand the make up of the risk profile and be able to identify and refer at-risk inmates to the interdisciplinary treatment team.		

Paragraph Author: Stern	III. A. 2. e. An inmate assessed with chronic disease shall [be] seen by a practitioner as soon as possible but no later than 24-hours after admission as a part of the Initial Health Assessment, when clinically indicated. At that time medication and appropriate labs, as determined by the practitioner, shall be ordered. The inmate will then be enrolled in the chronic care program, including scheduling of an initial chronic disease clinic visit.		
Medical Care Compliance Status:	Compliance: 7/29/16	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • 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 (II.I.A.2.e); (2) the need for patients to receive an Initial Health Assessment by a practitioner within 24 hours if clinically indicated during intake screening (III.A.2.f.); 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 (III.A.4..b(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):	See III. A. 2. a.		
Monitor's Recommendations:	See III. A. 2. a.		

Paragraph Author: Stern and Ruiz	III. A. 2. f. (Covered in III.A.1.a.) and (III.A.2.e.) All new admissions will receive an intake screening and mental health screening and evaluation upon arrival. If clinically indicated, the inmate will be referred as soon as possible, but no longer than 24-hours, to be seen by a practitioner as a part of the Initial Health Assessment. At that time, medication and appropriate labs as determined by the practitioner are ordered.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Medical Care: • (duplicate III.A.1.a.) Audit Step b: (Chart Review) Intakes conducted as soon as possible upon admission, no later than 24 hours • (duplicate III.A.2.e.) 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 (II.IA.2.e.); (2) the need for patients to receive an Initial Health Assessment by a practitioner within 24 hours if clinically indicated during intake screening (III.A.2.f.); 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 (III.A.4.b.(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: N/A 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: This provision covers element of Intake Screening and Health Assessment. The County does not yet conduct Health Assessments (see III. A. 2. a). With regard to Intake Screening, the County has made improvements, and some Intake Screenings are done well, but some problems remain, as described in III. A. 1. a., III. A. 1. E. and III. A. 1. f. Mental Health Care: Of the sample of records and data reviewed, a significant portion (greater than 20%) were seen outside of 24 hours by a provider. Of these, many did not have their medications started in a timely manner. Consent III. A. 1. a. also speaks to this		

	issue.
Monitor's Recommendations:	Medical Care: N/A Mental Health Care: 1. Please implement consistent assessment of psychiatric patients within 24 hours. This may require review and adjustment of the current screening process.

Paragraph Author: Stern and Ruiz	III. A. 2. g. All individuals performing health assessments shall receive comprehensive training concerning the policies, procedures, and practices for medical and mental health assessments and referrals.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16
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: The County is in the final stages of developing this policy. 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: The relevant policies, training curricula, and training have not yet been completed. Mental Health Care: None.		
Monitor's Recommendations:	Medical Care: None Mental Health Care: None.		

3. Access to Medical and Mental Health Care

Paragraph Author: Stern and Ruiz	III. A. 3. a. (1) The sick call process shall include… written medical and mental health care slips available in English, Spanish, and Creole.		
Medical Care: Compliance Status:	Compliance: 7/13; 10/14; 7/29/16	Partial Compliance:	Non-Compliance: 3/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance: 3/14; 10/14; 7/29/16	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) The sick call process shall include…opportunity for illiterate inmates and inmates who have physical or cognitive disabilities to confidentially access medical and mental health care.		
Medical Care: Compliance Status:	Compliance: 10/14; 7/29/16	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); 7/29/16
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: Preliminary review indicates that medical leadership requested County policy on the Americans with Disabilities Act.		
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: NA		
Monitors' Recommendations:	Medical Care: N/A Mental Health Care: Mental and medical providers should provide an advocate for all patients with cognitive or other disabilities that preclude or otherwise impair their ability to adequately access medical and mental health care. This may include inmates with pervasive developmental conditions or other disorders of cognition.		

Paragraph Author: Stern and Ruiz	III. A. 3. a. (3) The sick call process shall include…a confidential collection method in which designated members of the Qualified Medical and Qualified Mental Health staff collects the request slips every day;		
Medical Care: Compliance Status:	Compliance: 10/14; 7/29/16	Partial Compliance: 7/13	Non-Compliance:3/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance: 10/14; 7/29/16	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) The sick call process shall include…an effective system for screening and prioritizing medical and mental health requests within 24 hours of submission and priority review for inmate grievances identified as emergency medical or mental health care.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16	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> CHS now has a staff member assigned to indexing and monitoring medical grievances, so longitudinal data are being collected. <u>Mental Health Care:</u> I was informed by the Associate Director of MH that none of the grievances required upper level mental health review.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care:</u> SCR are usually triaged by RNs within 24 hours. However, the outcome of the triage is almost invariably a visit with a nurse. In many of these cases it is clear from the SCR that the problem is one which would more appropriately be handled by someone else (e.g. dentist, social worker, psychiatric practitioner, medical practitioner). While triage to a nurse would not, in and of itself be dangerous, given that there are delays between triage and nurse visit, and between nurse visit and definitive care visit, triage to a nurse introduces a delay in access to care. The County does not have a grievance type called "emergency medical grievances." Instead, all health-related grievances are automatically designated as emergency. While this is not harmful, it may divert staff resources to deal with problems that are not emergencies. On the other hand, the time frame for addressing emergency grievances is set at 7 days. If, in fact, a patient had a *bona fide* emergency, the 7 day time frame is too long. 3 out of 3 medical grievances the Medical Monitor reviewed with County staff, had between a 3 and 11 day delay between the patient-generated date of submission and the date of receipt by the County. If this delay is real, it is		

	unacceptably long, especially for true emergency grievances. However, as with other forms submitted, it is possible that patients have written the wrong date. Mental Health Care: I was informed by the Associate Director of Mental Health that none of the grievances required psychiatric review. Upon review of the grievances, eight of the grievances were related to mental health care. 12.5% were substantiated.
Monitors' Recommendations:	Medical Care: 1. The County needs to shorten the gap between a request for care and delivery of *definitive* care. Triaging to the person who can deliver that definitive care would help accomplish that goal. However, there are other models of care which can accomplish the same outcome, but with fewer steps (please see Model of Care in the introduction to this section of the report). 2. Emergency grievances must be addressed *as soon as they are received*. While the current assignment of all health grievances to the "emergency" category is not harmful, it may not be the best use of CHS staff resources. Thus the Medical Monitor suggests that the County consider creating 2 categories of health related grievances: routine and emergency, allowing the patient to chose the appropriate category. 3. The County needs to determine the source of the apparent delay between submission and receipt of medical grievances. A real delay (i.e. due to County error) is unacceptable, so if the County determines that the delay is real, it needs to eliminate it. If the delay is only an apparent one (i.e. due to patient error), it would also behoove the County to find a way to eliminate the error, or, at a minimum, memorialize its investigation, data, and analysis that demonstrates that the delay is only an apparent delay. Mental Health Care: Grievances as they relate to mental health care are being collected and reviewed. They are few and far between. This is worrisome. They are being reviewed and managed by the Chief Social Worker even though I was informed that they primarily deal with concerns of access to psychotropic medication. This may also be cause for concern, as well. The content of the grievances was not provided to the Monitors, nor were an analysis of the trends or issues related to common themes of the grievances. It is noteworthy that with a mental health caseload of over 2,000 patients, mental health grievances should be more than eight in number (the ones the mental health Monitor was provided to review) and should represent intake as well as other levels of care, including Levels I-IV and detox.

Paragraph Author: Stern and Ruiz	III. A. 3. b. CHS shall continue to ensure all medical and mental health care staff are adequately trained to identify inmates in need of acute or chronic care, and medical and mental health care staff shall provide treatment or referrals for such inmates.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 7/29/16	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); **7/29/16**
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: The Medical Monitor discovered two unsafe conditions that are not covered by any other provision of the CA, and are therefore addressed here. 1. Clinical encounters are conducted with insufficient confidentiality. This was observed during nurse encounters, but given the similarity in clinic layout for nurses and practitioners, it likely occurs during practitioner encounters as well. Encounters are conducted with the exam door open, other patients waiting in the hallway near the door, and often the patient being evaluated sitting near the door, sometimes only a few short feet from the other patients. Thus auditory privacy is not provided. Officers can also hear conversations even when a) there is not a need to know and b) there is a high enough security risk to overshadow the need for privacy. When situated next to the patients in the hallway, the Medical Monitor was able to hear confidential exchanges in exam rooms. And whether or not all the confidential exchanges can *actually* be heard, patients with whom the Medical Monitor spoke *thought* their conversations might be overheard, which can also be dangerous (because it may inhibit patient frankness). 2. Medical care (as opposed to MH care) on the MH inpatient units is problematic. Nurses on some of those units view the patient's medical problems as something beyond their ken and responsibility. For example, one nurse was unaware whether or not their patient had diabetes. For another patient, nurses failed to ensure that an x-ray was performed as ordered to rule a fracture (until it was pointed out by one of the Monitors). Mental Health Care:		

	N/A
Monitors' Recommendations:	Medical Care: 1. Patients must be provided with auditory (and visual) privacy during clinical encounters. Such privacy should always be provided vis-à-vis other inmates. It is recognized that, at times in a jail setting, such privacy cannot be provided vis-a--vis custody staff. However, on those occasions, breaching of privacy should be based on a patient-specific need-to-know, or need-to-be-present. 2. The total nursing needs of patients in specialized MH units must be addressed; nursing care cannot be limited to needs related to MH. Mental Health Care: N/A

4. Medication Administration and Management

Paragraph Author: Stern and Ruiz	III. A. 4. a. CHS shall develop and implement policies and procedures to ensure the accurate administration of medication and maintenance of medication records.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 7/29/16	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; 7/29/16	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 • 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: None.		

Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: There are a number of problems with the administration of medications and its documentation. 1. There are gaps in continuity of medication administration when patients transfer between facilities. 2. Some nurses pre-pour medications in a manner that is unsafe and may not be consistent with local regulations. Pre-pouring is the removal of patient specific medications from an appropriately labeled multi-dose source (e.g. bottle or bubble card) and placed in another container. 3. In some living units, pill line is conducted in under unsafe conditions. Those conditions are distractions, noise, and other simultaneous unit activities, all of which can break the nurse's concentration during a high-complexity high-risk activity. 4. Nurses (LPNs) fail to provide ordered medications, often with the explanation that the patient "no-showed" or "refused." This is a dangerous practice (see Refusals of Care and No-Shows in the introduction to this section of the report). Mental Health Care:
Monitors' Recommendations:	Medical Care: 1. There needs to be seamless provision of medications, uninterrupted by transfer from one facility to another. 2. Pre-pouring of medications should be limited to those situations in which it is absolutely necessary, e.g. delivery of medications to patients in an upper tier of a living unit. In those circumstances it should be done in a manner that is safe and compliant with local Board of Pharmacy regulations. 3. Pill line should be scheduled for each living unit in such a way that it is the exclusive planned activity for that time period. 4. All scheduled doses of medications must be administered, absent a legitimate reason (see Refusals of Care and No-Shows in the introduction to this section of the report). No-shows should not be accepted. All refusals must begin with a face-to-face encounter with a licensed health care professional (and not via second hand information from custody staff). Further action may be warranted based on medication-specific policies that the County needs to develop (e.g. "at the conclusion of pill line, the LPN will notify the RN of any patient who refuses a single dose of insulin, antibiotic, etc.") With regard to Recommendations 3 and 4 above, MDCR already has two living units (there may be others) in which pill line is conducted in a quiet controlled manner, and in which no-shows and refusals are rare. These living units (3D at MW, CO A. Gonzales; 6-3 at TGK, CO I. Etefia) provide excellent models for replications throughout MDCR. 5. Please see Refusals of Care and No-Shows in the introduction to this section of the report for more discussion on recommendations. 6. The Medical Monitor is removing the specific grievance rate cited in Audit Step h. Instead, it is recommended that the County continue to monitor this metric and work towards its decline. At such time as other indicators of the effectiveness

	of the medication delivery system are at a desirable level, the County should consider the then-current grievance rate as a good target value. Subsequent rises in the level will then be a valuable "early warning system" of any new problems in medication delivery. <u>Mental Health Care:</u> <u>Specific to mental health care, a closely related policy is the following:</u> *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.* Given the large mental health caseload, if it is viewed as unreasonably onerous to provide notice to the psychiatrists that the inmate(s) have not taken his or her medication for more than 24 hours, the County may seek to amend this provision formally. Examples used in other jurisdictions include refusals of three consecutive dosages of medications or refusals of greater than 50% of the psychotropic medication in one week period of time leading to notification of the psychiatrist and subsequent one on one contact.

Paragraph Author: Stern and Ruiz	III. A. 4. b. (1) Within eight months of the Effective Date…Upon an inmate's entry to the Jail, a Qualified Medical or Mental Health Professional shall decide and document the clinical justification to continue, discontinue, or change an inmate's reported medication for serious medical or mental health needs, and the inmate shall receive the first dose of any prescribed medication within 24 hours of entering the Jail;		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13 (Not yet due); 7/29/16	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); 7/29/16
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: None. It is not apparent that mental health is routinely tracking or monitoring medication adherence for patient care, risk management or quality assurance purposes.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: As noted elsewhere, patients do not always get needed medications upon admission. For example, a patient with hemophilia did not get her medication for weeks after arrival; a patient with hypertension was not referred to a practitioner to begin medications. Mental Health Care: As alluded to above, intake mental health grievances indicate that patients are not receiving necessary psychotropic and medications to manage their psychiatric symptoms or withdrawal in a timely manner.		
Monitor's Recommendations:	Medical Care: The County must ensure that patients continue to receive medically necessary medications upon admission without gap.		

	Mental Health Care: Implement systems for timely assessment and dispensation of patient medications at intake.

Paragraph Author: Stern and Ruiz	III. A. 4. b. (2) Within eight months of the Effective Date… A medical doctor or psychiatrist shall evaluate, in person, inmates with serious medical or mental health needs, within 48 hours of entry to the Jail.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13 (Not yet due)	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16
Measures of Compliance:	Medical Care: • (duplicate 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 ((IIIA2e); (2) the need for patients to receive an Initial Health Assessment by a practitioner within 24 hours if clinically indicated during intake screening (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 (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. A..2e.		
Steps taken by the County to Implement this paragraph:	Medical Care: See III. A. 2. a. In its response to a draft of this report, the County asked that the rating for this provision be changed from Non-Compliance to Compliance, based on the fact that "Steps taken by the County to Implement this Paragraph:"; "Monitor's analysis of conditions to assess compliance, including documents reviewed individuals interviewed, certification of the County's representations, and the factual basis for findings (s):"; and "Monitor's Recommendation:" sections, the Medical Care and Mental Health Care section refer to Section III.A.2.e [sic]. In this referenced section, the Medical Care Compliance Monitor found CHS in Full Compliance, as such the current section should follow suit." In fact, the Medical Monitor makes reference to Section III.A.2.*a* (CONSENT008), for which a rating of Non-Compliance was assigned, not Section III.A.2.e (CONSENT012). Thus the ratings are internally consistent and remain unchanged in the final report. Mental Health Care: See III.A.2.e.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: See III. A. 2. a. Mental Health Care: See III.A.2.e .		
Monitor's Recommendations:	Medical Care:		

	See III. A. 2. a. <u>Mental Health Care:</u> See III.A.2.e.

Paragraph Author: Ruiz	III. A. 4. c. Medication Administration and Management Psychiatrists shall conduct reviews of the use of psychotropic medications to ensure that each inmate's prescribed regimen is appropriate and effective for his or her condition. These reviews should occur on a regular basis, according to how often the Level of Care requires the psychiatrist to see the inmate. CHS shall document this review in the inmate's unified medical and mental health record.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16
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); 7/29/16
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:	Please see commentary under III. A. 4. a.		

Paragraph Author: Stern and Ruiz	III. A. 4. e. CHS shall implement physician orders for medication and laboratory tests within three days of the order, unless the inmate is an "emergency referral," which requires immediately implementing orders. [NB: Lab tests in this measure are only those related to medications. Email DOJ 8/27/13]		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16	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); **7/29/16**
Measures of Compliance:	Medical Care: • Audit Step a: (Chart Review) Patients will receive their first dose of non-emergent medications within 3 days of the order. • Audit Step b: (Chart Review) Patients will receive their first dose of emergent medications immediately. • Audit Step c: (Chart Review) Laboratory tests not marked as urgent will be drawn within 3 days. [NB: Lab tests in this measure are only those related to medications.] • Audit Step d: (Chart Review) Laboratory tests marked as urgent will be drawn immediately. [NB: Lab tests in this measure are only those related to medications.] Mental Health Care, as above and: 1. Policy regarding physician orders, laboratories and reporting 2. Review of medical and mental health records 3. Review of reports by psychiatrist regarding emergent or abnormal results 4. Review of response by psychiatrist to abnormal lab results		
Steps taken by the County to Implement this paragraph:	Medical Care: 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: Ordered medications are not always delivered within 3 days. Elsewhere in this report, we describe a patient for whom a medication for hemophilia was not ordered upon intake. Later in her stay, when the error was discovered and the medication finally ordered, it still took weeks for the medication to be delivered. Another patient we met in clinic was told he would receive Remeron. It was ordered on 7/18/16, but as of 7/28 we could still not find it on his MAR. Mental Health Care: Insufficient information was provided for this provision for a comprehensive review. The provision is in non-compliance.		
Monitor's Recommendations:	Medical Care: Medications must be administered within 3 days of order (unless otherwise ordered). Mental Health Care: Timely dispensation of medications as ordered will prevent both recidivism and emergent hospitalization.		

Paragraph Author: Stern and Ruiz	III. A. 4. f. (Covered in 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: 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16	Non-Compliance: 7/13 (NR); 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • (duplicate III.A.4.a.) 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 III.A.4.a.) Audit Step j: (Inspection) An effective curriculum is used during training that addresses qualifications of trainers, curriculum, assessment of competency. • (duplicate III.A.4.a.) 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: Please see comments in III. A. 4. 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. 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; 7/29/16	Non-Compliance: 3/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14; 10/14; 7/29/16	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: The County continues to make improvements to the EHR and is in the process of integrating the medication module with the rest of the EHR (Cerner). Mental Health Care: The County has implemented an electronic health record.		
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: Problems with documentation arise from two sources: software design and users. Many of the user-related problems are discussed elsewhere in this report, e.g. failure of pill line nurses to appropriately document medication refusals. Despite continuing improvement of the EHR, the change has been too slow and significant problems persist, almost all of which have the potential of harming patients. Unresolved problems described in previous reports are included here by reference. The following are examples of just some of the persisting problems with the EHR. A section of the EHR shows a patient's current medications. For one patient, this included two antibiotics (Bactrim, Ciprofloxacin). However according to Sapphire (the pharmacy module) these medications had expired months earlier. Had a physician relied upon the patient's medical record (as represented in the EHR) as being correct, the physician		

would have erroneously ordered the patient to take these two antibiotics, which would have needlessly exposed the patient to risks.

The Medical Monitor found the following documentation errors, all in one patient's EHR:
-An SCR of 6/28/15, resolved on 6/30, was scanned and filed in the EHR 3 times: 6/30, 7/5, and 7/10.
-An SCR of 7/12/15, resolved on 7/20, was scanned and filed in the EHR twice on 7/20.
-A refusal of 8/11/15 was scanned and filed in the EHR twice on 8/11, but labeled two different ways ("Refusal" and "SC").
-Single page documents with one-sided text are scanned as two pages.
-All scanned documents reflect the wrong time.
-An order sheet signed on 10/28/15 was filed in the EHR on 10/26, two days before it existed.
-A nurse progress note on 10/26/15 states "Refused sick call see form" but no such form appears on 10/26 (or later).

The Medical Monitor found the following documentation errors, all in another patient's EHR:
A relocation form created on 1/13/16 was filed:
-3 times on 1/13/16 as "Scanned other documents";
-1 time on 1/21/16 as "Consultation Note – Generic";
-1 time on 1/21/16 as "Non-CPOE – "PO0010";
-1 time on 1/26/16 as "CHS Refusal of Treatment";
(and all at the wrong time).
-An SCR of 1/3/16 was filed on 1/3, 1/4, and 1/7.
-An SCR of 1/10/16 was filed on 12/24/16 and 12/26/15, weeks before it existed.

A patient fell on 6/11/16. He was evaluated by a practitioner for this fall on 6/17, complaining of pain to his neck, back, and knee. The practitioner's note contains documentation of the patient's history and physical examination in two different fonts, one with "sentence structure capitalization," the other all caps. It is clear that the former was boiler plate template text, whereas the latter was free-text generated contemporaneously generated by the practitioner. The apparent template text is highly detailed about organ systems that bear no reasonable relationship to the purpose of the visit, such as:

"Tympanic membranes are clear, Normal hearing, oral mucosa is moist. No pharyngeal erythema."
"No carotid bruit, No jugular venous distention, No lymphadopathy, No thyromegaly. "
"No lymphadenopathyneck, axilla, groin."
"Lungs are clear to auscultation, Respirations are non-labored, breath sounds are equal, Symmetrical chest wall expansion."
"Cardiovascular: Normal rate, regular rhythm, No murmur, No gallop."

Thus it is possible, but highly unlikely, that the practitioner actually performed all the evaluations documented. In other words it is questionable whether the documentation is true.

<u>Mental Health Care:</u>
While the County has implemented an electronic medical record, issues remain with the system. Three primary issues which impact patient care are the following:

1) Patients are not admitted or discharged from the record. As a result, clinical orders remain outstanding and in

	the queue. Specifically, data received indicated that 33,658 orders remained in the queue as of 6/30/2016. 2) Because patients are not directly admitted or discharged from the record, they are also exceedingly difficult to find in the record. As a result, the staff has created a number of excel-based work-arounds to track patients and to attempt to locate records for them in the system. 3) The medication administration record does not 'marry' with the system. As a result, clinicians can not track what the patient is taking and not taking. This information is imperative for providing timely and adequate patient care, particularly in a jail and acute mental health settings.
Monitors' Recommendations:	<u>Medical Care:</u> All the problems described in the current report, as well as unresolved ones from previous reports, need to be addressed. In addressing at least some of these problems, the County should balance the benefits of asking health care staff to enter codified (vs. free text) information in the EHR vs. the costs in terms of slower work flow and shift of the clinician's attention during an encounter from the patient to the computer screen. The Medical Monitor observed numerous nurses spending inordinate amounts of time searching drop down lists to click on history and physical findings. During that time they had little interaction with the patient. If there is a management need to be able to determine the number of patients who have had left (as opposed to right) maxillary sinus pain, for example, codified data is valuable. Otherwise, it adds work with no corresponding benefit. Further, as noted in a previous report, these codified nurse encounter notes appear in a separate location from other progress notes in a difficult to access format, making it difficult for others to quickly and accurately understand what previous care the patient received. Thus consideration should be given to encouraging nurse and practitioner providers to enter as much information in free text and in easily accessible progress notes. <u>Mental Health Care:</u> Please update the electronic health record to address the medication administration record and order entry system.

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; 7/29/16	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 provided information regarding clinician productivity. It did not provide analysis regarding wait times for clinics or a review of the scheduling system. It did not provide analysis regarding mental health grievances.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	There needs to be an analysis of mental health scheduling for clinics (see recommendation below).		
Monitor's Recommendations:	Please provide an analysis of mental health scheduling for clinics, wait times for clinicians, and an assessment of utilization of resources. For example, is there an assessment of whether Use of Force vis-à-vis the Mental Health Population has been addressed and whether staff have been adequately allocated to provide treatment to these patients? If so, please submit with the next round of documents for February 2017.		

Paragraph Author: Stern and Ruiz	III. A. 5. c. (Covered in III.A.5.a.) CHS shall document all clinical encounters in the inmates' health records, including intake health screening, intake health assessments, and reviews of inmates.		
Medical Care Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 7/29/16	Non-Compliance: 3/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14; 10/14; 7/29/16	Non-Compliance: 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • (duplicate 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 IIIA5a) Audit Step b: (Chart Review) Electronic medical record are adequate. This would include, among others, the provisions of NCCHC J-H-01 and J-H-04. Mental Health Care: 1. Review of policy and procedure related to documentation 2. Review of medical record 3. Review of EHR, once implemented		
Steps taken by the County to Implement this paragraph:	Medical Care: See III.A.5.a.) Mental Health Care: See III.A.5.a.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: See III.A.5.a. Mental Health Care: See III.A.5.a.		
Monitors' Recommendations:	Medical Care: See III.A.5.a.) Mental Health Care: See III.A.5.a.		

Paragraph Author: Stern and Ruiz	III. A. 5. d. CHS shall submit medical and mental health information to outside providers when inmates are sent out of the Jail for health care. CHS shall obtain records of care, reports, and diagnostic tests received during outside appointments and timely implement specialist recommendations (or a physician should properly document appropriate clinical reasons for non-implementation).		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 5/15 (NR); 1/16 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14; 10/14; 7/29/16	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. <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 conditions to assess	<u>Medical Care:</u> 1. The County still does not have a process in place to assure that external referrals are tracked, and delays are reported		

compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	to appropriate personnel as alerts. 2. When patients return from outside visits, including specialist appointments, ER trips, and hospitalizations, practitioners are not routinely notified. We found this in 4 of 5 cases reviewed. In one case, the patient was sent to the ER for evaluation of a serious infection. The ER physician recommended that the patient be started on antibiotics. However, no practitioner was notified upon the patient's return, and thus the antibiotics were not ordered until the following morning when the patient was seen in clinic. 3. The recommendations of outside physicians are not always followed (and without explanation). A patient returned to MDCR after a hospitalization for a complicated alcohol withdrawal. Upon discharge, hospital doctors recommended that the patient be given a walker to assist with unsteady walking. The walker was not ordered. The patient became dizzy and fell. 4. Patients are not always sent to outside hospitals with sufficient clinical information. A patient was sent to a non-JMH ER without any transfer information. <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> The County needs to ensure that patient care is seamless between MDCR and outside venues by making sure that appointments occur as ordered, that adequate information is sent with the patient, and that upon return, recommendations are shared with, and acted upon by, practitioners in a timely manner. Depending on the success of policy changes, training, and EHR re-design to assure that these things happen, the County may want to consider vesting coordinating function within designated people or positions. For example it may be helpful to have a hospital discharge coordinating nurse. It may also be helpful for the physician and nurse sending a patient to the ER to give verbal report to their counterparts at the ER, and then set an expectation for a reciprocal communication at the time of discharge from the ER. <u>Mental Health Care:</u> N/A

6. Discharge Planning

Paragraph Author: Stern and Ruiz	III. A. 6. a. (1) CHS shall provide discharge/transfer planning…Arranging referrals for inmates with chronic medical health problems or serious mental illness. All referrals will be made to Jackson Memorial Hospital where each inmate/patient has an open medical record.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 1/16; 10/14; 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 1/16; 7/29/16	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. 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: Mental Health Care: The County hired a discharge planner and is in the process of updating its policy for Discharge Planning, CHS-049. The relevant policy has not been finalized.		
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: County records show that many patients did not receive discharge planning. Custody does notify CHS of planned releases, however, the Medical Monitor was unable to determine from the documents provided whether this notification occurs within the prescribed time period. The relevant policy has not yet been finalized. 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 places the onus on the patient to request medication upon release.		
Monitor's Recommendations:	Medical Care None Mental Health Care: 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 for patients with SMI as clinically appropriate.

Paragraph Author: Stern and Ruiz	III. A. 6. a. (2) Providing a bridge supply of medications of up to 7 days to inmates upon release until inmates can reasonably arrange for continuity of care in the community or until they receive initial dosages at transfer facilities. Upon intake admission, all inmates will be informed in writing and in the inmate handbook they may request bridge medications and community referral upon release.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 5/15 (NR); 1/16
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 1/16; 7/29/16	Non-Compliance 3/14; 5/15 (NR)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Releasing patients receive an adequate bridge supply of medications (up to 7 days-worth). • Audit Step b: (Inspection) The terms of this provision are incorporated in policy. Mental Health Care, as above and: 1. Policy regarding discharge planning 2. Referrals for inmates with chronic medical health problems or serious mental illness. 3. Providing a bridge supply of medications of up to 7 days to inmates upon release 4. Provision of an inmate handbook at admission indicating they may request bridge medications and community referral upon release.		
Steps taken by the County to Implement this paragraph:	Medical Care: N/A Mental Health Care: Please see III. A. 6. A. 1.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: County records show that many patients did not receive planned discharge medications. Mental Health Care: Please see III. A. 6. A. 1.		
Monitor's Recommendations:	Medical Care: None Mental Health Care: Compliance will include providing discharge resources and bridge medications to a representative sample (greater than 5%) of the mental health caseload.		

Paragraph Author: Stern and Ruiz	III. A. 6. a. (3) Adequate discharge planning is contingent on timely notification by custody for those inmates with planned released dates. For those inmates released by court or bail with no opportunity for CHS to discuss discharge planning, bridge medication and referral assistance will be provided to those released inmates who request assistance within 24-hours of release. Information will be available in the handbook and intake admission awareness paper. CHS will follow released inmates with seriously critical illness or communicable diseases within seven days of release by notification to last previous address.		
Medical Care: Compliance Status:	Compliance: 1/16	Partial Compliance: 10/14; 7/29/16	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; 7/29/16	Non-Compliance: 3/14; 5/15 (NR)
Measures of Compliance:	<u>Medical Care:</u> • Audit Step a: (Inspection) The Inmate Handbook and Intake Awareness Paper inform patients that they may request bridge medications and community referral within 24 hours after release. • Audit Step b: (Chart Review) Patients with serious illness or communicable diseases not addressed during incarceration will be contacted at their last known address by CHS within 7 days of release. • Audit Step c: (Inspection) The terms of this provision are incorporated in policy. • 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. <u>Mental Health Care, as above and:</u> 1. Policy regarding discharge planning 2. Evidence of referrals for inmates with chronic medical health problems or serious mental illness. 3. Evidence of providing a bridge supply of medications of up to 7 days to inmates upon release 4. Provision of an inmate handbook at admission indicating they may request bridge medications and community referral upon release.		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> <u>N/A</u> <u>Mental Health Care:</u> Please see III. A. 6. A. 1.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care:</u> The County provided a copy of the Inmate Handbook, supporting one of the requirements of this provision. No other applicable data was provided. A recommendation in our last report was: "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." The County did not provide evidence of such a software solution. <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:	Medical Care: None Mental Health Care: 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. 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; 7/29/16	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Compliance Status:	Compliance:	Partial Compliance: 3/14; 7/29/16	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> N/A <u>Mental Health Care:</u> The County did not provide the Mental Health Monitor the case file for the death which occurred for timely review prior to the on site tour. The Morbidity and Mortality Review policy is under revision.		

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 only one death during this review period, and based on the timing of the death, only a 10 day review was due prior to our visit. That review was successful in identifying many system deficiencies. However, it missed one major problem associated with LPNs accepting refusals from the patient. The County is working on its Mortality and Morbidity Review policy. 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 in a timely manner. 2. Data requested prior to the on-site tour was not provided with adequate analysis or identification of trends. 3. Opportunities for improvement were seldom identified or documented, stating instead that clinical care was adequate.
Monitors' Recommendations:	Medical Care: In the opinion of the Medical Monitor, the County should develop a single comprehensive Mortality and Morbidity policy which encompasses all aspects of quality improvement: *preventing* mortality, morbidity, and near misses of morbidity; *detecting* morbidity and near misses of morbidity (it is presumed that no procedure is required to detect mortality); *analyzing* these events (through such processes as RCA); and *repairing* any system problems detected. Mental Health Care: 1. Please provide reviews, analysis and case notifications 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 and other pertinent information. This has been a repeated issue with respect to mental health patients and appropriate triage. 4. Medication errors should be properly addressed with nursing, pharmacy, psychiatry and other stakeholders.

Paragraph Author: Stern and Ruiz	III. A. 7. b. Defendants shall address any problems identified during mortality reviews through training, policy revision, and any other developed measures within 90 days of each death or serious suicide attempt.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16	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; 7/29/16
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) The fixes developed as part of the corrective action plan following a medical death (see III.A.7.a.) will be implemented within 90 day of the event. Mental Health Care: 1. Review mortality reviews and corrective action plans for each inmate's death 2. Review of comprehensive morbidity review and corrective action plan for all serious suicide attempts or other incidents in which an inmate was at high risk for death. 3. Within 90 days of each death or serious suicide attempt, provide evidence of implementation of plans to address issues identified in mortality reviews		
Steps taken by the County to Implement this paragraph:	Medical Care: See Comments in III.A.7.a. Mental Health Care: The County provided mortality and morbidity reviews. The policy for mortality review is in the process of being updated.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: See Comments in III.A.7.a. Mental Health Care: See Comments in III. A. 7. a.		
Monitors' Recommendations:	Medical Care: See Comments in III.A.7.a. Mental Health Care: 1. Provide specific, concrete action items for corrective action with measurable goals.		

Paragraph Author: Stern and Ruiz	III. A. 7. c. Defendants will review mortality and morbidity reports and corrective action plans bi-annually. Defendants shall implement recommendations regarding the risk management system or other necessary changes in policy based on this review. Defendants will document the review and corrective action and provide it to the Monitor.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16	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; 7/29/16.
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Records reflect that bi-annually MDCR reviews and monitors the progress it's making in response to system changes made as a result of the mortality and morbidity [suicide attempt] reports generated under IIIA7b and IIIA7a and is making additional system changes/adjustments as needed. Mental Health Care: 1. Review minutes of morbidity and mortality reviews biannually 2. Review evidence of risk management system 3. Review corrective action plan for each serious suicide attempt or inmate death		
Steps taken by the County to Implement this paragraph:	Medical Care The County did not produce a bi-annual report, per se. However, it conducts monthly reviews of mortality and morbidity. Mental Health Care: 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):	Medical Care: The bi-annual reporting requirement is exceeded by the monthly reviews. On the other hand, the quality of these monthly reviews fall very short of the intent of this provision. For example, the monthly reviews focus more on current events and do not adequately capture the status of system changes related to previous events. The reviews suffer from the lack of a comprehensive Mortality and Morbidity Detection and Prevention quality improvement policy, which would guide the conduct of periodic reviews. As discussed elsewhere, roles of these meetings would include: collecting information about deaths, morbidities, and near misses, analyzing the events, prioritizing system changes driven by these events, monitoring progress on these system changes, and assuring that there are processes in place to monitor the new systems going forward. See additional comments in III.A.7.a. (CONSENT034) and in the section on Quality Improvement in the introduction to this section of the report. Mental Health Care: Morbidity and Mortality reviews, Corrective Action Plans, and Quality Improvement are opportunities to improve your collaborative system and make it work. They work best if they are not utilized as forums for finger pointing. As medical professionals, it is at our core to care for patients. Therefore, looking at our mistakes becomes even harder than it would otherwise be. Yet, if we remember that all outcomes, even negative ones, are typically a systems issue, perhaps		

	the process will be more productive.
Monitors' Recommendations:	Medical Care: The County needs a comprehensive Mortality and Morbidity Detection and Prevention policy incorporating elements discussed in this provision, related provisions, and the section on Quality Improvement in the introduction to this section of the report. Mental Health Care: 1. Corrective action plans benefit from actionable items and routine follow-up. This applies to suicide reviews, as well. 2. Quality Improvement Committee is encouraged to focus on not only the data, but why? How did we get here? Where do we want to go?

B. MEDICAL CARE

1. Acute Care and Detoxification

Paragraph Author: Stern	III. B. 1. a. CHS shall ensure that inmates' acute health needs are identified to provide adequate and timely acute medical care.		
Compliance Status:	Compliance:	Partial Compliance: 7/29/16	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 low • 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 and lab tests, which are 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 III.A.3.a.(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):	This is one of the most far-reaching provisions of the CA, touching on key parts of the acute health care delivery system. Acute care includes emergency care, urgent care, and non-urgent episodic care. There is good evidence that access to urgent care has improved and is working well. Patients in both general population and isolation cells report few to no barriers when trying to obtain urgent care via oral requests to COs. This is difficult to achieve and the degree to which this functions well at MDCR is laudable. Some progress has been made in the provision of emergency care. Under the leadership of the new Director of Nursing, the County obtained new rolling emergency response cabinets ("crash carts"). The emergency response medical team at TGK (based in the Booking area), seems to be well-versed in emergency response. However, we observed significant problems with other aspects of emergent and non-urgent episodic care. (The component of emergency response reliant on custody staff is discussed in a different provision: CONSENT068/IIIC3g.) Emergency Care 1. While the TGK Booking area staff are well-versed in the contents and use of the crash cart, this was not so at other locations we visited. Crash carts were missing equipment or had extra equipment. Supervisory staff were not familiar with the operation of certain equipment. Supplies were not where they were supposed to be within the cart. The inventory system was not uniform across facilities. Any of these can result in delays during emergency treatment or resuscitation. 2. A recent emergency response video revealed significant errors in the provision of emergency care. The patient, who appeared to be unconscious, was moved from a lying position to a sitting position without knowledge of her blood pressure (if a patient's blood pressure is low and they are moved to a sitting position, this will further lower the blood pressure, which can be dangerous). Medical emergency responders performed cardiopulmonary resuscitation (CPR) without the pulmonary component, i.e. without providing rescue breathing, during a prolonged time at the beginning of the resuscitation. Non-Urgent Episodic Care 3. Patients typically communicate their need for non-urgent episodic care by submitting SCRs. All such requests require a subsequent face-to-face encounter to evaluate the patient. In one case we found, this did not happen, and instead the patient received "care by correspondence." The patient complained of cold symptoms. He was not examined; the nurse just ordered medications. While patients are often correct in their self-diagnoses, they are not licensed health care professionals, so when they seek our input it must be provided in a competent manner. In this case, the nurse did not have nearly enough information to make an accurate diagnosis. 4. Based on patient report – and verified on record review – there remain consistent and unacceptably long delays in addressing SCRs. We found delays as long as 10 days from the date of submission of the SCR until the patient was first seen. 5. The quality of care provided by nurses during evaluations for non-urgent episodic problems is at times inadequate. Some examples follow: -A nurse evaluating a patient for a new episodic problem, spent more time conducting a Review of Systems (a procedure that has relatively little value in the focused assessment of a simple complaint) than on the primary complaint itself. When the patient did provide a positive response to one of the Review of Systems questions (something that would then require further targeted questioning and, possibly, examination and testing), the nurse simply recorded the response and moved on. The patient, on MH Level 3, also mentioned problems sleeping at night due to "thinking a lot" which, for a patient on the mental health caseload, required further investigation.

	No further investigation was conducted. -A nurse evaluating and treating a patient for increasing pain following a dental extraction did not evaluate the patient for dry socket. -When nurses did examine patient abdomens, they did so incompletely (pressing lightly in one or two random locations) and with the patient in a seated position. -Some nurses did not know how to select the appropriate sized blood pressure cuff. -A nurse managed a patient with chest pain independently without input from, or immediate referral to, a practitioner. In addition, the management was clinically inadequate. For example, the nurse did not ascertain any cardiac related history or risk factors, did not obtain vital signs, and did not conduct an examination of the heart or lungs. 6. When patients are seen in follow-up of nurse visits by a practitioner, the care can be problematic. A practitioner saw such a patient for burning on urination on 12/17/15 and ordered a urinalysis and other tests to be done in 1 week (i.e. by 12/23). Instead, the tests were not done until 18 days later (1/4/16). The practitioner also ordered a follow-up examination to be done in 2 weeks (i.e. on 12/30). This visit did not take place until almost 5 weeks later (on 1/13/16). 7. When patients have acute problems after hours, practitioners sometime order EKGs. Because the ordering practitioner is not on the premises, the practitioners do not usually read the EKG themselves. Instead they rely on a computer-generated reading produced by the EKG machine. These computer-generated readings are subject to error. Therefore the life-and-death decisions that are made based on the EKGs should only be made after the EKG has been read by a practitioner. 8. LPNs are conducting clinical assessments, independently, which is beyond their scope of practice. A complaint letter received during the drafting of this report let to discovery of a post-fall evaluation done by an LPN who determined that the patient had no injury.
Monitor's Recommendations:	1. Most of the problems described above are too complex to lend themselves to simple recommendations. They require examination of the entire system of acute care, policies, and training, including examination of whether the current model of care (patients expressing their need for care via written messages; non-urgent episodic care delivered by nurses, etc.) is the most appropriate model (see Model of Care in the introduction to this section of this report). 2. There are simple ways to obtain rapid reading of EKGs by practitioners after hours, among them: faxing the EKG to the practitioner; obtaining a stat reading from a JMH staff member; asking the practitioner in the Intake area to review it. 3. The Medical Monitor is removing the specific grievance rate cited in Audit Step h. Instead, it is recommended that the County continue to monitor this metric and work towards its decline. At such time as other indicators of the effectiveness of access to urgent care are at a desirable level, the County should consider the then-current grievance rate as a good target value. Subsequent rises in the level will then be a valuable "early warning system" of any new problems in access to urgent care. 4. LPNs cannot be allowed to perform clinical assessments independently. The County should discontinue this practice immediately.

Paragraph Author: Stern	III. B. 1. b. (Covered in III.B.1.a.) CHS shall address serious medical needs of inmates immediately upon notification by the inmate or a member of the MDCR Jail facilities' staff or CHS staff, providing acute care for inmates with serious and life-threatening conditions by a Qualified Medical Professional.		
Compliance Status:	Compliance:	Partial Compliance: 7/29/16	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	• (duplicate III.A.3.a.(4) Audit Step b: (Inspection) Review of emergency medical grievances shows that they are handled immediately and appropriately. • (duplicate III.B.1.a.) 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 III.B.1.a.) 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 III.B.1.a.) 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 III.B.1.a.) 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 III.B.1.a.) Audit Step e: (Inspection) The number of grievances for barriers to urgent care is fewer than 3 per 1000 ADP/year. • (duplicate III.B.1.a.) 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 III.B.1.a.) 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):	See III. B. 1. a.
Monitor's Recommendations:	See III. B. 1. a.

Paragraph Author: Stern	III. B. 1. c. CHS shall sustain implementation of the Detoxification Unit and the Intoxication Withdrawal policy, adopted on July 2012, which requires, inter alia, County to provide treatment, housing, and medical supervision for inmates suffering from drug and alcohol withdrawal.		
Compliance Status:	Compliance:	Partial Compliance: 7/29/16	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):	Six charts of patients were reviewed who were undergoing detoxification (5 were chosen randomly, 1 was reviewed incidentally after the case was selected for review for a different reason). All charts contained some problem with care during detoxification. The least serious of these problems was that we were unable to ascertain the credential of the person performing many of the COWSs and CIWAs; sometimes the test results do not indicate the credential or even the name of the provider performing them. In two patients, some CIWAs and COWSs that were ordered were not done. One patient showed evidence of significant deterioration, but no action was taken to diagnose or treat this (he eventually became unresponsive and required emergency evacuation to the hospital). One patient had very high blood pressures for which inadequate arrangements were made for his care post-release from the detoxification unit. In another case, the admitting practitioner requested some lab tests (basic metabolic profile, comprehensive metabolic profile, urinalysis) upon admission on 5/13/16. However, these tests were not actually entered as orders until 5/20…3 days after the patient was released from jail.		
Monitor's Recommendations:	1. Most of the problems described above are too complex to lend themselves to simple recommendations. They require examination of the detoxification process, from intake, to admission, to intra-unit operation, to discharge into general population. 2. The problem with documentation of the identity and credential of the provider performing COWSs and CIWAs is more easily addressed and should be fixable with a software patch that creates and populates this information from information already available through the login process.		

2. Chronic Care

Paragraph Author: Stern	III. B. 2. a. CHS shall sustain implementation of the Corrections Health Service ("CHS") Policy J-G-01 (Chronic Disease Program), which requires, inter alia, that Qualified Medical Staff perform assessments of, and monitor, inmates' chronic illnesses, pursuant to written protocols.		
Compliance Status:	Compliance:	Partial Compliance: 7/29/16	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) 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		
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):	We identified many lapses in good, reliable chronic care. Some examples are contained elsewhere in this report (e.g. a patient who did not get follow-up care and medications for hemophilia; a patient who did not get their hypertension addressed in Intake). Some other examples follow: -A patient followed in chronic care clinic (CCC) was referred to the Nephrology Clinic for evaluation. This never happened. -A patient with hypertension was being followed in CCC. He had a CCC visit on 1/24/16. His blood pressure was 148/95 (which is high), but the practitioner concluded that his "bp [is] well controlled" and "will add HCTZ [a blood pressure medication] 25." This conclusion does not make sense because a) the patient's blood pressure was not well controlled, but b) if the practitioner though it were, there was no reason to add another blood pressure medication. Further, up to now the patient's blood pressure had been relatively well controlled, so this rise in pressure required inquiry into why it rose. For example, was the patient adherent to the medication regimen? This did not happen. The practitioner ordered the patient's blood pressure to be checked daily for 7 days. This was not done. During a CCC visit on 4/6/16, the practitioner's documentation included: "Heart exam: WNL [within normal limits], chest: WNL. kidney: WNL." This documentation regarding the heart and lung examination is inadequate for a patient with a heart-related disease – it lacks sufficient detail. This documentation regarding the kidney examination is meaningless. -A patient with a history of chronic kidney disease, GERD, hypertension, and coronary heart disease/MI, arrived on 1/24/16 with a history of being on clopidogrel, statin, amlodipine, ranitidine, temazepam, and lisinopril prior to admission. During his CCC visit of 2/29 the practitioner failed to note the history of kidney disease (he had last been seen in Nephrology clinic in 2014 and needed follow-up). The practitioner also failed to elicit any cardiac-related history or current symptoms, or evaluate why the patient was no longer taking aspirin. The patient's blood pressure in clinic that day was 181/116 (which is dangerously high), but it is not clear what, if any changes the practitioner made in the patient's care plan. The practitioner failed to repeat the patient's blood pressure measurement to confirm that it was dropping, and in fact, the blood pressure was not checked again until 3/4 at which time it was still elevated (though down to 155/85). This patient's blood pressure had required immediate and daily checks at the 2/29 CCC visit until it was stabilized.		

Monitor's Recommendations:	The County needs to make improvements to the quality of care provided for chronic illnesses. These efforts will likely be multi-factorial, including but not limited to: reviewing the process by which the County vets candidates for practitioner positions; monitoring the quality of care delivered during CCC; assuring that referrals to clinic occur without lapse; assuring that practitioner orders are carried out without lapse.

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

3. Use of Force Care

Paragraph Author: Stern and Ruiz	III. B. 3. a. The Jail shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15-minute in-person visual observation by trained custody. Qualified Medical Staff shall perform 15-minute checks on an inmate in restraints. For any custody-ordered restraints, Qualified Medical Staff shall be notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.		
Medical Care: Compliance Status:	Compliance: 7/29/16	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; 7/29/16
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: Mental health Monitor was informed by CHS that it has no current policy on the utilization of restraint with mental health inmates; the policy which was submitted, dated 2014, was labeled "draft." Another policy is under development.		
Monitor's analysis of conditions	Medical Care		

to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	There was one case involving use of restraints for clinical purposes. Care during this episode was appropriate. Mental Health Care: Policies with regard to Use of Force, Response to Resistance and inmates with special needs are discordant with respect to the Consent Agreement, generally accepted practices, and current operating procedure. The Mental Health Monitor received data from CHS staff that reflected that Emergency Treatment Orders are utilized an average of fifteen (15) times per month. Subsequent review of a random sample of records noted that these emergent treatment orders were not accompanied by a progress note in the majority of cases. I was informed that a new progress note has been designed to address this deficiency. With respect to Use of Force and Emergency Hospitalization, approximately 148 patients were sent for fractures,
Monitor's Recommendations:	Medical Care: None Mental Health Care: Please update mental health correctional restraint policy consistent with national guidelines.

Paragraph Author: Stern	III. B. 3. b. The Jail shall ensure that inmates receive adequate medical care immediately following a use of force.		
Compliance Status:	Compliance:	Partial Compliance: 7/29/16	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) for every Response to Resistance recorded by custody there is a clinical assessment immediately thereafter, documented in the EHR (Note: an Incident Addendum does NOT satisfy this requirement) b) 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 Medical Monitor reviewed 4 uses of force (RTRs). In all 4 cases there was a clinical assessment immediately thereafter. However, all 4 revealed problems with care and documentation. In 2, no clinical evaluation was documented. In the other 2, an evaluation was conducted (by an RN). However in both latter cases the nurse failed to indicate the nature of the force used. In the absence of this information, it is impossible for the examiner to perform an adequate clinical evaluation. In one of these two cases, at some point during the same day as the nurse's evaluation, the patient appeared at the JMH ER and was found to have a fractured finger. The patient's medical record fails to contain any information explaining clinical events leading to this appearance in the ER.		
Monitor's Recommendations:	1. Post use-of-force clinical evaluations must be conducted on all inmates. 2. The evaluation must document the nature (and time) of the force used, and the history and examination must be appropriate for that force.		

Paragraph Author: Stern	III. B. 3. c. Qualified Medical Staff shall question, outside the hearing of other inmates or correctional officers, each inmate who reports for medical care with an injury, regarding the cause of the injury. If a health care provider suspects staff-on-inmate abuse, in the course of the inmate's medical encounter, that health care provider shall immediately: 1) take all practical steps to preserve evidence of the injury (e.g., photograph the injury and any other physical evidence); 2) report the suspected abuse to the appropriate Jail administrator; and 3) complete a Health Services Incident Addendum describing the incident.		
Compliance Status:	Compliance:	Partial Compliance: 10/14	Non-Compliance:7/13 (NR); 3/14 (NR); 5/15 (NR); 1/16 (NR); **7/29/16**
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):	The Medical Monitor could not find compliance with Audit Step c because its review relies on an adequate medical record. As described in III. B. 3. b. the medical records reviewed all failed to contain a key element: the nature of the force used. That information is necessary in order to judge whether "the force may be excessive." In its response to a draft of this report, the County asked that the rating for this provision be changed from Non-Compliance to Partial Compliance, based in part on the fact that "CHS has reviewed the clinical space at TGK, MWDC, and PTDC and has determined that the space is conducive to meet privacy issue." Based on the Monitor's review of clinic space, most of the spaces mentioned *can be* conducive to providing privacy, but most of them are not used that way by nurses or practitioners, i.e. doors are left open and other patients and officers can be or were observed to be, within earshot of health care professional-patient conversations.		
Monitor's Recommendations:	The Medical Monitor did not review all the parts of 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: 7/29/16	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR);
Unresolved/partially resolved issues from previous tour	7/29/16: The specific definitions of "emergency referrals" and "urgent referrals" have yet to be updated to include a psychiatric or behavioral health component.		
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.		
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 are under review.		
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; 7/29/16	Non-Compliance: 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 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:	CHS revised the policy CHS-033, Receiving Screening. It is in the process of revising 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."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Because the County is actively more than 80% finished in its process of re-writing its policy, it meets criteria for partial compliance of this provision. In addition, the County is practicing the policy by actively referring patient to mental health care on a daily basis. No internal audits were provided for review.		
Monitor's Recommendations:	For the next tour, please provide: 1. Complete and final policy. 2. Records demonstrating relevant staff training to the policy. 3. Records demonstrating internal audits of 14 day mental health assessments (Numbers within standard practice, numbers not within standard practice and plan to correct, if necessary) 4. Records demonstrating internal audits relative to referrals by type.		

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; 7/29/16</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">CHS has revised policy relevant to Interdisciplinary Treatment Teams and Basic Behavioral Health Services. Internal audits and data with relevant analysis were not submitted with information regarding medication management, group therapy, and discharge planning information.</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><td></td><td>May</td><td>June</td><td>July</td><td>Sept</td><td>Nov</td><td>Average</td></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>
Information relevant to the first half of 2016 was not provided. 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.</td></tr>
<tr><td>Monitor's Recommendations:</td><td colspan="3">CHS and MDCR are encouraged to continue to further tighten policy, collect data, analyze it. A robust continuous quality improvement program is necessary to self-monitor. Immediate recommendations include the following:
1. Provide new hires corrections-specific training including suicide prevention, restraint management, and emergency treatment orders,
2. Initiate regular peer review.
3. Implement patient-centered treatment plans.</td></tr>
</table>

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; 7/29/16	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 have been revised. The Behavioral Health Curriculum is in the process of implementation.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	During this on-site tour, the Mental Health Monitor received information indicating that bottlenecks continue to occur that demonstrate delays in access to care. For example, she was informed that delays at intake prevent inmates from being timely assessed by psychiatry. Analysis of data provided indicated that the average delay for access to care was 4.5 hours[8]. The Second Finding of concern is that the current intake mental health screening tool assigns a majority of the patients (greater than 60%) as 'high risk.' This has created ongoing space issues and access to care issues. 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. For example, in one case, a rambling, disorganized and thought disordered patient was admitted and bounced between Levels II and I for two days. The patient saw a psychiatrist 48 hours later, and was never prescribed psychotropic medication.		
Monitor's Recommendations:	1. Adjust and redistribute staff including nurse practitioners according to acuity and need. Consider placing psychiatrist(s) at point of entry during peak flow times if this eliminates back logs and reduce duplication of effort. 2. Utilize behavioral (non-pharmacologic) treatment options where possible. This will include increasing programming for Level III and IV patients at Metro West.		

[8] Data obtained from Arrestees Processed with More than Four Hours Between Stations, 2nd Wait time.

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 ; 7/29/16	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 Policy 058A was updated and approved.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS mental health staff will benefit from training on the policy and its implementation. On the job training in terms of patient-specific treatment planning will be helpful.		
Monitor's Recommendations:	1. Treatment plans should be individualized, and patient-centered. They should include concrete measurable and observable goals for each patient. 2. Progress notes/medical records of patients with severe mental illness (SMI) should reflect the individualized treatment plans.		

	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; 7/29/16	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:	CHS Policy 058A has been revised and approved. It is in the process of implementation.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS Policy 058 A was submitted and approved. The minutes from the Mental Health Committee Meeting outlined how many patients were at each level month to month. No further analysis or internal audits were provided for review related to long the patients stayed at each level nor how many patients on each level receive a written interdisciplinary treatment plan within 30 days following evaluation. This information should be submitted for compliance with the next tour in the form of an internal audit / quality improvement review.		
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. 3. Please submit how many patients are on the mental health caseload on each level and how many patients on each level receive a written interdisciplinary treatment plan within 30 days following evaluation for the next tour in the form of an internal audit / quality improvement review.		

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; 7/29/16	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:	Policy CHS-058-A has been revised. It is in the process of implementation. Further review was not undertaken.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As noted previously, policy CHS-058-A indicates that patients on Levels 1A, 1B and 2 will receive written interdisciplinary treatment plans. Patients on Levels 3 and 4 will not have an IDTT meeting to discuss and review their treatment. For patients on these levels, their 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).		
Monitor's Recommendations:	Please implement individualized treatment plans as per Consent Agreement and as clinically indicated.		

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; 7/29/16	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 was revised and approved. It is in the process of implementation. Outstanding issues include review and validation of the level system (as a whole) given that leveling and re-leveling of patients continues to be problematic, as noted by both interview of staff and review of medical records.		
Monitor's Recommendations:	1. Collect baseline data 2. Validate intake screen 3. Adjust intake screen 4. Collect new data and compare to baseline data of intake screen 5. Analyze and adjust as needed		

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); 7/29/16
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 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; 7/29/16
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 policy 058-B is adequate. Group therapy for patients on Levels III and IV is offered to an average of 20 to 50 patients a week. This is 6% of the mental health caseload at Metro West.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The County was previously using the phrase qualified mental health provider (QMHP) as a social worker or psychologist, not a psychiatrist. As a result, Level IV patients were managed by mid-level providers or social workers, every 90 days (instead of having routine visits with psychiatry every 90 days) and the psychiatrists were functionally relegated to putting out fires. During this tour, we noted that although psychiatry time was identified as two psychiatrists at Metro West, actual allotted time is eight hours that are split between other facilities. Again, the psychiatrists are forced to triage and only see the most acute cases and/or new intakes. Follow-up and refills will understandably fall through the cracks, leading and likely precipitating crises down the road. This will need to be monitored.		
Monitor's Recommendations:	1. Please monitor access to care, inmate on inmate violence vis-à-vis mental health level and mental health grievances.		

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; 7/29/16
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 policy 058-B was recently updated and submitted. Its full implementation is pending. Level III patients 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. No internal audits or data specific to productivity relative to the Level of Care was provided for this tour.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Full review not conducted pending training and implementation of policy.		
Monitor's Recommendations:	As alluded to above, consider tracking 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 stabilizing in the appropriate setting; ii. psychotropic medication, as clinically appropriate; iii. private assessment with a Qualified Mental Health Professional on a daily basis for the first five days and then once every seven days for two weeks; iv. evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; and v. access to individual counseling and group counseling as deemed clinically appropriate by the treating psychiatrist.		
Compliance Status this tour:	Compliance: <date>	Partial Compliance: 7/13; 1/16; 7/29/16	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 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 policy as outlined above meets the terms of the Consent Agreement. Training on the policy and its implementation are pending. A full review was not conducted.		
Monitor's Recommendations:	The following is suggested. Continuous quality improvement indicators which track triage, accuracy of leveling (triage), dispensation of medication, and access to 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; 7/29/16	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 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 policy is adequate and consistent with the requirements of the Consent Agreement. Full review of implementation of the policy was not conducted.		
Monitor's Recommendations:	1. Provide constant observation for those patients on Level 1A with high acuity. This should be tracked. 2. Please initiate treatment teams and planning for the greater than 80% of patients. 3. Please provide appropriate hygiene for menstruating females, even if deemed high acuity. This may be appropriately managed by placing the patient on 1:1 status and providing her with mesh panties and access to showers as needed.		

Paragraph Author: Ruiz	III. C. 2. h. Mental Health Treatment Stage II will include an expansion of mental health care and transition services, a more therapeutic environment, collaboration with other governmental agencies and community organizations, and an enhanced level of care, which will be provided once the Mental Health Treatment Center is opened. The County and CHS will consult regularly with the United States and the Monitor to formulate a more specific plan for implementation of Stage II.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16	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:			
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 have been 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. 4. Increase in use of force vis-à-vis the mental health population		
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; 7/29/16	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 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)	Full review of implementation of CHS 058 B was not conducted. Internal audits were not provided. Preliminary data indicated that of 362 referrals for 'suicide alerts' in January 2016, only 166 were completed, or 46%.		
Monitor's Recommendations:	Track and implement a system to ascertain appropriate follow-up care for inmates referred for Level I care.		

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; 7/29/16	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:	In December 2014, patients were transferred from PTDC to TGK, where they receive acute Level I and Level II mental health care. Elements of a therapeutic environment include access to consultation in a private setting and access to group therapy.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Internal audits were not provided and complete data relevant to the numbers of patients on psychotropic medications on Levels I-IV was not provided. Full review of this provision was not completed.		
Monitor's Recommendations:	Please complete internal audits and ensure adequate access to acute Level I care. Address access to adequate treatment space and recreation time for the provision of both group therapy and 1:1 therapy.		

	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; 7/29/16
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, 2015, 2016: Plans remain 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 regarding clothing, bedding, and other property given to suicidal inmates on a case-by-case basis and supported by signed orders of Qualified Mental Health Staff. (3) Ensure that each inmate on suicide watch has a bed and a suicide-resistant mattress, and does not have to sleep on the floor. (4) Ensure Qualified Mental Health Staff provide quality private suicide risk assessments of each suicidal inmate on a daily basis. (5) Ensure that staff does not retaliate against inmates by sending them to suicide watch cells. Qualified Mental Health Staff shall be involved in a documented decision to place inmates in suicide watch cells.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 3/14; 7/29/16	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.		
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 policy. Given that policy has yet to be completed, suicide prevention training and its other substantive components are pending also. A full review of this provision was not conducted.		
Monitor's Recommendations:	Please complete policy and implement staff training as soon as possible.		

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); 7/29/16
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:	This County has implemented a suicide screening tool. The screening tool did not include the specific risk factor "recent significant loss – such as the death of a family member or close friend." Rather, it included a wider net.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As per Appendix A, the following are to be assessed and evaluated at any point during incarceration as part of the **<u>suicide risk assessment</u>**: Any of the following: 1. Suicide risk screening indicates moderate or high risk 2. Any suicide attempt in the past 3. Any suicidal ideations, with intent/plan within the past 30 days 4. Any command hallucinations to harm self within the past 30 days 5. Any combination of the following: a) Suicidal ideations within the past year with or without intent/plan b) Suicidal gestures (current and/or within past year) c) One or more of the following diagnoses: i) Bipolar Disorder, Depressed ii) Major Depression With or Without Psychotic Features iii) Schizophrenia iv) Schizoaffective Disorder v) Any diagnosis within the Pervasive Developmental Disorder Spectrum vi) Any other factor(s) determined by the interdisciplinary team (IDT) as contributing to suicide risk (e.g. recent loss, family history of suicide, etc.) 6. Any history of self-injurious behavior (SIB) resulting in injury requiring medical attention within the past year		
Monitor's Recommendations:	1. Patients with diagnoses within the Pervasive Developmental Disorder Spectrum or Autism Spectrum will require an advocate or staff member to assist with access to care and appropriate communication as needed. Signs or symptoms that patients may be under distress include any aggression or departure from baseline behavior resulting in major injury. 2. Implement suicide risk assessment including triggering events and thresholds as noted in Appendix A.		

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 indicated, including constant observation or interval visual checks. The MDCR Jail facilities' supervisory staff shall regularly check to ensure that corrections officers implement the ordered levels of observation.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 3/14	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16; 7/29/16
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, 2015, and 2016, review of samples of suicide/self harm cases indicated that patients were not placed on constant observation. This finding was confirmed by the fact that several patients succeeded in injuring themselves despite being on Level IA. 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)	In record reviews, insufficient documentation established that satisfactory constant observation, supervision, and mental health care were provided.		
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; 7/29/16	Non-Compliance: 10/14 (NR); 5/15 (NR)
Unresolved/partially resolved issues from previous tour:	• 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:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies, including screening and suicide risk assessments.		
Steps taken by the County to Implement this paragraph:	CHS policies 033 and 003 speak to its procedures regarding intake and suicide prevention. CHS has hired and placed additional staff at intake.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Please complete revision and training on suicide prevention policy.		
Monitor's Recommendations:	Train staff to corrections-specific intake and suicide prevention policies and practices. Suicide prevention drills on site will be helpful.		

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; 7/29/16	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:	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 Level 2		
Monitor's Recommendations:	Treatment plans should include concrete and measurable, individualized treatment goals for patients.		

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; 7/29/16	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 refers to the availability of rescue tools that shall be used in an attempt to cut a ligature and save a patient, if needed.		
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 rescue 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 rescue tools. Towards this end, mock drills may be helpful.		

Paragraph Author: Stern and Ruiz	III. C. 3. g. Suicide Assessment and Prevention The Jail will keep an emergency response bag that includes appropriate equipment, including a first aid kit, CPR mask or Ambu bag, and emergency rescue tool in close proximity to all housing units. All custodial and medical staff shall know the location of this emergency response bag and the Jail will train staff how to use its contents.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 5/15; 1/16; 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 5/15; 1/16; 7/29/16	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) There are emergency response bags 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: N/A 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):	Medical Care: (Discussion of emergency equipment intended for the exclusive use of medical staff has been moved to III. B. 1. a. (CONSENT037). Discussion here is limited to emergency equipment kept on or near the living units, and intended primarily (or initially) for use by custody staff.) While some emergency equipment was complete, where it was supposed to be, and inventory lists were present, and while some custody staff were very familiar with the equipment and its location, there continue to be facilities and units where this is not the case. In response to questions to COs about this equipment, among COs		

	who did not have sufficient knowledge, one of the Monitors received replies such as "I don't normally work this floor," "I don't know - I'm on light duty," and "You need to ask the booth officer." Mental Health Care: Although emergency bags were available, not all staff knew how to utilize them.
Monitors' Recommendations:	Medical Care: The County must assure that all emergency equipment on the living units is complete, in the proper location, and accompanied by inventory lists that are checked regularly. The County must also assure that all officers who work on a unit are familiar with the location and use of all emergency equipment. Some tools to use to achieve this assurance include: improving initial and period training; conducting emergency drills; and scheduling supervisory checks. The County should also assure that emergency equipment is placed in logical locations. For example, on one unit visited (TGK female unit 45) the equipment is located outside the unit, but the sole CO is not allowed to leave the unit unattended to retrieve it. Thus in the event of a hanging, for example, access to a cut-down tool would be delayed until other officers arrived. Mental Health Care: 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; 7/29/16
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 was 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; 7/29/16	Non-Compliance: 3/14;10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: 1. Manual of MDCR and mental health policies and procedures 2. Review of tracking mechanism reflecting inmates for whom mental health has provided opinion in disciplinary proceeding and final decision. 3. Review of medical records for inmates involved in disciplinary actions with mental health history, including possible notation or evidence of consultation with Qualified Mental Health Staff.		
Steps taken by the County to Implement this paragraph:	CHS has collaborated with MDCR and produced policy CHS-008A.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	No numeric data or analysis was provided for 2016 regarding disciplinary measures.		
Monitor's Recommendations:	Please track data and conduct an internal analysis of the disciplinary process and outcome for patients on the mental health caseload.		

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, 7/29/16	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. This policy 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)	A full review of this provision was not conducted, as the revised policy is in draft form and staff training has not been implemented. Behavioral health rounds are currently occurring on the special management units once per week. Medical rounds are occurring daily; patients with mental health symptoms are reportedly referred to mental health. I was informed that medical rounds include 'an eye out' for signs of mental and emotional distress.		
Monitor's Recommendations:	It is recommended that behavioral health rounds occur for patients on special management units at least three times per week. **NOTE: Consent III.C.5 a is in partial compliance. For the next tour, please provide all relevant documentation and evidence of compliance. The Mental Health Monitor needs to have this material to maintain and or find the relevant paragraphs in compliance.**		

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, 7/29/16
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, patients placed on constant observation did not receive such.		
Monitor's Recommendations:	Kindly implement constant observation for patients deemed at highest acuity 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; 7/29/16	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 that were submitted for review.		
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. Progress notes should specifically detail why patients are restricted from out of cell time if it is deemed counter-therapeutic.		
Monitor's Recommendations:	Document of individualized patient-centered decision-making in progress notes. For example, if a patient is too disorganized to leave his cell, a notation / order such as, "Patient over-stimulated by out-of-cell time. May shower with escort," will suffice.		

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; 7/29/16	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:	Patients on Levels I and II have been transferred to TGK. Patients on Levels III and IV have been transferred to Metro West.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Outstanding issues include: 1. Dorm-style setting of Metro West 2. Office space for face to face visits		
Monitor's Recommendations:	Consider partitioning the space in Metro West if this does not block visibility or affect safety. Other options may include increasing programming.		

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; 7/29/16	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 policy 058 A discusses treatment plans.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	A sample of charts that was reviewed contained interdisciplinary treatment plans. Another sample of charts that was reviewed did not. This should be completed on a consistent basis and should include patient-centered treatment as well as a risk profile.		
Monitor's Recommendations:	Implement patient centered individualized treatment planning. Treatment plans should include suicide risk assessments, as clinically appropriate, as well as risk profiles.		

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; 7/29/16	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.'		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The policy will undergo minor revisions.		
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; 7/29/16	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 under review.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	No data or internal audits relative to custodial segregation were provided for review.		
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. Review and analyze data and trends relative to mental health status and length of stay of patients in custodial 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; 7/29/16	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)	CHS-044 is under revision. No internal audits or reviews were provided relative to custodial segregation, per se. Minutes from the MH Committee Meeting indicated that of 244 cases reviewed by mental health for disciplinary reviews, 209 were 'cleared.' Cleared was not otherwise defined. As a result, it is unknown how many patients may have been diverted from custodial segregation and how many patients were referred for appropriate mental health care.		
Monitor's Recommendations:	Please provide clear documentation and analysis of: 1. CHS Police 044 requires revision. It is recommended that the definition of 'long-term' placement in custodial segregation be defined and contraindications to placement in custodial segregation be outlined consistent with the CA. 2. For future tours, please provide: 3. Number of patients on Levels I-IV per month referred for disciplinary proceedings and placed in custodial segregation 4. Outcome of mental health review / consults prior to placement. 5. Number of patients per Level per month in custodial segregation referred to mental health care (i.e. incidence of mental health illness). 6. Outcome of mental health referral. 7. Length of placement for patients (Levels I-IV) in custodial 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; 7/29/16	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:	Please see III. C. 6. A. (1)		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	No data or internal audits relative to custodial segregation were provided for review. The most recent draft policy states that a patient is to be placed on constant observation until seen by a QMHP. Once the patient is seen, the QMHP should immediately make a determination regarding the patient's mental health safety and treatment level, and a relocation form will be submitted accordingly. As stated by the CA, the patient should be monitored at a frequency of no longer than 15 minute staggered intervals.		
Monitor's Recommendations:	1. Complete revision of policy. 2. Train staff to policy. 3. Implement policy. 4. Study efficacy / perform internal reviews / obtain feedback. 5. Make change(s) if necessary. 6. Review adverse outcomes, if any, for learning opportunities.		

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), 7/29/16
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of log documenting that QMHP has rounded on patient three times per week 3. Review of medical records and observation logs for implementation of policies		
Steps taken by the County to Implement this paragraph:	CHS-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 most recent updated version of the policy includes language which states that QMHP will round on patients in custodial segregation three times per week. However, in practice, these patients are being seen once weekly by a QMHP. They are being seen or rounded upon by medical staff daily. Medical staff that observe signs or symptoms of mental illness refer patients to mental health.		
Monitor's Recommendations:	As stated above, inmates with SMI in custodial segregation should receive rounds by a QMHP three times per week. For Feb 2017, please provide written documentation of rounds on SMU noting appropriate referrals for treatment as clinically indicated and/or signs of stability. Proper documentation should progress notes that include intermittent review of patient's out of cell time, access to recreation, food intake, particularly if the patient has been losing weight, psychotic or manic, and adherence to medication.		

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); 7/29/16
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of logs documenting that MDCR has permitted recreation and showers at least three times per week 3. Review of log of patient in custodial segregation with SMI		
Steps taken by the County to Implement this paragraph:	CHS-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)	I was informed that patients were receiving minimal out of cell time. No specific information was provided regarding diversion from custodial segregation for patients with severe mental illness or provisions for heightened care for those with SMI in custodial segregation.		
Monitor's Recommendations:	1. Permit out of cell time and increased programming for patients with severe mental illness as per CA. 2. For the next tour, please provide internal audits reflective of diversions from custodial segregation for patients with severe mental illness..		

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; 7/29/16	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:	For the next tour in February 2017, please provide an internal review of documentation / written approval for placement of Level 1 and 2 patients in custodial segregation. This information will be required in order to maintain and/or move the provision into partial / compliance.		

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; 7/29/16	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. A cursory review of information relative to disciplinary proceedings provided indicated that information from mental health was available for the hearings. However, this data was not analyzed and no synopsis was provided to detail what number of patients, if any, were diverted from custodial segregation.		
Monitor's Recommendations:	Provide data indicating referral for assessment and treatment prior to placement in custodial segregation. For the next tour in February 2017, an internal review of diversion from custodial segregation and referral to adequate treatment will be requested in order to maintain and/or move the provision into partial / compliance.		

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; 7/29/16	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)	This provision was not comprehensively reviewed. Although specific data was not provided to evaluate whether patients were referred for assessment due to developing symptoms of mental illness while in custodial segregation, the tele-psychiatry log indicated that various patients had access to mental health care after hours; it was not specifically noted whether these patients were from custodial segregation.		
Monitor's Recommendations:	As previously mentioned, staff should be trained to corrections-specific policy and procedure. In addition, for all future tours, 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.		

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; 7/29/16	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)	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. The tele-psychiatry log was submitted for review: it cited names of patients seen from all cites after hours, indicating that these patients had access to care. However, this information could not be independently verified with the data provided. This will be further reviewed in February 2017.		
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; 7/29/16	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)	Rounds documentation for the SMU was reviewed. Many sheets looked as if they had been filled out all at one sitting rather than filled out over the course of a several hour shift. Intervals were not staggered on several logs. Other logs were complete and nicely done, with descriptive terms in the spaces, as appropriate.		
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; 7/29/16	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; 7/29/16	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Medical Care: • 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. Mental Health Care: 1. Manual of MDCR and mental health policies and procedures 2. On-site tour of facility 3. Review of grievances 4. Inspection that mechanism for placement of sick call and access to care is timely		
Steps taken by the County to Implement this paragraph:	Medical Care: N/A		

	Mental Health Care: 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):	Medical Care: 1. The quality of welfare checks for patients in isolation cells who do not receive medications is variable across facilities, within facilities, and even in one case, variable within the same nurse. In some cases where patients are not scheduled to receive medications, the nurse either just looks in the patient's room without any oral interaction, or does not check on the inmate at all. 2. Almost all patients reported that COs summon nurses right away when needed. One problem that exists, however, is that in isolation cell units without in-cell buzzers and where the CO is not stationed within the living unit, patients have to wait for the CO to make rounds in order to request urgent medical care. While those rounds were reported by patients to be regular and predictable, the time between them can be up to 30 minutes. Thus in the event of an emergency, where time is of the essence (e.g. chest pain), the inability to summon aid immediately would be unsafe. 3. Some patients elect to give their SCR slips to the officer rather than the nurse. However, this is by choice, and the patients clearly understand that they can give it a nurse if they desire. Thus this does not pose a threat to confidentiality. 4. Confidentiality during examination for patients in isolation cells is a moot issue because all examinations are currently conducted in the clinic. There is a plan to begin conducting clinic examinations in a room adjacent to the male and female units at MW. However, the plan includes provisions for visual, and hopefully auditory, confidentiality. 5. The relevant policies and training curricula have yet to be developed. Mental Health Care: 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:	Medical Care: 1. The County needs to develop the relevant policies and training curricula for this provision. 2. The County needs to find a mechanism by which patients can summon emergency help immediately in those units where the COs are not omnipresent. Mental Health Care: Custody staff reported that access to mental health staff schedules would be helpful, as many staff see patients at approximately the same times. As a result, office space is limited. By accessing staff schedules, custody could stagger appointments and improve patient flow.

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; 7/29/16	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)	Insufficient data was provided to completely assess whether patients were referred for assessment due to developing symptoms of mental illness while in custodial segregation. The tele-psychiatry log and sick call log indicated that patients were referred from PTDC and TGK for psych treatment. It did not specifically state whether these patients were referred from custodial segregation.		
Monitor's Recommendations:	Any information specific to the timely 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 for the next on site tour in order to maintain or achieve partial/ compliance.		

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; 7/29/16	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 Information provided during July 2016 tour indicated that CHS had back-filled vacancies with agency and contractors, particularly for non-attractive shifts such as weekends.		
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.		
Monitor's Recommendations:	1. Re-evaluate and validate your intake screen. 2. Reassess your level system. 3. Deploy staff according to acuity and system need. 4. Assess for inefficiencies.		

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; 7/29/16	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:	As previously stated, in May 2015, after receiving feedback, CHS revised its staffing plan. 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. A Behavioral Health curriculum has been reviewed and has been approved pending revisions.		
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; 7/29/16	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. The Behavioral Health Curriculum is approved pending revision.		

	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; 7/29/16	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. Training specific to correctional mental health is in the process of implementation.		
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; 7/29/16	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 and review of data, Dr. Junquera performs primarily administrative functions. She answers administratively to Dr. Razdan as her supervisor.		
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; 7/29/16	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 after the on-site tour.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Training materials submitted after the on-site tour were not timely for review relative to this report. It was noted, however, that while on site, the Mental Health Monitor met with the training team and discussed plans for training the staff utilizing web-based methods.		
Monitor's Recommendations:	For future submissions, kindly submit material including training materials, staff matrices, and any relevant documents 30 days prior to scheduled on site, or January 27, 2017.		

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, 7/29/16	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)	CIT records were submitted for review. The records reflect that no mental health or CIT training has occurred since April / May of 2015.		
Monitor's Recommendations:	Please restart mental health, suicide and CIT training as per the Consent Agreement.		

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; 7/29/16	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 or information was submitted for review of this provision. However, we were informed that Captain Denson has been assigned to assist with communication between mental health and custody, which has facilitated communication and improved mental health issues between TGK, PTDC, and Metro West.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	No written policy entitled interagency communication has been developed between MDCR and CHS. In practice, the two organizations are currently working well.		
Monitor's Recommendations:	Continue with collaboration between custody and mental health in daily huddles and other modalities.		

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; 7/29/16
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:	No information was submitted relative to this provision.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's	Insufficient information was provided to analyze this provision.		

representations, and the factual basis for finding(s):	
Monitors' Recommendations:	Material that 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; 7/29/16
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; 7/29/16
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):			
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; 7/29/16	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; 7/29/16	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. 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. For example, review of the Quality Management Meeting Minutes indicated that while trends in use of force as they relate to patients on the mental health caseload may have been tracked, no system or intervention was implemented to correct that trend in a timely manner. This has similarly been the case with the identification of trends such as hoarding of psychotropic medications, etc. Data is captured and trends may be identified, but no further analysis or self-correction is documented or deployed.		
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 as needed.		

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; 7/29/16	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. Quality Management Meeting Minutes were reviewed. 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. For example, the information submitted did not include analyses of the information collected, did not provide a hypothesis of what had transpired and did not provide a description of any interventions that had been implemented to prevent the outcome from happening again. Thus, although the County is collecting the Quantros data and reviewing it, it is not clear how it is utilizing this information.		
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; 7/29/16
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 did not include elements of the provision which are necessary for compliance as per the Consent Agreement, which include: (1) Provide oversight of the implementation of mental health guidelines and support plans; (2) Analyze individual and aggregate mental health data and identify trends that present risk of harm; (3) 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.		
Monitor's Recommendations:	Please provide risk management data including the elements outlined above. Specifically, please demonstrate how the County is utilizing the Quantros data to effectively manage its system. Alternatively, if the Quantros data is insufficient, please demonstrate what additional data may be helpful and how it plans to gather this information.		

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; 7/29/16	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. There is little evidence of analysis of aggregate trends.		
Monitor's Recommendations:	Please provide evidence of analysis of aggregate data and intervention.		

D. Audits and Continuous Improvement

1. Self Audit Steps

Paragraph Author: Stern and Ruiz	III.D.1.b. Qualified Medical and Mental Health Staff shall review data concerning inmate medical and mental health care to identify potential patterns or trends resulting in harm to inmates in the areas of intake, medication administration, medical record keeping, medical grievances, assessments and treatment.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 1/16; 7/29/16	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; 7/29/16	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 has made a key personnel change related to this provision. 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: The County conducts some review of its data, but the process is still in its early stages of development. Very little has changed with regard to this provision since the last report. For this reason, the key elements of the analysis from the last report are repeated. In addition, please see the Quality Improvement section in the introduction to this section of the report. 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.		

	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. <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 the information they are collecting. This included information regarding the number of patients being managed per level, the number of patients involved in responses to resistance, and the number of patients being diverted to other forms of treatment.
Monitor's Recommendations:	<u>Medical Care:</u> The County must develop a cohesive, all-encompassing QI program that ties together all the elements of QI, as described in

	the Quality Improvement section in the introduction to this section of this report. <u>Mental Health Care:</u> 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. The County and CHS shall develop and implement corrective action plans within 30 days of each quarterly review, including changes to policy and changes to and additional training.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16	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; 7/29/16
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) Review of appropriate documents reveals that within 30 days of quarterly reviews, MDCR staff have developed and implemented corrective action plans addressing potentially harmful patterns or trends in medical care. The corrective action plans address the active and underlying (or root) cause(s) in a sustainable manner (e.g. changes to policy, procedures, job descriptions, training curricula.) Mental Health Care: Review of corrective action plans. Corrective plans shall be submitted in a timely manner and shall be qualitative; addressing causes not just symptoms of harm.		
Steps taken by the County to Implement this paragraph:	Medical Care: Please see comments in III.A.7.a., III.A.7.c., and III.D.1.b. Mental Health Care: 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):	Medical Care: Please see comments in III.A.7.a., III.A.7.c., and III.D.1.b. as well as the Quality Improvement section in the introduction to this section of this report. Mental Health Care: Corrective action plans were not provided within 30 days of each quarterly review.		
Monitor's Recommendations:	Medical Care: Please see recommendations in III.A.7.a., III.A.7.c. and III.D.1.b. as well as the Quality Improvement section in the introduction to this section of this report, which are included here by reference. Mental Health Care: None		

2. Bi-annual Reports

Paragraph Author: Stern and Ruiz	III.D.2.a. Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: (1) All psychotropic medications administered by the jail to inmates. (2) All health care delivered by the Jail to inmates to address serious medical concerns. The report will include: i. number of inmates transferred to the emergency room for medical treatment and why; ii. number of inmates admitted to the hospital with the clinical outcome; iii. number of inmates taken to the infirmary for non-emergency treatment; and why; and iv. number of inmates with chronic conditions provided consultation, referrals and treatment, including types of chronic conditions.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16	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; 7/29/16
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: Due to the timing of the Monitors' visits relative to the calendar year (and bi-annual reports), the bi-annual report for the period just ending are not typically ready at the time of the Monitors' reviews. Thus the Monitor examines the report for the previous period. The County did produce and submit to the Monitors a bi-annual report for the period July-December 2015. Mental Health Care: Insufficient data was provided to assess this provision in a timely manner.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: The bi-annual report contains only one of the required elements: the number of patients transferred to the ER for medical treatment. All other elements (including the reason for ER transfers) are missing. Mental Health Care: The County did not provide sufficient information to assess this provision in a timely manner. Bi-annual reports which have been submitted have not included the information outlined above. For example, the Mental Health Monitor may received a list of inmates transferred to the emergency department but will nit receive the reason why. The report will arrive without analysis and discussion of trends regarding utilization of psychotropic medications, utilization of services, and other concerning issues.		

Monitor's Recommendations:	Medical Care: The County needs to provide a report responsive to all the requirements of this provision. The Medical Monitor recommends, however, that these elements be incorporated into the broader quality improvement program as captured in a comprehensive Mortality and Morbidity Detection and Prevention policy. Indeed, such information as the number and reasons for ER transfers, for example, is information that the County will want to collect and monitor (i.e. report) more often than every 6 months. Further, it will want to augment these raw numbers with analysis of the appropriateness (and avoid ability) of these transfers as well as efforts to reduce them. Mental Health Care: Kindly provide the requested information in its entirety in a timely manner.

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); 7/29/16
Measures of Compliance:	<u>Mental Health:</u> • The Mental Health Monitor receives bi-annual reports of health care delivered to inmates **including the volume of and reason** for episodic clinic visits, follow-up/chronic care clinic visits, **ER transfers**, **and hospitalizations.** • Bi-annual reports are 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 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. The Mental Health Monitor has also received incomplete information regarding emergency room transfers and hospitalizations and untimely information regarding self-injurious behavior as it relates to patients to patients from the jail.		
Monitor's Recommendations:	Kindly provide information, including the Bi-annual collaborative custody/health care report that meets the requirements of the Consent Agreement.		

	III.D.2.a. (4) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: Inmate counseling services. The report and review shall include: 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; 7/29/16
Measures of Compliance:	Mental Health: • The Mental Health Monitor receives bi-annual reports of health care delivered to inmates including the volume of and reason for episodic clinic visits, evidence of timely follow-up/chronic care clinic visits, group therapy and individual therapy. • Bi-annual reports are 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 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 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); 7/29/16
Measures of Compliance:	• The Mental Health Monitor receives bi-annual reports of health care delivered regarding inmates involved in disciplinary reports at each level of care, the date of any hearing that may have resulted as a result of the disciplinary hearing, whether a QMHP participated in the disciplinary action, and the outcome. • Bi-annual reports are 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 for July of 105 in September 2015.		
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 for Jan-June 2015 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) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following:… [6] Reportable incidents. The report will include: i. a brief summary of all reportable incidents, by type and date; ii. [Joint audit with MH] a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit; and iii. number of grievances referred to IA for investigation.		
Medical Care: Compliance Status:	Compliance: 1/16	Partial Compliance: 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 1/16; 7/29/16	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. Mental Health Care: 1. Review of bi-annual reports 2. Review of incident reports 3. Review of inmate deaths, including those which died following transfer from MDCR to Jackson Healthcare		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> Due to the timing of the Monitors' visits relative to the calendar year (and bi-annual reports), the bi-annual report for the period just ending are not typically ready at the time of the Monitors' reviews. Thus the Monitor examines the report for the previous period. The County did produce and submit to the Monitors a bi-annual report for the period July-December 2015. <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 bi-annual report contains only one of the required elements: inmate deaths. All other elements are missing. <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 was odd.		
Monitors' Recommendations:	<u>Medical Care:</u> The County needs to provide a report responsive to all the requirements of this provision. The Medical Monitor recommends, however, that these elements be incorporated into the broader quality improvement program as captured in a comprehensive Mortality and Morbidity Detection and Prevention policy. Indeed, such information as the number of injuries, for example, is information that the County will want to collect and monitor (i.e. report) more often than every 6 months. Further, it will want		

	to augment these raw numbers with analysis of the cause and preventability of these injuries as well as efforts to reduce them. Mental Health Care: Pursue further analysis of data and trends.

Paragraph Author: Stern and Ruiz	III.D.2.b. (Covered in III.D.1.c.) The County and CHS shall develop and implement corrective action plans within 60 days of each quarterly review, including changes to policy and changes to and additional training.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16	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; 7/29/16
Measures of Compliance:	Medical Care: • (duplicate 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. Mental Health Care: Same as comments in III.D.1.c.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Same as comments in III.D.1.c. Mental Health Care: Same as comments in III.D.1.c.		
Monitors' Recommendations:	Medical Care: Same as recommendations in III.D.1.c. Mental Health Care:		

IV. COMPLIANCE AND QUALITY IMPROVEMENT

Paragraph Author: Stern and Ruiz	IV.A Within 180 days of the Effective Date, the County and CHS shall revise and develop policies, procedures, protocols, training curricula, and practices to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement. The County and CHS shall revise and develop, as necessary, other written documents such as screening tools, logs, handbooks, manuals, and forms, to effectuate the provisions of this Agreement. The County and CHS shall send any newly adopted and revised policies and procedures to the Monitor and the United States for review and approval as they are promulgated. The County and CHS shall provide initial and in-service training to all Jail staff in direct contact with inmates, with respect to newly implemented or revised policies and procedures. The County and CHS shall document employee review and training in policies and procedures.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 1/16; 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14; 7/29/16	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR);1/16
Measures of Compliance:	<u>Medical Care:</u> • Audit Step a: (Other) This compliance measure will be assessed by exception, i.e. failure to meet any of the 3 requirements below as they pertain to any other provision of the Consent Agreement. a) Develop/revise operational documents to implement the Consent Agreement, b) Provide initial and in-service training to relevant jail staff with respect to new/revised policies and procedures, c) Send new policies and procedures to Medical Monitor for approval. <u>Mental Health Care:</u> 1. Policies and procedures 2. Schedule for production, revision, etc. of written directives, logs, screening tools, handbooks, manuals, forms, etc. 3. Schedule for pre-service and in-service training 4. Lesson plans 5. Evidence training completed and knowledge gained (e.g. pre and post tests) 6. Observation 7. Staff interviews.		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> 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. <u>Mental Health Care:</u> The County is in the process of updating policy and forms.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed,	<u>Medical Care:</u> See above. <u>Mental Health</u> The County is updating policy and forms. It also needs to validate and operationalize data collection/analysis systems, intake		

verification of the County's representations, and the factual basis for finding(s):	and screening, and quality improvement.
Monitor's Recommendations:	<u>Medical Care:</u> See various recommendations throughout this report. <u>Mental Health Care:</u> 1. Begin process of designing dashboard for quality improvement. 2. Assign individuals accountable to each specific goal on the dashboard. 3. This would include **protected time** for administrative duties not clinical ones. 4. Begin work to identify obstacles in work flow or systems of delivering care. 5. Eliminate easiest obstacles / "low hanging fruit." 6. Assess impact on dashboard. 7. Repeat.

Paragraph Author: Stern and Ruiz	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; 7/29/16	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; 7/29/16	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • Audit Step a: (Inspection) MDCR has policies and procedures governing its quality improvement process • (duplicate 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 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. Policies and procedures regarding incident reports, including criteria for screening for critical incidents and suicide attempts (see also III.A.3); 2. Documentation of referrals of grievances for investigations; outcomes. 3. Corrective actions for incidents not referred as required. 4. Review of medical and mental health policies and procedures regarding referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc. 5. Medical and mental health policies and procedure regarding review of medical grievances to screen for critical incidents. 6. Documentation of referrals to investigators by medical and/or mental health staff, if any.		
Steps taken by the County to Implement this paragraph:	Medical Care: The County performs a limited number of the activities required under provisions III.D.1.b. and III.D.1.c. that overlap with this provision. For example, they do conduct regular quality improvement meetings and do review deaths and make changes based on findings from those reviews. However, many critical elements are still missing (see comments in III.D.1.b. and III.D.1.c. and the Quality Improvement section in the introduction to this section of this report). Mental Health Care: CHS has provided a draft policy in reference to Quality Improvement. It has not provided a draft procedure.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's	Medical Care: N/A Mental Health Care: The draft policy is acceptable.		

representations, and the factual basis for finding(s):	
Monitors' Recommendations:	Medical Care: Please see the Quality Improvement section in the introduction to this section of the report as well as comments in provision III. A. 7. a. Mental Health Care: CHS may benefit from outlining a **procedure** which provides criteria that the committee will use as a guideline for reviewing: • critical incidents • serious suicide attempts (see also III.A.3); • referrals of grievances for investigations; • corrective actions for incidents not referred as required; • review of medical and mental health referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc.

Paragraph Author: Stern and Ruiz	IV. C On an annual basis, the County and CHS shall review all policies and procedures for any changes needed to fully implement the terms of this Agreement and submit to the Monitor and the United States for review any changed policies and procedures.		
Medical Care Compliance Status:	Compliance: 1/16; 7/29/16	Partial Compliance: 7/29/16	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; 7/29/16	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 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 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. In response to a draft of this report, the US DOJ opined that the Monitor's findings do not support a rating of Compliance (which appeared in the draft). Technically the US DOJ is correct. As such the rating has been changed. The rating has been changed to Partial Compliance because a) the County has completed review of a limited number of policies and because a year has not yet transpired since these were approved, the County is not out of compliance, and b) the County has sent some policies to the Medical Monitor for approval (Audit Step a from CONSENT119 (IV.A) – see Measures of Compliance above). Mental Health Care: The majority of CHS' policies are in draft form. They require varying levels of revisions. Please make all policies, even those under review, available to staff. The intent of policy revision is to improve and update policy, not to withhold them from		

	practicing providers while they are being updated.
Monitor's Recommendations:	Medical Care: None Mental Health Care: To CHS' credit, it has begun the process of revising its policies. This will be an ongoing process and should be.

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

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

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