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
The Honorable Beth Bloom

Independent Monitors' Report No. 7

April 4, 2017

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Introduction – Compliance Report # 7
United States v. Miami-Dade County
April 4, 2017

This is the seventh 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 February 27, 2017 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 March 17, 2017, with a requested date to return comments of March 31, 2017. All parties provided comments that were carefully considered by the Monitors as this report was finalized. CHS requested that the Monitors review the compliance rating for five provisions. Both Drs. Ruiz and Greifinger carefully considered CHS' position on these five provisions in preparing this final report. In fact, the final review included a "re-review" of all paragraphs to assure accuracy.

The Monitors thank 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 report provides a summary update of compliance status:

The narratives regarding both the Settlement Agreement and the Consent Agreement provide the analysis of findings, and recommendations.

Compliance with the Summary Action Plan

The summary action plan, dated May 18, 2016, committed to full compliance by mid-February 21, 2017. As noted on page 91 of the report, compliance has not been reached.

Report of Compliance
Settlement Agreement

Introduction

Compliance Report # 7 describes Miami-Dade Corrections and Rehabilitation's (MDCR) efforts toward meeting the requirements in the Settlement Agreement. In this report, the Monitors also assessed compliance in maintaining compliance with the Settlement Agreement, as well as examining the County's assertions regarding moving some provisions from partial to full compliance.[1]

MDCR has made significant progress by achieving compliance with all but two paragraphs of the Agreement. As noted below, there is a considerable amount of work that must be done before August 11, 2017 (a month before the next scheduled tour) to sustain this compliance. MDCR's leadership has assured the Monitors that this work will be accomplished.

Summary of Compliance - Settlement Agreement
As of Compliance Tour # 7

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
7	53	3	0	0	56

Remaining Challenges

The remaining challenges for the County include:

- Develop a long-range plan to replace PTDC, where conditions continue to deteriorate even with funds spent to maintain the physical plan. There is no plan at this time; although the Monitors understand there is a proposal to spent as much as $126 million to rehab PTDC.
- 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 involving inmates on the mental health caseload.

[1] Darnley R. Hodge, Sr. assisted the monitoring for this report by touring each facility, meeting with SIAB, reviewing responses to letters received by the lead Monitor from inmates, and assessing grievance responses.

- Strategize to lower the number of inmate/inmate altercations, enhancing protection from harm.
- Implement the offender management system.
- Refine critical incident reviews, root cause analysis and action planning.
- Continue to 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 Monitors acknowledge that training was conducted since the last tour, but the changes needed in terms of internal culture change are more long term.

Leadership at MDCR

The Monitors note, again, their concern about the stability of leadership in MDCR. Interim Director Junior is the third director since the Settlement Agreement was signed. The retirement dates of his two predecessors were known enough in advance to allow the County to provide for a timely transition. Interim Director Junior has been in this status since May 2016. In addition, there are eight, soon to be ten, top leadership positions in MDCR in "acting" status. Some of these individuals have been in "acting" status for ten months.

The Monitors are very clear that we have no concern about the competence of these professionals. However, it is naïve to believe that having this many top leaders in acting status with an "interim" director, for almost a year, does not take its toll on personnel at all levels. It also suggests to the Monitors that there is a lack of priority or urgency in permanently filling these positions. While there is documented progress, this has been accomplished, in the view of the Monitors, despite these organizational challenges.

Replacement Jail Beds

The conditions at the Pre-Trial Detention Center (PTDC) are raising questions of the constitutionality of confinement and protection of harm issues. These conditions include the harm to inmates resulting from the physical layout without staff to directly supervise, inmate/inmate violence, the age of the building, and the need for drastically improve cleanliness of the physical plant and inmate living areas. There are areas of the PTDC that were triple-bunked, which constitutes crowding.

The Commission on Accreditation for Corrections "Performance-Based Standards for Adult Local Detention Facilities" fourth edition establishes, "Single cells provide at least 35 square feet of unencumbered space. At least 70 square feet of total floor space is provided when the occupant is confined for more than 10 hours per day." During the tour the Monitor measured 14.1 square feet of unencumbered space on the tenth floor of PTDC where inmates were triple bunked.

On the same floor, the clothes washer was found to be unplugged. Staff accompanying the Monitor was unable to start a washing cycle. The electric junction box was no longer attached. Insulation on overhead pipes was frayed. There was no process to control

cleaning tools (brooms, mops, brushes, buckets etc.) and no evidence of an inventory check or sign-in/out for the tools. The lack of control increases the risk the tools could be used as weapons against other inmates and/or staff.

PTDC was built in 1959, and has a well-documented history of lack of preventive maintenance until several years ago. The physical plant of a jail ages 3.5 years for every year in operation. Therefore, PTDC has a physical plant age of 203 years old! [2] This is astonishing. Yet, the County does not have a plan to replace this structure, and is considering investing more money in renovation of this building.

Since the first compliance report, the Monitors have urged the County to develop plans to replace these beds; and there is no plan to date. The Monitors understand and appreciate the fiscal constraints of the jurisdiction. We understand that a master plan will be developed in the next year, and again, stress attention to the importance of the safe and secure conditions of confinement.

The Monitors will continue to assess the inmate conditions and level of violence at the PTDC.

Use of Force and Inmate/Inmate Violence

MDCR has made significant progress in its review of incidence of uses of force and analysis of inmate/inmate violence. Of concern are uses of force involving inmates on the mental health caseload. Often the use of force occurs when staff separate combative inmates. Reported uses of force increased 41% in 2016 over 2015. Reported inmate/inmate violence increased 4% in 2016 over 2015.

In 2014, MDCR founded the Trend Analysis and Action Planning Unit (TAAP) to compile and analyze data on critical areas including:

- Response to resistance (use of force);
- Battery on inmate (inmate/inmate assaults);
- Inmate grievances;
- Disciplinary reports; and
- Shakedown results.

An important component of the process of examining critical issues is the Senior Management Board who reviews the information, gathers more information as needed, and focus on corrective action plans. This is an outstanding process to increase accountability.

[2] Martin, Mark D. and Thomas A. Rosazza, Resource Guide for Jail Administrators, U. S. Department of Justice, National Institute of Corrections, December 2004, page 70 http://static.nicic.gov/Library/020030.pdf

As described below, the portion of the process that requires additional work to meet the requirements of the Settlement Agreement is action planning. The Monitor's concerns about the action plan content was conveyed to MDCR in January 2017.

Maintaining Compliance – Self-Audits and Action Plans

The Monitors recognize and acknowledge the hard-work and dedication of the MDCR staff in addressing the issues of quality assurance, quality improvements, self-audits, and action planning. As the relevant policies have been completed compliance has been noted for the paragraphs in the Settlement Agreement that include these requirements.

However, this recognition of the hard work to date is provisional. This means that prior to the next tour, MDCR must provide evidence that the agency can collect data, analyze that data, produce both credible root cause analyses, and credible action plans. Specifically, regarding the action planning the Monitor is looking for at a minimum:

- an accurate assessment of the objective – that is issue to be addressed in an action plan as required by the Settlement Agreement (e.g. the core issue, not the symptom),
- identification of measurable outcomes,
- incremental measurable steps to achieve the outcome,
- assignment of specific individuals to do the work,
- deadlines and timelines,
- report of outcomes, changes, etc.,
- evaluative assessment if the plan achieved the outcome(s), and
- if not achieved, revisions/updates to the plan.

These root cause analyses and action planning initiatives must be collaborative with CHS as defined by the issue. CHS and MDCR should also collaborate on their collective and individual updates to their QA/QI and self-audit policies. This is not to suggest one policy but rather that the processes are coordinated, where appropriate.

The specific paragraphs which require this work be provided to the Monitor no later than August 11, 2017 are[3]:

- III. A.1.a. (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.
- III.A.4.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

[3] In addition, there are two paragraphs that remain in partial compliance based on this tour: III.A.3., and III.A.1.a. (2).

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.

- III.A.5.a. (1)-(3)
  (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.
- III.A.5.c. (2) (i-ix). 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 note whether a use of force was videotaped, and if not, explain why it was not videotaped.
- 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.
- 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.

- 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.
- 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
- IIII.D.2. b. The County will analyze these reports and take appropriate corrective action within the following quarter, including changes to policy, training, and accountability measures.
- IV. B. Compliance and Quality Management. 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.

The consequences for not providing the information required will be the risk of moving the paragraph into partial compliance.

Inmate Grievance Process

Both the Settlement Agreement and the Consent Agreement address the inmate grievance process.[4] MDCR has been in compliance with the provision of the SA since July 2016. CHS

[4] Settlement Agreement, III.C., Consent Agreement, III.A. 3. (4); III.D. 1.b.

is in partial compliance and non-compliance with the pertinent sections. While the Monitors acknowledge MDCR's work, this is *unified* grievance process. At the next tour, MDCR's compliance status will change to partial compliance if CHS has not achieved compliance with the two relative provisions.

Attention to Recommendations in the Monitoring Report

The Monitor asks that MDCR pay particular attention to any recommendations provided in this compliance report, by paragraph. These recommendations will result in documentation of sustained compliance.[5]

Compliance with the Prison Rape Elimination Act (PREA)

MDCR has indicated that a PREA audit will be scheduled for July 2017. The Monitors urge that the report of this audit be available at the time of the September 2017 tour so that this required paragraph in the Settlement Agreement can be assessed for compliance. Additionally, this report includes a recommendation to the Police Department's Special Victims Unit regarding statements from CHS regarding an alleged inmate victim's medical/mental health status.

Collaboration with CHS

All the Monitors urge continued attention to the collaboration with CHS. While certainly this relationship has improved since the monitoring began, there are unexplainable lapses. For example, a critical lapse, in the view of the Monitors, was MDCR's not sharing their internal review/investigation of critical incidents with CHS. CHS conducts an internal review of incidents, of which MDCR is aware from their representatives' participation on various committees. But for whatever reason, MDCR did not share their internal reviews. In these cases, the interchanging of information, comparing notes, correcting the record, developing plans to address deficiencies, and implementing corrections was deficient, and could result in future harm to inmates. While the parties assure the Monitors that this matter has been addressed, the fact that it occurred is an example of how the collaboration is not as robust as needed.

[5]MDCR reports in their review of the draft: The Department remains committed to maintaining sustained substantial compliance with the provisions of the Settlement Agreement. Additionally, the Department will assess and review for practical application the recommendations as outlined in the compliance report but respectfully request that compliance not be downgraded due to recommendations.

Next Steps

The monitoring of the Settlement Agreement is reaching the stage where the obligation of the MDCR is to demonstrate on-going compliance with its own policies and procedures. This along with the issues of self-auditing and continuous improvement, critical incident review, root cause analysis, and action planning provides a road map for achieving and maintaining compliance for the period prescribed in the Settlement Agreement.

The Monitor extend their congratulations to MDCR for achieving this milestone and are available to assist in assessing the interim deliverables.

7th Compliance Tour - Settlement Agreement - Summary of Compliance Tour the Week of February 27, 2017[6]

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

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

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
				compliance is subject to change at the next tour. See Consent III.A.5.c.2. vii.
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.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
III.A. 5. c. (13)	x			
III.A. 5. c. (14)	x			
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 February 27, 2017

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: 3/3/17, 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 continued 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. Root cause analysis, action planning, and implementation of those plans, with documented outcomes, are needed as proofs of compliance on the next tour for any areas found to be trending toward harm to inmates.			

<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:
(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.</td></tr>
<tr><td>Compliance Status:</td><td>Compliance:</td><td>Partial Compliance: 3/3/17, 10/24/14, 7/29/16</td><td>Non-Compliance: 3/28/14, 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">See below.</td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><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.</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="4">Work continues to implement the new offender management system. It is behind schedule. The County's IT department has taken an aggressive approach to managing this project. The implementation matrix, including due dates was provided to the Monitor.</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">The classification module of the new offender management system is not due to be completed by the County until mid-September 2017. As such the classification system cannot be validated without the data from the system.
The bed analysis report was thorough, except for more needed attention to indicators of changes needed to practice, and action plans, where indicated.</td></tr>
<tr><td>Monitor's Recommendations:</td><td colspan="4">1. Update plan for validation of the classification system and timetable.
2. 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.
3. Assure that future bed analysis reports contain conclusions and specific recommendations for action.</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: (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: 3/3/17, 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 who walked through the facilities reviewed log; additional sample logs were provided. For the next tour, the Monitors would like to review an internal inspection of the logs.			
Monitor's Recommendations:	1. Review internal inspection of the logs as part of the on-going self-assessment of practices.			

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: 3/3/17, 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:	<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) 1. Monitors would like to review an internal inspection of a review of logs before the next tour (same recommendation as in July 2016 report). If MDCR is not going to conduct an internal audit, MDCR should be prepared to provide documentation other than logs. (see 4., above)			

<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 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: 3/3/17, 7/29/16, 10/24/14</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">A concern was raised regarding cameras in PTDC that were not always recording. MDCR assured the Monitors that this was rare, and that the daily inspection of the cameras led to identification of the problem and repair. TAAP should assure that their review flag non-working and/or non-recording cameras are promptly identified, and repairs undertaken.</td></tr>
<tr><td>Monitor's Recommendations:</td><td colspan="4">1. Continue to demonstrate that video camera systems are working, including recording, and if cameras require repair these are quickly identified and fixed.
2. Assure that TAAP reviews flag when cameras are not working as part of their review of uses of force. Identify those instances in the TAAP reports.</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: 3/3/17, 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 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)	MDCR provided samples of completed logs for all facilities.			
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: 3/3/17, 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:	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:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Review of logs indicates compliance.			
Monitor's Recommendations:	1. Assure inspection of logs as part of the internal inspection/audit process.			

<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:
(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.</td></tr>
<tr><td>Compliance Status:</td><td>Compliance: 3/3/17, 7/29/16, 1/8/16</td><td>Partial Compliance: 10/24/14</td><td>Non-Compliance: 3/28/14, 7/19/13</td><td>Other: Per MDCR not reviewed in 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 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.</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 of the inspections, and the identification and analysis of results of shakedowns.</td></tr>
<tr><td>Monitor's Recommendations:</td><td colspan="4">1. Develop, implement and action plans, as necessary to address findings.</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: (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: 3/3/17, 7/29/16, 1/8/16	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15.
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training for officers who transfer from one division to another. 2. Facility specific operational procedures/written directives. 3. Lesson plans on facility-specific safety and security. 4. Proof of attendance within 30 days of assignment. 5. Demonstration of knowledge gained (e.g. pre-and post-tests) 6. Examples of remedial training, if any.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Same as previous report: 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:	Same as previous report: 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: 3/3/17	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)	Indication of training was provided. Trends will be reviewed before and during the next compliance tour.			
Monitors' Recommendations:	Continue to provide CIT and other enhanced mental health training to custodial staff.			

Paragraph	III. A. 1. Safety and Supervision: a. MDCR will take all reasonable measures to ensure that inmates are not subjected to harm or the risk of harm. While some danger is inherent in a jail setting, MDCR shall implement appropriate measures to minimize these risks, including: (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: 3/3/17	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:				
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 continues to collect data regarding this issue; and provide some analysis. What is missing are credible root cause analysis and action plans. MDCR is working with the County's office of management and budget to develop objective performance measures, including assistance to the TAAP unit. The activities proposed by OMB are scheduled to be completed by the end of March 2017. **MDCR is advised that in order for this paragraph to remain in compliance at the time of the next tour, there must be credible action plans provided. If the policy needs to be amended, this can be submitted as evidence of continued compliance**.			
Monitor's Recommendations:	1. Amend the policy as needed. 2. Produce credible root cause analysis, and action plans. These action plans must identify the underlying cause of the issue (rather than the symptom), provide specific, measurable, objective actions, assignment of persons to complete the work, the timetable for the work, and how the success of the action plan will be measured. The process must identify if the action plan was effective in addressing the issue, and if not, the next steps. These action plans can be provided to the Monitor as they are developed. 3. Provide the Monitor with the outcomes of interventions/trainings provided to MDCR by the County's OMB.			

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: 3/3/17, 7/29/16, 5/15/15	Partial Compliance: 10/24/14, 3/28/14	Non-Compliance: Not yet due (11/27/13)	Other: Per MDCR not reviewed in 1/16.
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Completion of a comprehensive staffing analysis. 2. Review by the monitor. 3. Documentation of discussions, recommendations by the monitor regarding the comprehensive staffing analysis.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR has assured the Monitor that sufficient funds have been approved by the Board of County Commissioners to support staffing. This includes the provision of funds for overtime (overtime in the first quarter of 2016 is slightly more than first quarter of 2015). The budget information was provided. MDCR produces a credible staffing analysis. The County has contracted with a firm to conduct a staffing analysis for public safety agencies.			
Monitor's Recommendations:	Nothing at this time; continue to assess funding to match staffing needs.			

Paragraph Coordinate with Drs. Ruiz and Greifinger	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: 3/3/17, 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:				
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 Greifinger; 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 Greifinger; 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				
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: MDCR has received no information from CHS that inmates are not getting to appointments timely. The opportunities to raise any issues are at the MAC and "mini-MAC' meetings.			
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. (see narrative in the Consent Agreement section of this report.) 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: 3/3/17, 7/29/16, 5/15/15,	Partial Compliance: 10/24/14; 3/28/14	Non-Compliance: Not yet due 11/27/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. 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)	No change from findings in previous report. Hiring and pre-service training has been adjusted to accommodate vacancies. The County has assured MDCR that if more pre-service training classes are needed, they will accommodate.			
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: 3/3/17, 7/29/16,1/8/16	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		
Monitor's Recommendations:	See III.A.2.a., above		

III.A.3. Sexual Misconduct

Paragraph Coordinate with Drs. Ruiz and Greifinger	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: 3/3/17, 7/29/16, 1/8/16, 3/28/14, 7/19/13	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.		
Steps taken by the County to Implement this paragraph:	MDCR continues to update internal practices following a self-audit in preparation for a formal audit.		
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR indicates that a PREA compliance audit is scheduled for July '17. A self- assessment has been concluded which is guiding internal activities in preparation for the audit. A review of four files at MDPD's SVU (the cases opened since the last monitoring tour) results in the recommendations below. • One file indicated that an inmate was on the mental health caseload, based on a telephone conversation with CHS' medical director. It is unlikely that the medical director had any first-hand knowledge about the alleged inmate victim; and secondly any opinion regarding the inmate's mental health status should rely on the inmate's provider. • It would be helpful to have a summary page in the investigative file that indicates the status of the investigation, rather than having to rely on leafing back through the investigation to answer pertinent questions. Additionally, MDCR and CHS need to assure the PREA coordinator is the point of contact for all relevant work.		
Monitors' Recommendations:	1. Prepare for and complete PREA audit. Assure that the audit findings will be available at the time of the September 2017 tour. 2. Assure that SVU receives written reports or in-person interviews (rather than telephone interviews) from CHS regarding the medical and/or mental health status of alleged inmate victims and that the information come from the appropriate provider (not the CHS medical director). 3. SVU should consider including an investigative summary page for the file.		

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 act 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: 3/3/17, 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 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)	MDCR continues to produce quarterly reports. **MDCR is advised that in order for this paragraph to remain in compliance at the time of the next tour, there must be credible action plans provided. If the policy needs to be amended, this can be submitted as evidence of continued compliance**.			
Monitor's Recommendations:	See III.A.1.a. (11)			

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: 3/3/17, 7/29/16, 10/24/14	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/14	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<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. Provide any inspections/audits of internal compliance to the Monitors ahead of the next tour.			

<table>
<tr><td>Paragraph</td><td colspan="3">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.</td></tr>
<tr><td>Compliance Status:</td><td>Compliance: 3/3/17, 7/29/16, 1/8/16</td><td>Partial Compliance: 5/15/15; 10/24/14; 3/28/14</td><td>Non-Compliance: 7/19/13</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="3"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="3"><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.</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="3"></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">The offender management system (OMS) is still being implemented. The current system supports the requirements of this paragraph.</td></tr>
<tr><td>Monitor's Recommendations:</td><td colspan="3">No recommendations at this time.</td></tr>
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<table>
<tr><td>Paragraph
Coordinate with Dr. Ruiz
See Also Consent III.A.5.c.2. vii</td><td colspan="4">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.</td></tr>
<tr><td>Protection from Harm: Compliance Status:</td><td>Compliance: 3/3/17, 7/29/16, 5/15/15</td><td>Partial Compliance: 10/24/14</td><td>Non-Compliance: 3/28/14, 7/19/13 (not yet due)</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">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.</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 assess compliance, verification of the County's representations, and the factual basis for finding(s)</td><td colspan="4">Protection from harm:
Documentation provided by MDCR indicates that events 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.

Mental Health:</td></tr>
</table>

	There is evidence that responses are being provided to inmates on the mental health caseload who file grievances. There is a disproportionally low number of grievances submitted from this population indicating attention/advocacy is needed for this population. Additionally, the responses are not sufficiently in-depth in terms of problems solving rather than justifying the actions taken or not taken.
Monitors' Recommendations:	<u>Protection from Harm/Mental Health:</u> 1. Need to coordinate with CHS to assure all inmates' medical care includes visual screening for these incidents. 2. 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: 3/3/17, 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)	**Prior to the next tour – the revised policy regarding 2., below, and the associated lesson plans must be completed**.			
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 has been a recommendation for the last three reports. It needs to be addressed.**			

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: 3/3/17, 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)			
Monitor's Recommendations:	1. For next tour, an updated list of training lesson plans and a sample of those trained will be needed to document on-going compliance.		

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: 3/3/17	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)	See III.A.1.a (11) and III.A.4. a. **MDCR is advised that in order for this paragraph to remain in compliance at the time of the next tour, there must be credible action plans provided. If the policy needs to be amended, this can be submitted as evidence of continued compliance**.		
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.		

<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: 3/3/17, 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>
</table>

Monitors' analysis of conditions to 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.**
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 (3) MDCR shall develop and implement a policy to ensure that staff adequately and promptly report all uses of force within 24 hours of the force.		
Compliance Status this tour:	Compliance: 3/3/17, 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.		

Paragraph	III.A. 5.c. (4) MDCR shall ensure that use of force reports: i. are written in specific terms and in narrative form to capture the details of the incident in accordance with its policies; ii. describe, in factual terms, the type and amount of force used and precise actions taken in a particular incident, avoiding use of vague or conclusory descriptions for describing force; iii. contain an accurate account of the events leading to the use of force incident; iv. include a description of any weapon or instrument(s) of restraint used, and the manner in which it was used; v. are accompanied with any inmate disciplinary report that prompted the use of force incident; vi. state the nature and extent of injuries sustained both by the inmate and staff member vii. contain the date and time any medical attention was actually provided; viii. include inmate account of the incident; and ix. note whether a use of force was videotaped, and if not, explain why it was not videotaped.			
Protection from Harm: Compliance Status:	Compliance: 3/3/17	Partial Compliance: 7/29/16, 1/8/16, 10/24/14, 3/28/14	Non-Compliance: 7/19/13	Other: Other: Not reviewed per MDCR 5/15
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force reports; specifications for reporting. 2. Review of incident reports. 3. Review of investigations. 4. Review of inmate disciplinary reports. 5. Review of lesson plans. 6. Review of Medical Care/mental health records regarding injuries, including any required off-site hospitalizations. 7. Review of sample of staff workers' compensation claim relating to uses of force, inmate/inmate altercations. 8. Remedial, corrective action if necessary. 9. Review of digitally recorded incidents. 10. Review of MDCR Inmate Violence Report			
Steps taken by the County to Implement this paragraph:	See III.A.5.c. (1)			
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As noted in the immediately previous compliance report, 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 response to the Monitor's December 2015 and July 2016 analysis of the incidents. **MDCR is advised that in order for this paragraph to remain in compliance at the time of the next tour, there must be credible action plans provided. If the policy needs to be amended, this can be submitted as evidence of continued compliance**.
Monitors' Recommendations:	**1. Assure that there is a statement taken from inmate(s) involved with a use of force. It is unacceptable to note that the inmate is not available. Documentation of this specific point will be necessary for this paragraph to remain in compliance at the next tour date.**

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: 3/3/17, 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:	<u>Protection from Harm:</u> 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)	The TAAP unit receives the packages and reviews. There is coordination if any required items are missing or incomplete.			
Monitor's Recommendations:	None at this time as long as TAAP continues to evaluate the quality of the reports received in connection with uses of force and assures there is remediation of any deficiencies.			

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: 3/3/17, 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)	A sample of TAAP reports were reviewed documenting continual compliance.			
Monitor's Recommendations:	None at this time as long as TAAP continues to evaluate the quality of the reports received in connection with uses of force and assures there is remediation of any deficiencies.			

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: 3/3/17, 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)	**NOTE: A similar provision in the Consent Agreement, III.B.3. is noted in partial compliance by the medical/mental health Monitors.** A sample of TAAP reports were reviewed documenting continual compliance.			
Monitors' Recommendations:	None at this time as long as TAAP continues to evaluate the quality of the reports received in connection with uses of force and assures there is remediation of any deficiencies.			

Paragraph	III. A. 5.c. **(See CA III.B.3.c.)** (6) MDCR shall maintain its criteria to identify use of force incidents that warrant a referral to IA for investigation. These 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: 3/3/17, 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:	Assure that CHS staff are trained per CA III.B.3.c.			
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)	There is a concern about the adequacy of CHS' notes/medical record regarding the condition of the inmate and the detail of any injuries resulting from uses of force. A sample of TAAP reports were reviewed documenting continual compliance. **NOTE: A related provision in the Consent Agreement, III.B.3. is noted in partial compliance by the medical/mental health Monitors.**			
Monitor's Recommendations:	1. MDCR collaborate with CHS to assure that CHS staff are getting the training needed in terms of identifying and recording any injuries associated with uses of force. **2. Review CA III.B.3.c. to determine if any policy changes are needed for MDCR's use of force policy.**			

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: 3/3/17, 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 15 use of force reports; all contained photographs.			
Monitor's Recommendations:	1. Continue to self-monitor compliance via TAAP.			

Paragraph	III.A.5.c. (8) MDCR shall ensure that a supervisor is present during all planned uses of force and that the force is videotaped.			
Compliance Status:	Compliance: 3/3/17, 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)	A sample of TAAP reports were reviewed documenting continual compliance.			
Monitor's Recommendations:	1. The Monitor will review the documentation on all planned use of forces in the September 2017 tour.			

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: 3/3/17, 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)		
Monitor's Recommendations:	1. Track internal disciplinary. 2. Track referrals to the SAO on these cases, and outcomes.		

Paragraph	III.A.5.c. **(See CA III.B.3.b.)** (10) The Jail will ensure that inmates receive any required medical care following a use of force.			
Compliance Status:	Compliance: 3/3/17, 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)	A sample of TAAP reports were reviewed documenting continual compliance. **NOTE that Consent III.B.3.is in partial compliance.**			
Monitors' Recommendations:	See recommendations in III.A.5.c. (2)			

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: 3/3/17, 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)	**NOTE that CA III.B.3.is in partial compliance** This report was not provided for this tour; but will be necessary to maintain compliance for the September 2017 tour. **MDCR is advised that in order for this paragraph to remain in compliance at the time of the next tour, there must be credible action plans provided. If the policy needs to be amended, this can be submitted as evidence of continued compliance**.			
Monitor's Recommendations:	**1. Provide this report any time before the September 2017 tour.** 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: 3/3/17, 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)	**MDCR is advised that in order for this paragraph to remain in compliance at the time of the next tour, there must be credible action plans provided. If the policy needs to be amended, this can be submitted as evidence of continued compliance**. **NOTE that CA III.B.3. is in partial compliance.**			
Monitor's Recommendations:	1. Analyze the data in the quarterly reports. 2. Develop plans of action as needed. 3. See recommendations in III.5.c. (2)			

Paragraph	III.A.5.c. (13) MDCR shall maintain policies and procedures for the effective and accurate maintenance, inventory and assignment of chemical and other security equipment.			
Compliance Status:	Compliance: 3/3/17, 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)	Documentation regarding maintenance of the logs was provided, indicating consistency with the policy/procedures.			
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: 3/3/17	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)	**MDCR is advised that in order for this paragraph to remain in compliance at the time of the next tour, there must be credible action plans provided. If the policy needs to be amended, this can be submitted as evidence of continued compliance**.			
Monitor's Recommendations:	1. Provide any updates to the QA/QI policies. 2. Provide action plans			

<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: 3/3/17</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">Evidence provided on site.</td></tr>
<tr><td>Monitor’s Recommendations:</td><td colspan="4">1. Provide an update of the 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: 3/3/17</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"></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)	There were no cases regarding uses of force referred to the SAO since the July 2016 tour. The Monitor met with the SAO and she expressed some concerns that the number is zero. Urge MDCR to discuss this with the SAO in their monthly meetings. MDCR must reply on the MDPD to respond to investigations where criminal charges may occur (e.g. inmate/inmate, excessive use of force, PREA). MDCR should consider training staff to be cross certified and trained to conduct some initial investigations to improve outcomes, particularly around inmate refusals to give statements to police officers. MDCR will need to develop the data to support such a position, including but not limited to how other agencies similarly situated (for example, Orange County, Osceola County, Volusia County, Escambia County) respond in similar situations and the current level of staff resources required of MDPD in their responses to the jail and in subsequent investigations. Compliance is granted even though no MOU with the State's Attorney's Office has been developed, as suggested as a compliance measure since the first report. This matter needs to be addressed by the County. By the time of the preparation for the next tour, the County needs to provide information about whether this is planned, or not, and if not, what provisions can be made to assure effective investigations.
Monitor's Recommendations:	1. Update of SIAB standard operating procedures to assure more aggressive oversight of review conducted at the facility-level. 2. Develop a MOU with the State's Attorney regarding referrals to that office, or provide the reasons why this will not be accomplished. 3. Document the legal basis for MDCR's initiation/conduct of investigations that may/could result in criminal charges. 4. Evaluate the efficacy of cross certifying investigative staff, training, and oversight to improve internal investigations.

III. A.6. Early Warning System

Paragraph	III. A. 6. Early Warning System 1. Implementation (1) MDCR will develop and implement an Early Warning System ("EWS") that will document and track correctional officers who are involved in use of force incidents and any grievances, complaints, dispositions, and corrective actions related to the inappropriate or excessive use of force. All appropriate supervisors and investigative staff shall have access to this information and monitor the occurrences. (2) At a minimum, the protocol for using the EWS shall include the following components: data storage, data retrieval, reporting, data analysis, pattern identification, supervisory assessment, supervisory intervention, documentation, and audit. (3) MDCR Jail facilities' senior management shall use information from the EWS to improve quality management practices, identify patterns and trends, and take necessary corrective action both on an individual and systemic level. (4) IA will manage and administer the EWS. IA will conduct quarterly audits of the EWS to ensure that analysis and intervention is taken according to the process described below. (5) The EWS will *analyze the data according to the following criteria:* i. number of incidents for each data category by individual officer and by all officers in a housing unit; ii. average level of activity for each data category by individual officer and by all officers in a housing unit; iii. identification of patterns of activity for each data category by individual officer and by all officers in a housing unit; and iv. identification of any patterns by inmate (either involvement in incidents or filing of grievances).			
Compliance Status:	Compliance: 3/3/17, 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:	Protection from Harm: 1. Policies and procedures establishing and maintaining the early warning system; including criteria for thresholds and referrals. 2. Existence of a fully functioning early warning system. 3. Reports generated by the early warning system as described above. 4. Evidence of employee actions (e.g. remedial training, EAP, disciplinary actions, terminations) based on early warning system. 5. MDCR report of trends, etc. regarding use of force and employee corrective actions. 6. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of	Information was provided indicating the outcomes of EWS reviews. EWS status of staff involved with uses of force now included in TAAP reviews.			

the County's representations, and the factual basis for finding(s)	
Monitor's Recommendations:	None at this time. For next tour will be reviewing updates of the data regarding outcomes of EWS alerts in terms of remedial training, counseling, prosecutions, terminations, etc.

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: 3/3/17, 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	III. A. 6. Early Warning System c. On an annual basis, MDCR shall conduct a documented review of the EWS to ensure that it has been effective in identifying concerns regarding policy, training, or the need for discipline.		
Compliance Status:	Compliance: 3/3/17, 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)		
Monitor's Recommendations:	1. See recommendations III.A.6. a. (1)- (5)		

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: 3/3/17	Partial Compliance: 7/16, 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):	None			
Measures of Compliance:	<u>Fire and Life Safety:</u> 1. Develop a detailed controlled document inventory of all fire and life safety equipment for each facility. The list should include but is not limited to sprinkler heads, fire alarm pull boxes, and smoke detector units, and its location for each facility 2. Establish either a MDCR or facility specific formal policy outlining the procedure and staff responsibility including accountability for the monthly inspection, repair, and or replacement of all fire and life safety equipment included in the controlled document inventory. 3. Annual master calendar for all internal and external inspection of all fire and life safety system components. 4. Completed, signed, and supervisory review of all inspection and testing reports, along with documented corrective actions taken to resolve identified non-conformances.			
Steps taken by the County to Implement this paragraph:	MDCR originally developed and implemented policy, DSOP 10-022, entitled "Fire Response and Prevention Plan" effective 7/2/12. That policy was reviewed and accepted by the Monitor and DOJ in February 2015. It was authorized 10/24/16. The revised policy establishes in Section XI.A that the Fire Inspection Specialist (FIS) shall conduct inspections and document findings on the monthly Fire Inspection Report when applicable. Monthly Fire Inspection Report findings from the FIS shall be submitted to the CAB (Compliance and Audit Bureau) Captain and forwarded to the Director. If non-conformities or deficiencies require immediate correction, the FMB (Facilities Management Bureau) shall ensure timely repairs are completed. The Facility Bureau Supervisor shall follow-up to ensure that FMB completes the repairs. Section XI.C. establishes that the Fire Safety/Sanitation Officer (FSSO) shall ensure that fire safety equipment is inventoried and operable at all times and to conduct a fire/safety inspection of the entire facility in accordance with the weekly Fire Inspection Report Checklist that includes fire extinguishers, a visual check of the power generator, fire alarm systems, Self-Contained Breathing Apparatus (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 CAB. In turn CAB is required to conduct monthly follow-up to ensure that the FMB repairs violations documented on the Monthly Comprehensive Fire Safety Sanitation Inspection Report.			

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Prior to the tour MDCR provided copies of the monthly Fire Extinguisher Inventory Inspection report for Boot Camp, MWDC, PTDC and TGK for August, September, October, November, and December. At the tour, the Monitor reviewed the inventory/inspection report for February at each facility. The inventory and report identify by location all fire extinguishers by location and by a unique identifier. The inventory includes all extinguishers in storage at each facility and the specific extinguishers in storage needing repairs. The report demonstrates that faulty equipment has been replaced. The reports are complete and signed. Fire extinguishers are inspected and recharged every three years under contract for all facilities. MDCR also provided copies of the monthly fire inspection summary reports for August, September, October and November for all facilities prior to the tour. The reports are complete and include photos of all identified non-conformities, along with photos demonstrating that repairs were completed and therefore demonstrate closure of the inspection. When a repair is not completed the report includes documentation from FMB as to the reason repairs could not be completed. In those instances, the following month's report continues to identify the existing non-conformity thereby no existing non-conformities are forgotten or fall through the crack. MDCR provided an 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 does 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 conducted.
Monitor's Recommendations:	1. Assure the monthly Fire Inspection Reports continue to document that corrective actions were completed for all non-conformances.

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: 3/3/17,10/14, 3/14, 7/13	Partial Compliance: 7/16	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:	MDCR has an established a "Fire Safety Inspection Interval Schedule as an attachment to DSOP 10-022. It establishes requirements that fire extinguishers are certified (by contracted vendors) and that all fire alarm systems are tested and certified. All automatic fire alarms, sprinkler systems smoke detection systems, emergency exits, and fire extinguishers will be inspected and certified by a contracted vendor as well as by the local fire authority having jurisdiction in accordance with Florida Administrative Code Chapter 69A, Rule 54 "Uniform Fire Safety Standards for Correctional Facilities. The Inspection Schedule further ensures that an annual review of each piece of emergency or life safety equipment is conducted at the location of assignment, validating the purpose, and function of the equipment. When required, a functionality test will be conducted. Annual fire inspection and equipment tests conducted by the local fire department will suffice for this requirement. Miami-Dade County maintains a current contract with Florida Fire Alarm, Inc. for fire alarm testing (Contract No #6694-0/18 (Primary) and Metro Dade Security System, Inc. (Secondary). MDCR also maintains a contract with National Fire Protection, LLC (NFP) (Primary) and McGilvary Mechanical, LLC (Secondary) for fire sprinkler systems.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Following the previous tour MDCR provided copies of the contracts identified above. MDCR provided copies of the completed Fire Alarm System inspection for Boot Camp (completed 3/11/16); for MDWC (completed 3/18/16); for PTDC (completed 3/25/16); and TGKCC (completed 4/5/16). All were completed by Florida Fire Alarm, Inc. MDCR also provided a copy of the inspection for TTC completed on 4/8/16. However, that facility is currently closed for inmate housing. MDCR provided copies of the sprinkler system completed inspections for MWDC (completed 3/25/16); PTDC (completed 4/5/16); TGKCC (completed 4/5/16). All were completed by National Fire Protection LLC.			

	MDCR provided a copy of the Miami-Dade County Fire Rescue inspection for MWDC completed 12/1/16. As the inspections were all completed in March and April 2016, the 2017 inspections are not yet due. The Monitor will require copies of all inspections for 2017 prior to the September tour. Because copies of the inspections were provided and demonstrated approval, the provision is once again substantially compliant.
Monitor's Recommendations:	1. Provide evidence of 2017 compliance with the provision prior to the September 2017 tour to maintain compliance.

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: 3/3/17	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 entitled "Key Control" was authorized 7/11/2012. Revisions to it were reviewed and accepted by the Monitor (5/27/15) and DOJ (8/7/15). It was formally authorized by the Director on 11/4/16. The new key control policy eliminates the need for a separate emergency key control policy for each facility as emergency keys for all facilities are consistent 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. The emergency /evacuation keys of the facilities are located as follows: PTDC: In the front booth TGK: Central Control Boot Camp: Shift Commander's office and at East Gate 2 MWDC: Central Control The Key Control Officer at each facility shall ensure that all emergency key rings included keys to all doors and locks along the facility's primary and secondary evacuation routes; keys for the secure perimeter of the facility; glow sticks to provide light during a power outage; and ring label and notched keys. The Key Control Officers shall ensure that an extra emergency key ring, containing off-site emergency keys is provided to the closest detention facility for severe emergencies. The policy requires that staff be trained to identify emergency keys by both sight and touch. MDCR has established a formal lesson plan for emergency key training for second line supervisors (Sergeants) and above that includes both lecture and a blindfold practicum exercise and written pre-and post-test for trainees. 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.			
Monitor's analysis of conditions to assess compliance, verification of	Prior to this tour MDCR provided copies of the sign-in sheets and test scores along with evidence of successful blindfolded practicum assessments for a "train the trainer" training for14 facility key control officers, the facility safety			

the County's representations, and the factual basis for finding(s)	and sanitation officer and field training officers. This group is responsible to train the designated second line supervisor and above at each facility. MDCR also provided sign-in sheets, and pre-and post-test scores along with evidence of successful blindfold practicum assessments for all staff who have completed emergency key training since the previous tour. It includes training for 6 staff at Boot Camp, 34 at MWDC, 30 at PTDC, and 60 at TGKCC 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. Key control officers are testing emergency keys at least quarterly and documenting the testing in the electronic key control log.
Monitor's Recommendations:	1. Continue to provide evidence of training to the revised policy and procedure for key control officers and designated staff. 2. 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.

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: 3/3/17	Partial Compliance: 7/16; 1/16; 5/15; 10/14; 3/14; 7/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour(s):			
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:	The revisions to DSOP 10-022 entitled "Fire Response and Prevention Plan" was authorized on 10/24/16. Section XII states, "The CAB Captain or DSO shall ensure that all fire drills are documented on the Fire Drill Report to ensure effective staff response to a fire emergency. Fire Drill Procedures are comprised of Fire Drill Levels I-IV as depicted on the Fire Drill Level Overview Sheet. The degree of difficulty is increased with each consecutive level. The Fire Drill Report is used to evaluate staff response during a fire drill. Each area supervisor shall conduct fire drills, complete Fire Drill Reports; and review past Fire Drill Reports to assess staff readiness and proficiency when responding to emergencies. Revisions to DSOP Policy 10-006 entitled "Emergency Procedures RE: Evacuation was authorized on 10/24/16 by the Director. Section IV states, "MDCR conducts fire drills (levels 2, 3, and 4) that include evacuation of inmates, except when safety and facility security may be jeopardized. The level 1 drill (simulation exercises) shall be used to evaluate staff readiness when the evacuation of inmates will jeopardize facility security. The CAB Fire Safety Specialist shall ensure evacuation/fire drills are conducted at least quarterly in each facility and on all shifts. Shift Supervisor shall conduct 3 fire drills per month, 1 on each shift." The breakdown of drill types includes: 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.		

	MDCR also provided recently reviewed and updated facility specific post orders: Boot Camp: Effective 11/4/16 MWDC: Effective 11/1/2016 PTDC: Effective 11/1/2016 TGK: Effective 11/1/2016 The Post Orders establishes that a copy of the CAB 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 CAB. If any non-conformances are identified during the drill, it is considered a "failed drill." New since the previous tour, CAB conducts a monthly audit of all fire drills for each facility that includes a review of the videos taken during the drill. When the CAB auditor identifies non-conformities, he/she submits a request for corrective action to the facility supervisor. They, in turn, must provide a corrective action plan and evidence that the corrective action was taken to close out the audit report.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As of this tour the policies referenced above are now authorized. 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 2017, along with copies of the monthly fire drill reports for September, October, November, and December 2016 for review. In the four-month period, each facility had three drills. Most important, the drill assessments continue to improve. The December drill observations and analysis were significantly improved over the previous months following the Technical Assistance Visit by the Monitor in early December. Prior to the tour MDCR provided a copy of the July and August audits completed by CAB. The purpose of the written audit report is to demonstrate that MDCR is conducting an objective assessment of all drills for each facility each month. That review includes watching the drill video, identifying areas of concern with the drill and an assessment of the drill report. The auditor then submits the report back to each facility and requests written corrective actions for any non-conformities. The audit report is closed when all corrective actions have been taken and accepted by the auditor. The Monitor suggests that facilities needing to submit corrective actions assure that the responses meet the 10-day response time. Facilities generally are taking too long to respond. The audit tool is an excellent step in assuring management that the drills are effectively assessed and changes made as needed. The Monitor suggests for improvement that the drill scenario be written and submitted along with the drill report so the auditor will know what to expect when viewing the videos and reviewing the reports.
Monitor's Recommendations:	1. 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. 2. Provide the Monitor with copies of the drill reports, along with the review and analysis and document any corrective actions taken.

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: 3/3/17	Partial Compliance: 7/16; 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):	None			
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". It was formally authorized on 11/4/16 by the Director. The Policy requires MDCR to maintain Safety Data Sheets (SDS) for all chemicals, labeling requirements for all chemical containers including working containers, and procedures to ensure safe usage protocols regarding dilution, storage, supervision, training, inventory, issuance, and use. It establishes procedures for chemical spills and disposal of hazardous chemicals/materials. The Policy establishes that staff assigned to Sanitation Units be provided four hours of chemical control training prior to assignment. The training lesson plans are developed by Training Bureau staff and approved by the Training Bureau Supervisor. It further establishes that Sanitation Staff shall ensure that inmate workers are trained on chemical usage prior to their assignment. All inmate workers shall view the "Inmate Sanitation Worker Orientation " video" that includes types of chemicals, chemical labels, use of personal protective equipment, and first aid instructions. Inmate workers are required to sign the "Inmate Orientation/Training Video Acknowledgement" form in either English, Spanish, or Creole documenting that they have received chemical control training regarding safety and usage. The documentation is placed in the Inmate Profile System (IPS) folder. MDCR has developed an 8-hour lesson plan dated 10/26/16 for chemical control plan based on the policy and procedures and is used to train facility Safety and Sanitation Officers (FSSOs) and MDCR employees permanently assigned to facility sanitation units. They have also established and are maintaining chemical control inventory logs and sign-in/out logs for use by all facilities.			

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 Boot Camp, TGK, MWDC, and PTDC. At each facility, the FSSOs were completing the chemical inventory correctly. The chemical storage rooms are organized well and provide secure access to staff. Inmate workers are only allowed to handle chemicals that have been diluted in accordance with the chemical manufacturer's specifications. Safety Data Sheets (SDSs) are available for all chemicals stored at the entrance of the respective chemical control rooms. MDCR has begun to install electronic dispensing systems for all laundry washers at each facility for personal laundry. MDCR is planning to install automatic dispensing equipment at all facilities similar to the system currently operating at TGKCC where each housing unit has its own automatic dispensing equipment. The contract includes a provision where the chemical system provider will be required documented training of all designated staff for all shifts at each facility. The Monitor reviewed a copy of the training lesson plan and noted that it followed the requirements of the policy. MDCR provided a database spreadsheet identifying 82 of 89 staff had completed either the 8 or 4-hour chemical control training and who received the training including the pre/post training test scores. The eight-hour class includes the four-hour chemical control training and training for chemical spill response. On this tour, I did not observe inmate workers using chemical so I could not assess whether adequate supervision was provided. As a result of the policy authorization and training the provision is substantially compliant
Monitor's Recommendations:	2. Continue to provide evidence of training of all chemical control training to FSSOs and other designated staff prior to the next tour. 3. Consider developing a training program for inmate workers on the safe and effective use of chemicals used for housekeeping.

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: 3/3/17	Partial Compliance: 7/16; 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):				
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 previously provided a copy of the 8-hour lesson plan for initial fire and life safety training that is being provided to all current MDCR correctional employees. The training was developed in accordance with the current edition of DSOP Policy 10-022 (Fire Response and Prevention Plan) effective 10/24/16 and DSOP Policy 10-006, (Emergency Procedures RE: Evacuation effective 10/24/16. DSOP Policy 10-022 requires the CAB Captain, in conjunction with the Training Bureau Supervisor to be responsible for ensuring that there is an ongoing fire safety/procedure training program to include fire watch training. DSOP Policy 10-006 establishes, "All staff shall be trained and understand emergency evacuation procedures in order to respond quickly. All staff shall receive mandatory in-service training annually which include evacuation procedures. Biennial training shall be included to ensure safe and effective use of fire and emergency equipment." The training shall be in accordance with the approved Training Bureau lesson plan. Staff knowledge shall be measured through pre-and-post testing of evacuation procedures. MDCR has recently completed a two-hour on-line refresher module for biennial training that includes specific performance objectives for all sworn employees who previously received the 8-hour Fire and Life Safety Course. This course also includes a 10-question pre-and-post test. MDCR maintains a database of all sworn staff that is required to have initial training and ultimately the biennial refresher training. Currently MDCR has 2041 sworn staff. They have developed a schedule demonstrating that all staff will have received the initial training by mid-2018. See details below. MDCR provided copies of a data-base that shows the pre-and-post test scores for participants of the training. In previous submittals, MDCR provided copies of sign-in sheets and copies of completed tests. That documentation is always available to the Monitor to review during the tour.			

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	At this tour MDCR provided documentation of initial fire safety training for officers demonstrating that in 2015, 43 officers were trained; 476 completed training in 2016 and that 141 officers have completed training in 2017. It is planned that 1200 staff will be trained and the remaining 339 officers plus new staff will complete training in early 2018. The 43 officers trained in 2015 will receive the on-line refresher training in 2017 and the 476 who received the initial training in 2016 will receive the on-line refresher training in 2018. MDCR provided a copy of the training database report that is maintained to track progress in training. During this tour, the Monitor participated in about two hours of the 8-hour fire and life safety training program held at TTC. The lecture training provided was excellent. The Monitor also observed training for deployment and use of SCBA equipment, fire hose deployment and use, and observed the training for officers on evacuation from a smoke-filled room. The training was excellent. That said, the Monitor strongly believes that MDCR consider eliminating the SCBA equipment and training and the fire hose deployment and use. MDCR should consider whether it really intends to have correctional staff deploy and use a fire hose or whether that is the responsibility of the local fire department. The Monitor's observation of the SCBA donning and the review of a fire drill that demonstrated staff have extreme difficulty in donning and doffing equipment quickly and effectively. The fire drill video clearly showed that the officer attempted to don the SCBA, but just put it over one shoulder and then laid it down on a table to assist an inmate. Those actions are not in accordance with the policy or the training and the Monitor questions the safety of the officers in an actual emergency under extreme stress. The discussion should include not only CAB staff, but also include the trainers who observe the performance of trainees. As an alternative MDCR might consider creating a voluntary "Emergency Response Team" for each facility that can be properly trained and receive regular refresher training on dedicated equipment to respond to all types of emergencies including fire and evacuation. It takes regular repeated training to assure officers are capable to safely respond in stressful situations. While not part of the provision, the Monitor suggests that because medical personnel assigned to MDCR are part of the response team, training be provided to them consistent with CHS requirements and not conflicting with MDCR policies and procedures. Consideration should also be included for Maintenance Bureau staff that also will be part of a response such as mechanical system workers, electricians, and plumbers. The training process for both CHS and Maintenance needs to be memorialized. Following discussions with the Training Bureau, the Monitor suggests that process of how the training log is consistently maintained and provides up-to-date information. Currently that process is not memorialized to assure both that it is accurate, but more importantly followed correctly and consistently.

	The Monitor strongly suggests that the process for officers who do not adequately perform in fire drills receive corrective training be developed and implemented consistently by all facilities.
Recommendations	1. Review the need for staff use of SCBA equipment and for deployment and use of a fire hose for large fires. Use of a fire extinguisher to eliminate a small fire is a reasonable expectation. 2. Create a written process and procedure for maintaining the fire and life safety training log. 3. Develop a process and procedure for training both CHS staff and Maintenance Bureau staff who are expected to support MDCR during a fire and/or life safety emergency that includes a process to maintain the training log for them.

III. C. Inmate Grievances

Paragraph Coordinate with Drs. Ruiz and Greifinger See also Consent Agreement III.A.3.a.(4) and III.D. 1.b.	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: 3/3/17, 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 inmate grievances per the specifications above. 2. Updated inmate handbook. 3. Review of grievance forms (Creole, English, Spanish) 4. Review of procedures for LEP inmates, and illiterate inmates. 5. Review of a sample of grievances. 6. Observation of grievances boxes and processing of grievances. 7. Interview with inmates. 8. Evidence of referral of grievances alleging use of force; sexual assault. 9. Quarterly tracking/data reporting; recommendations, if needed. 10. Documentation of collaboration between security and medical/mental health regarding inmate grievances. 11. Quarterly report of trends, by facility; corrective action plans, if any. Medical Care:			

	• Review of Quality Improvement Plan and bi-annual evaluations • QI committee minutes • Clinical performance measurement tracked and trended over time, with remedial action timelines and periodic re-measurement • Review of grievances, responses, and data analysis <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> If the issues associated with CHS' handling of grievances are not resolved by the next tour, this paragraph risks being moved to partial compliance. **NOTE that <u>CA III.A.3.</u>is in 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. See note in introduction about MDCR's continued compliance absent compliance by CHS. 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

<table>
<tr><td>Paragraph
Coordinate and Grenawitzke</td><td colspan="4">III. D. Self Audits
1. Self Audits
MDCR shall undertake measures on its own initiative to address inmates' constitutional rights or the risk of constitutional violations. The Agreement is designed to encourage MDCR Jail facilities to self-monitor and to take corrective action to ensure compliance with constitutional mandates in addition to the review and assessment of technical provisions of the Agreement.
c. On at least a quarterly basis, command staff shall review data concerning inmate safety and security to identify and address potential patterns or trends resulting in harm to inmates in the areas of supervision, staffing, incident reporting, referrals, investigations, classification, and grievances. The review shall include the following information:
(1) documented or known injuries requiring more than basic first aid;
(2) injuries involving fractures or head trauma;
(3) injuries of suspicious nature (including black eyes, injuries to the mouth, injuries to the genitals, etc.);
(4) injuries that require treatment at outside hospitals;
(5) self-injurious behavior, including suicide and suicide attempts;
(6) inmate assaults; an
(7) allegations of employee negligence or misconduct.
b. MDCR shall develop and implement corrective action plans within 60 days of each quarterly review, including changes to policy and changes to and additional training.</td></tr>
<tr><td>Protection from Harm: Compliance Status:</td><td>Compliance: 3/3/17</td><td>Partial Compliance: 7/29/16, 10/24/14</td><td>Non-Compliance: 3/28/14, 7/19/13</td><td>Other: Per MDCR not reviewed 5/15, 1/16</td></tr>
<tr><td>Fire and Life Safety: Compliance Status:</td><td>Compliance: 3/3/17</td><td>Partial Compliance: 7/29/16, 10/24/14</td><td>Non-Compliance: 3/28/14, 7/19/13</td><td>Other: Per MDCR not Reviewed 1/16; 5/15</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4">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.</td></tr>
</table>

	2. Inspections should result in identifying specific non-conformities to the policies and include the assigning of persons responsible for taking and documenting corrective actions including oversight to measure the effectiveness of same.
Steps taken by the County to Implement this paragraph:	
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: The policy was completed in October 2016 placing this paragraph in provision compliance – meaning that the Monitor recognizes the hard work by MDCR to get to this point. However, continued compliance will require: modifications to the policy based on the work with the County's OMB to refine root cause analysis and action planning; collaboration with CHS' QA/QI processes; and production of credible root causes analyses (per policy) and action plan. This requirement is noted in other paragraphs in this report. MDCR does not have to wait until just prior to the next tour to submit document they believe maintain compliance with this paragraph and these conditions.
Monitors' Recommendations:	Protection from Harm: 1. See above – as well as the introduction to this report which clearly identifies the requirements to remain in compliance. Fire and Life Safety: 1. Develop and implement a plan to train MDCR officers who are responsible for conducting internal audits and reporting. 2. Engage in data analysis to identify trends that may require modifications to DSOP policies and/or training materials.

<table>
<tr><td>Paragraph</td><td colspan="4">D. Self Audits (See CA III. D. 2.)
2. Bi-annual Reports
a. Starting within 180 days of the Effective Date, MDCR will provide to the United States and the Monitor bi-annual reports regarding the following:
(1) Total number of inmate disciplinary reports
(2) Safety and supervision efforts. The report will include:
i. a listing of maximum security inmates who continue to be housed in dormitory settings;
ii. a listing of all dangerous contraband seized, including the type of contraband, date of seizure, location and shift of seizure; and
iii. a listing of inmates transferred to another housing unit because of disciplinary action or misconduct.
(3) Staffing levels. The report will include:
i. a listing of each post and position needed at the Jail;
ii. the number of hours needed for each post and position at the Jail;
iii. a listing of correctional staff hired to oversee the Jail;
iv. a listing of correctional staff working overtime; and
v. a listing of supervisors working overtime.
(4) Reportable incidents. The report will include:
i. a brief summary of all reportable incidents, by type and date;
ii. data on inmates-on-inmate violence and a brief summary of whether there is an increase or decrease in violence;
iii. a brief summary of whether inmates involved in violent incidents were properly classified and placed in proper housing;
iv. number of reported incidents of sexual abuse, the investigating entity, and the outcome of the investigation;
v. a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit;
vi. number of inmate grievances screened for allegations of misconduct and a summary of staff response; and
vii. number of grievances referred to IA for investigation.
2. The County will analyze these reports and take appropriate corrective action within the following quarter, including changes to policy, training, and accountability measures.</td></tr>
<tr><td>s</td><td>Compliance: 3/3/17</td><td>Partial Compliance: 7/29/16, 1/8/16, 5/15/15, 10/24/14</td><td>Non-Compliance: 3/28/14, Not Yet Due (10/27/13)</td><td>Other:</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4">Directive needs to be completed</td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><u>Protection from Harm:</u>
1. Policies and procedures regarding self-audits.</td></tr>
</table>

	2. Bi-Annual Reports. 3. Corrective action plans, if needed. 4. Evidence of implementation of corrective action plans, 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)	Protection from Harm: **See III.D.1 a. and b. Same conditions are applied here to continued compliance with this paragraph. These sections are in partial or non-compliance.** **These sections will be assessed in the next tour.**
Monitor's Recommendations:	Protection from Harm: See CA III.D.1. a. and b.

IV. Compliance and Quality Management

Paragraph Coordinate with Grenawitzke	IV. COMPLIANCE AND QUALITY IMPROVEMENT (duplicate CA 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: 3/3/17	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: 3/3/17	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: See III.D.1. a and b. 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: 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:	None at this time.

Paragraph Coordinate with Grenawitzke	IV. COMPLIANCE AND QUALITY IMPROVEMENT (See also 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: 3/3/17	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: 3/3/17	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:				
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: See III.D. a. and b. Fire and Life Safety:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: See III.D. a. and b. See also introduction to this report. Fire and Life Safety:			
Monitor's Recommendations:	Protection from Harm: See III.D. a. and b. 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 (See also 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: 3/3/17, 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: 3/3/17, 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: .		
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 schedule 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: 3/3/17, 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: 3/3/17, 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: 1. Providing drafts of revised/new policies for all provisions of Fire and Life Safety 2. Providing drafts of training plans for fire, life safety, sanitation, key control, chemical control that include documentation that the plan address all of the provisions of the applicable policies for each of the provisions. 3. Training Schedule and a training matrix that identifies specifically what training is required for each position within MDCR 4. Evidence of how training effectiveness will be measured and process for addressing staff that can or do not demonstrate MDCR specified effectiveness.			
Steps taken by the County to Implement this paragraph:	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.			
Monitor's Recommendations:	Protection from Harm, Fire and Life Safety None at this time.			

Compliance Report # 7
Consent Agreement - Medical and Mental Health Care
Report of Compliance Tour, February 2017

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

Consent Agreement – Status of Compliance[7]

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[8]
5	4	50	61	0	115
6	10	65	40	0	115
7	16	51	48	0	115[9]

Preparation for the Tour

We have continuing concerns of CHS' responsiveness to the Monitors' data requests ahead of the tour. The information provided in response to the document request was, in some cases unanalyzed data, with few, if no, recommendations – indicating if CHS had engaged in the analysis. Some of the data was internally inconsistent. The other possible interpretation is that CHS analyzed the data, and chose not to the share it with the Monitors. It is unclear if CHS is using the information to inform decisions. Dr. Ruiz was clear in her communication with Director Estrada about what the expectations are for the future responses to informational requests. We urge CHS to provide a point of contact to compile, verify if it is responsive, assure internal consistency of the data, and liaison with the requesting Monitor.

[7] 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.

[8] Joint reporting paragraphs removed.

[9] For historical data regarding compliance by paragraph, see Appendix B.

Compliance with Summary Action Plan

The medical and mental health Monitors assessed CHS' compliance with Summary Action Plan (SAP), filed with the Court on May 18, 2016. The SAP committed CHS to full compliance by February 21, 2017.

As noted above, this compliance was not achieved.

Medical Care

This was the first on-site compliance tour for the current medical Monitor. The medical Monitor conducted this review with the assistance of Catherine M. Knox, RN, MN, CCHP and Angela Goehring, RN, MSA, CCHP, who were both familiar with the operations of MDCR and CHS through prior compliance reviews.

Progress toward meeting compliance with the Consent Agreement has been somewhere between slow, and stalled, in all the required medical areas: intake screening, health

discharge planning, mortality and morbidity reviews, acute care and detoxification, chronic

The implementation of an effective quality management program will assist the CHS management and clinical leadership teams to identify opportunities for improvement; develop action plans with clear accountabilities for specific personnel, with timelines and milestones; measurement; analysis; and tracking and trending performance. A focus on self-critical analysis is imperative for the success of such programs. The quality management program should include an annual plan and evaluation; clinical performance measurement; grievance analysis; evaluation of training; and morbidity and mortality review, among others.

Mental Health Care

Specific to the timeline outlined in the Summary Action Plan, the Mental Health Monitor focused its review on specific harm to patients. These areas included review of preventable injury, such as seizure necessitating transfer to the emergency department on an urgent basis, failure to provide timely access to care (leading to harm), and morbidity and mortality.

Inefficient Screening

On average, the nurses at booking refer three out of five or 63% of patients to the mental health caseload. This number is high when compared to other correctional facilities, both large and small. More concerning, however, is that the most common cause for transfer to the emergency department was seizure. The second reason for transfer was assault. Curiously, persons on the mental health caseload made a statistically significant percentage of the involved in uses of force.

One of the cases reviewed demonstrates that negative outcomes can be prevented by re-organizing the system. Meet Patient A. He was admitted in mid-September and the nursing assessment stated upon intake that, "He was involved in an assault." It did not characterize the assault or the nature of the injury. No vital signs were taken or noted in the first note. Later, his blood pressure was elevated at 159/100.

The following day, nursing note diagnosed, "Alcohol, HTN, status post altercation, psych level II, detox protocol in progress." Despite the fact that the detox protocol was in progress, Patient A had not actually received any medication.

Two days later, Patient A was administered an Emergency Treatment Order. The nursing note described him as "angry, incoherent, combative." He was transferred to the hospital for a brain scan to assess for an injury. Once there, they found he suffered a closed displaced fracture during the 'take down.' His blood pressure prior to transfer: 170/100. This indicates that Patient A had not received medication per the detoxification protocol and was hallucinating and incoherent due to delirium, a potentially fatal psychiatric emergency.

Patient A received Haldol and Benadryl. He was admitted to the intensive care unit. This situation was preventable.

A similar situation occurred with a Patient B. He acknowledged a history of seizure at intake, as well as a history of opioid abuse. Within twenty-four hours of intake, he was described as, "Constantly moving, hallucinating, extremely agitated, pants fell off." Not long afterward, he was described as, "Confused, very anxious, cuffed in chair." Patient B was also delirious. He was given multiple doses of Benadryl, Ativan, and Haldol until he became somnolent.[10] Emergency medical services were called and Patient B was admitted to the intensive care unit.

Compliance Coordinator and Quality Improvement

The County has hired a Compliance Coordinator. In coordination with the Compliance Coordinator, the Director of Quality Improvement should capitalize on this opportunity to put forth a solid policy on quality improvement and implement a plan for performance measurement. The County should utilize the data it has collected and analyze it both to deploy the resources it has hired in the previous months as well as to mitigate harm to inmates. Patterns and trends should be analyzed.

Coordination with MDCR

There is an opportunity to improve coordination and hence patient outcomes. CHS should develop and produce for MDCR daily schedules for the delivery of services to

[10] The emergency department quick triage chief complaint was: drug overdose.

each housing unit in which Level 1 and 2 inmates are held. It would also be optimal to also develop and produce schedule for units housing Level 3 and 4 inmates as well. This schedule should include, but not be limited to, medical administration, individual and group counseling, and appointment times for other mental health and psychiatric services (including the names of the providers the MDCR staff can expect). While this is no way to accommodate emergencies, which arise with this population, the lack of structure for activities over which CHS has control is a negative for both the patients and the corrections staff who are supervising the housing units. The development and periodic updating of schedules will enhance MDCR's staffing coverage. The schedules also provide a level of accountability for MDCR staff in terms of knowing the times when CHS staff are or are not in the units as scheduled. Improved communication will also enhance safety and outcomes.

During the next tour, the Monitors will review if this recommendation has been addressed, or assess any alternatives developed by the parties to improve coordination.

Summary of Status of Compliance - Consent Agreement
Tour #7[11]

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.		MH	Med	
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. (See (IIIA1a) and C. (IIIA2e))		MH	Med	
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	

[11] For the historic profile of compliance, by paragraph, for the Compliance Agreement – see Appendix B.

4. Medication Administration and Management				
III.A.4.a.		MH	Med	
III.A.4.b(1)		Med	MH	
III.A.4.b(2)			Med; MH	
III. A. 4. c.		MH		
III. A. 4. d.			MH	
IIIA.4.e.		MH	Med	
III.A.4.f. (See (III.A.4.a.)		MH	Med	
5. Record Keeping				
III.A.5.a.		Med; MH		
III.A.5 b.			MH	
III.A.5.c.(See III.A.5.a.)		Med; MH		
III.A.5.d.		Med; MH		
6. Discharge Planning				
III.A.6.a.(1)		MH	Med	
III.A.6.a.(2)		MH	Med	
III.A.6.a.(3)		MH	Med	
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		Based on rating from information available in July 2016
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			

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: Greifinger 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; 3/3/2017	Non-Compliance: 3/14 (NR)
Mental Health Care: Compliance Status:	Compliance: 5/15	Partial Compliance: 3/14; 10/14; 1/16; 7/29/16; 3/3/2017	Non-Compliance: 7/13 (NR)
Measures of Compliance:	Medical Care: • Observation of process • Medical record review • 24-hour threshold • Review of nursing orientation and in-service education Mental Health Care, as above and: 1. Record review that qualified mental health staff are conducting mental health screening and evaluation 2. Results of internal audits 3. Review for policies, procedures, practices. 4. Review of in-service training. 5. Interview of staff and inmates.		
Steps taken by the County to Implement this paragraph:	Medical Care:		

	Intake screening is performed by RNs. Nurses do their best to provide confidentiality in a physical space that is not especially conducive to privacy. Screening for sexually-transmitted infection (syphilis, gonorrhea, Chlamydia) began two weeks prior to the tour. Mental Health Care: Patients are being interviewed and screened for mental health issues. Screening occurs within the presence of an officer.
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 nursing education program is inadequate, not correctional based, and lacks hands on return demonstration components to ensure competency. Week one of nurse orientation is spent at Jackson Health covering required topics such as blood borne pathogens, fire safety, human resource policies and procedures, use of the AED, IV pumps, and blood glucose monitoring. MDCR correctional staff orients the nurses to safety and working with inmates in a correctional environment. Week two covers reading of the health care policies and procedures, training on the electronic health record, Sapphire medication software, writing incident reports, meeting with department directors and administrators and orientation to the unit. Critical topics not covered: • Conducting intake screening and understanding "street lingo", creating a safe milieu to encourage patient self-report of illicit drug use, signs and symptoms of drug and alcohol withdrawal and detoxification, and assessment skills using CIWA/COWS. • Practice with sick call protocols and demonstration of competency in performing a physical exam • Admission and discharge to the infirmary, medical observation and housing process • Development of nursing care plans for infirmary and medical observation care • Hands on experience with contents of the crash cart, back board, oxygen, and other emergency response equipment • Response to man down calls • Response to mass disasters • Preparation of the medication cart, pharmacy management i.e., formulary vs. non-formulary, medication re-orders, returns, and perpetual inventory • Response to traumatic injury i.e., officer abuse • Professional boundaries specific to corrections • Recognition of withdrawal symptoms • Patient safety • PREA • Discharge planning and bridge medications The nurse educator assigned to CHS is not familiar with correctional specific terminology needed to be effective when interviewing inmates and obtaining history of lifestyle practices on the street that impact the patient's health upon entry to the jail system. The educator should experience at each post in the correctional health services program to be positioned to effectively teach the knowledge and skills necessary for the correctional professional nurse.

	Review of curriculum from an alcohol/drug withdrawal in-service revealed incorrect information on the time frames for demonstration of withdrawal symptoms. Training curriculum related to patient care should be reviewed by a physician or psychiatrist before being placed in the in-service education and new hire orientation tool kit. A history of complications from drug and/or alcohol withdrawal is the greatest predictor of subsequent complications. The intake questionnaire is deficient, in that there are no questions as to whether the incoming patient has had tremors, seizures, DTs or other complications of withdrawal in the past. Records of 18 inmates who were admitted between September 2016 and January 2017 were reviewed. Records were selected from a list of intakes January 15 – 21, 2017, from a list of patients with provider appointments scheduled on 1/31/2017 and from a list of inmates who had been sent to the ED in December 2016. All three lists were provided by CHS. Findings: • Intake screening is accomplished within 24 hours and completed by registered nurses. • Inmates identified as having medical or mental health problems are referred for additional evaluation by qualified medical and mental health professionals. Of eight inmates identified as having emergent or urgent health care needs by the screening nurse only four were seen within the required timeframe. • Previous health records were requested, reviewed by the provider and the information incorporated into the plan of care only occasionally (6/17). • Of the 10 inmates who reported taking medication at the time of intake, eight had treatment continued (the type of medication may have been different but the purpose was consistent with diagnosis) and the first dose was given within 24 hours. <u>Mental Health Care:</u> The tool being utilized for mental health and suicide screening refers approximately 60-70% of the population for mental health evaluation. The County performed a pilot study on a suicide screening tool and reported that the NY suicide screening tool was not useful, as it referred patients at a higher acuity than its prior suicide screening tool (i.e. patients were referred for evaluation by a Qualified Mental Health Professional [QMHP] at 2 hours vs 4 hours). Sixty to seventy percent of the population on the mental health caseload is high relative to other jails; this number should be closely examined for possible and continued over-referrals. Procedures may need to be streamlined and over-reliance on poly-pharmacy may be a factor.
Monitors' Recommendations:	<u>Medical Care:</u> 1. Revise the intake screening form to help identify high risk of withdrawal from drugs and/or alcohol 2. Improve supervision of the intake process to improve continuity of care 3. Include the medical intake process in the clinical performance measurement component of the QI Plan 4. Make the nursing orientation and in-service education relevant to CHS' work <u>Mental Health Care:</u> 1. The County should streamline its intake procedure. 2. Existing data should be analyzed for to identify areas for opportunity and bottle necks.

	3. Mental health staff should be placed in areas where their skills may be optimized to alleviate bottlenecks and maximize throughput. For example, ARNPs and/or psychiatrists may be useful directly in intake and social workers may be useful to provide therapeutic programming for Level I and IIs that are not adherent to medication.

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; 3/3/2017	Partial Compliance: 3/14; 10/14	Non-Compliance:
Measures of Compliance:	Mental Health: 1. Results of internal audits demonstrating compliance with NCCHC indicator J-E-05 2. Results of internal audits demonstrating completion of intake screening upon admission 3. Result of internal audit demonstrating 90% or more of inmates who screen positively shall be referred to qualified mental health professionals for further evaluation 4. Record review 5. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	CHS has revised policy CHS-033: Mental Health Screening and Evaluation.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Mental health staff assigned to intake screening are QMHPs (social workers) and nurse practitioners. Internal audits provided related to intake screening indicated that 88% of intake screens were "appropriate" for the level assigned. 12% were not appropriate. The review did not specifically state who conducted the review, what date it was conducted, or what was the criteria of an appropriate referral; upon further exploration, we were informed that an appropriate referral was defined as 'the criteria of the level.' Data provided during the on-site tour indicated that median wait times during intake between medical stations were 11.9 hours or approximately 4 hours above the allotted time to see mental health. Times were not provided or specified to see psychiatry, although I was told (verbally) that psychiatry typically sees the patient the following day. Outstanding issues continue to be timeliness to see a psychiatrist, bed placement, and the overall number of mental health referrals.		
Monitor's Recommendations:	1. As discussed above, intake should be streamlined. 2. All mental health clinicians should be trained to identify symptoms of withdrawal and allowed to refer directly to detox. 3. Revise and validate mental and suicide screening procedures at intake to better capture signs and symptoms of withdrawal, suicide risk, and symptoms consistent with Appendix A. 4. Complete self-audits of accuracy of level and triage system for mental health 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; 3/3/2017	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 revised its policy on basic mental health care. 2. The County is in the process of revising its policy on suicide prevention and restraint.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	I requested a list of patients that had been placed on constant observation. I received a list of patients that had been placed on suicide precaution. These terms are not interchangeable, as some patients which are on suicide precaution may not require constant observation, but rather staggered 15-minute checks. The County has not implemented a way to identify constant observation in the electronic medical record. CHS' ability to provide the list demonstrates that there is an effort to clarify. The policy is drafted; but needs to be clearer in terms of having an order for patient based on the diagnosis and housing.		
Monitor's Recommendations:	The Mental Health Monitor recommends the County implement definitions and systems for the following: 1. Constant observation should be noted in the electronic medical record by an order and; 2. Emergent psychiatric referrals should be noted in the electronic medical record by an order.		

Paragraph Author: Greifinger 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: 3/3/17, 7/29/16,	Non-Compliance: 3/14 (NR); 10/14
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 5/15; 3/3/2017	Non-Compliance: 3/14 (NR); 10/14; 1/16; 7/29/16
Measures of Compliance:	<u>Medical Care:</u> • Medical record review <u>Mental Health Care, as above and:</u> 1. Record review of adherence to screening, assessment, and trigger events as described in Appendix A 2. Review of housing logs; 3. Review of observation logs for patients placed on suicide precaution. 4. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	<u>Medical:</u> Not applicable <u>Mental Health Care:</u> As per revised policy 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):	<u>Medical Care:</u> The intake process is not timely for the identification of serious medical needs and risk of harm. <u>Mental Health Care</u> The Correctional Health services Intake and Hold Time Analysis July – December 2016 was reviewed. This documentation demonstrated that turnaround time for 'suicide' (presumed emergent referrals and constant observation) had a median of 1.7 hours and an average of 3.2 hours with a standard deviation of 22.8 hours (!). This time falls well outside the expected two hours if the standard deviation is taken into consideration. CHS is moved into partial compliance acknowledging that an effort has been made to collect the data.		
Monitors' Recommendations:	<u>Medical Care:</u> 1. The County is beginning an analysis of the booking process aimed at streamlining and identifying barriers to timely (4-5 hours) booking. These findings should be implemented. <u>Mental Health Care:</u> 1. As indicated above, intake vis-à-vis mental health would benefit from a fresh perspective and a streamlined approach. Recommendations include redistribution of staff to maximize strengths and minimize bottlenecks. 2. Constant observation should be an order that is recorded separately in the electronic medical record		

	3. One: one observation should be an order that is recorded separately in the electronic medical record 4. An emergency psychiatric referral is an order that should be recorded separately in the electronic medical record. 5. An urgent psychiatric referral should be recorded separately in the electronic medical record.

Paragraph Author: Greifinger 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, 3/3/17	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; 3/3/2017	Non-Compliance: 7/13 (NR); 3/14 (NR);
Measures of Compliance:	Medical Care: • Medical record 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). 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: Prior medical care through JHS is available through the EHR. Other medical records are sought. Mental Health Care: The electronic health record (EHR) contained records from Jackson. Many of the charts reviewed contained records from outside providers, as well, which had been scanned into the EHR.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: Only 6 of 17 incoming inmates (35%) who had a history of treatment for a current condition had their records requested and reviewed by practitioners. Mental Health Care: Although many records are available from prior contacts within the Jackson system, few progress notes referred to the content of outside medical records. Transfer notes from the emergency department and from the hospital did not mention the outside diagnosis, procedure or injury which had precipitated that inmates' treatment at Jackson.		
Monitors' Recommendations:	Medical Care: 1. Monitor clinical performance in this area and implement effective remedies. Mental Health Care: 1. Practitioners should review available medical records and incorporate the pertinent findings into their notes and decision-making. This is particularly relevant to whether the inmate has a prior history of mental illness, trauma, or suicidal behavior.		

Paragraph Author: Greifinger 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, 3/3/17	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; 3/3/2017	Non-Compliance: 3/14 (NR)
Measures of Compliance:	Medical Care: • Medical record review • Interview Mental Health Care: Review policy. Review cases. Review referrals to the emergency department.		
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: The County has implemented an intake screening which screens for withdrawal on a cursory basis. Per policy, mental health is not permitted to directly refer to detox, and all clients must be referred to the medical provider to be cleared for detox prior to placement.		
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.1.a for recommendations on improving identification of risk for withdrawal and improving risk identification. Withdrawal from methadone during pregnancy is life-threatening for the fetus. CHS has no provision for methadone maintenance for pregnant inmates who have been enrolled in a methadone maintenance program in the community. Mental Health Care: CIWA and COWS were not being completed on a consistent basis for patients at risk of detox. In addition, for patients in active withdrawal, patients were managed with high doses of anti-psychotics and lorazepam, one to the point of stupor, necessitating emergent transfer to the hospital. He was subsequently diagnosed with "intentional overdose."		
Monitors' Recommendations:	Medical Care: 1. 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. 2. Develop resources Mental Health Care:		

	1. Mental health care staff should be consulted on any patient or person suspected of dual diagnosis or who develops active hallucinations or delirium[12] in the setting of substance abuse, intoxication, or withdrawal.

[12] Delirium is a psychiatric emergency.

Paragraph Author: Greifinger and Ruiz	III. A. 1. g. (See also 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), 3/3/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 5/15; 1/16; 7/29/16; 3/3/2017	Non-Compliance: 7/13 (NR); 3/14 (NR)
Measures of Compliance:	<u>Medical Care:</u> • Review training materials <u>Mental Health Care, as above:</u> 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 comments and recommendations on nurse orientation and in-service education in III.A.1.A.		
Monitor's Recommendations:	See comments and recommendations on nurse orientation and in-service education in III.A.1.A.		

2. Health Assessments

Paragraph Author: Greifinger	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; 3/3/2017
Measures of Compliance:	*The measures of compliance from the Settlement Agreement and/or Consent Agreement and/or what you will use to measure compliance* • Medical record review		
Steps taken by the County to Implement this paragraph:	None		
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 has just begun the performance of routine Health Assessments.		
Monitor's Recommendations:	1. Conduct Health Assessments in compliance with this provision of the CA. 2. Conduct health assessments by physicians or mid-level practitioners. RN health assessments have very low yield. 3. Establish primary care relationships with patients at this time, for preventive care, chronic care, and medication management.		

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; 3/3/2017
Measures of Compliance:	<u>Mental Health:</u> • Review of policy regarding mental health evaluation and screening • Record review for adherence to screening, assessment and trigger events as described in Appendix A. • 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.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See last report; no progress on data analysis and results of review of mental health assessments. CHS not doing the assessments as required.		
Monitor's Recommendations:	1. Please provide data with timely analysis and explanation of findings. 2. 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; 3/3/2017	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[13], suicide risk assessment should be viewed as an ongoing process, as it may be necessary at any point during incarceration.		
Measures of Compliance:	Mental Health: 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:	Relative to this provision and its procedure, CHS responds to adverse mental health events by documenting the utilization of emergency treatment orders with a progress note. As of July 2016, it began tracking these emergency treatment orders, which is an improvement.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	As indicated above, CHS began tracking emergency treatment orders, which is an improvement. August, September, October, and November demonstrated an increase in utilization of emergency treatment orders for reasons that were unclear. December 2016 demonstrated a drop in the number of emergency treatment order that were utilized. Possible reasons for this were not discussed in the bi-annual report. Individual cases reviewed did not show that a face-to-face evaluation was conducted by a psychiatrist. However, a face to face evaluation was completed by an ARNP on the day of the crisis.		
Monitor's Recommendations:	1. Continue to track utilization of emergency treatment orders. 2. Please provide analysis and hypotheses as to why utilization fluctuates month to month and/or by shift, weekend, etc. 3. Following utilization of ETOs or restraint, patients should be referred for appropriate follow up and placed on the mental health caseload, as appropriate.		

[13] 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); 3/3/2017
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 'risk profile' that was submitted was a copy of the suicide and homicide screening tool that is utilized at intake. A typical risk profile is one that is utilized during an interdisciplinary treatment team that appropriately weighs the patients' strengths and weaknesses, including the patient's support systems and motivations for treatment to assess his or her risk for violence and self-harm, as applicable. Weaknesses may include history of substance use, age, sex, number of prior offenses, etc.		
Monitor's Recommendations:	1. In order to achieve compliance, all requested material shall be received in a timely manner. It is recommended that the County perform regular self-audits and reviews of its program and that this material be submitted on a quarterly or bi-annual basis.		

Paragraph Author: Greifinger	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); 3/3/2017
Measures of Compliance:	Medical Care: • Medical record review for timeliness and scope		
By policy, patients with identified chronic disease are provided with medication within 24 hours and enrolled in a chronic disease clinic.	By policy, patients with identified chronic disease are provided with medication within 24 hours and enrolled in a chronic disease clinic.		
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):	• Eight of ten incoming inmates reporting being on medication prior to arrest had treatment continued within 24 hours. Two fell through the cracks. • Providers do not enroll inmates with chronic disease in the chronic care program at intake. • Chronic care follow up appointments are not scheduled timely and the frequency of appointments is not based upon the patient's condition. Patients whose condition is poor are seen at the same frequency interval as those whose condition is in good control. • Chronic care appointments are not schedule to coincide with the time medication needs to be renewed resulting in discontinuity of care. • Failure to provide timely, clinically appropriate chronic care results in preventable emergency room visits and hospitalization		
Monitor's Recommendations:	Clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time.		

Paragraph Author: Greifinger 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), 3/3/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16; 3/3/2017	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Medical Care: • Medical record review Mental Health Care: 1. Record review that QMHP are conducting mental health screening and evaluation 2. Results of internal audits 3. Review of 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: By policy, inmates identified as having medical or mental health problems are referred for additional evaluation by qualified medical and mental health professionals. Mental Health Care: The County provided the results of an Intake and Hold Time Analysis dated July – December 2016 for review.		
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: Of eight inmates identified as having emergent or urgent health care needs by the screening nurse only four were seen within the required timeframe. Mental Health Care: Both the records reviewed and the data provided demonstrate patients were seen outside 24 hours by a provider. Many did not have their medications started in a timely manner.		
Monitor's Recommendations:	Medical Care: 1. Clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time. Mental Health Care: 1. As stated above, intake screening should be re-organized so that patients may be seen and assessed. Medications and labs should be started in a timely manner.		

Paragraph Author: Greifinger 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, 3/3/17
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; 3/3/2017
Measures of Compliance:	Medical Care: • Applies to RN's and mid-level practitioners • Review lesson plan • Review training records • Assure training by appropriate level of professionals • Demonstrate proficiencies 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. See comments and recommendations on nurse orientation and in-service education in III.A.1.A. Mental Health Care: Little information, although sparse, was provided regarding training as it relates to mental health assessments and referrals. Pre-and post-test materials and scores were not provided. In the future (and to achieve compliance), this information will be necessary. In addition, classes should include drills and hands on information for participants.		
Monitor's Recommendations:	Medical Care: 1. Continue training. 2. Supervise through clinical performance measurement. 3. See comments and recommendations on nurse orientation and in-service education in III.A.1.A. Mental Health Care: 1. As indicated above, classes should include hands-on information for participants so that they are prepared to administer their learning on the job. Correctional medicine requires learning boundaries with your patient without being overly sarcastic or condescending. This is a gentle balance.		

3. Access to Medical and Mental Health Care

Paragraph Author: Greifinger 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, 3/3/17	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; 3/3/2017	Partial Compliance: 7/13	Non-Compliance: 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: 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: Greifinger 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, 3/3/17	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; 3/3/2017
Measures of Compliance:	Medical Care: • 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: Mental Health Care: No information or data was provided that indicated County has provided a way for detainees with impaired communication to access care.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: The sick call nurse at TGK verbalized the process to access the language line for patients unable to speak English. There are several health staff fluent in Spanish and Creole available as well. The TGK medication nurse reported accepting verbal sick call requests for illiterate patients or disabled patients. Mental Health Care: For medical sick call form, the information is translated into the appropriate language, but there is no assignment of staff to assist inmates with cognitive disorders. This work needs to be assigned to an appropriate person at the housing unit level. It is not appropriate to assign the charge nurse to this task. The Monitor reviewed CHS' position regarding moving this provision to partial compliance; but the Monitor was not persuaded that the process is as described. Further information is required prior to the next tour.		
Monitors' Recommendations:	Medical Care: 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: Greifinger 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, 3/3/17	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; 3/3/2017	Partial Compliance: 7/13	Non-Compliance: 3/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • Inspection and interview Mental Health Care: 1. Review of policy and procedure for sick call 2. Review of log tracking sick call requests and referral for care 3. Review of medical records to assess access and implementation of adequate care 4. Interview of staff 5. Interview of inmates		
Steps taken by the County to Implement this paragraph:	Medical Care: 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: • Signs with instructions on how to access health care were prominently posted in the hallways inmates use in MWDC and PTDC. • Nurses receive sick call requests directly from inmates during medication pass and use a key to open a specifically designated sick call box on each unit and pick up any requests that have been put there. Nurses also distribute sick call request forms to individual inmates upon request and leave a supply at the officer's desk as necessary. • In PTDC an inmate was used to communicate with another inmate in a bunk in a cell about his health status when the inmate on the bunk refused to come to receive morning medication. The use of an inmate to communicate with another about their health compromises privacy of health encounters. Mental Health Care: See previous report.		
Monitor's Recommendations:	Medical Care: N/A Mental Health Care: N/A		

Paragraph Author: Greifinger 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, 3/3/17	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; 3/3/2017	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • Medical record review • Observation Mental Health Care, as above and: 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:	Medical Care: CHS now has a staff member assigned to indexing and monitoring medical grievances, so longitudinal data are being collected. Mental Health Care: Grievances, including mental health grievances, are discussed during MAC. The mental health grievances make up a small percentage of the total grievances (over the last six months, the percentage has varied from 3% to 7%).		
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: 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: Grievances as they relate to mental health care are being collected. However, given the high number of persons on the mental health caseload, the number of mental health grievances is too few. One would expect that the number of grievances would more accurately reflect the makeup of the population of the institution.
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 choose 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: Rather than suppress grievances to manage appearances, grievances should be managed as a reflection of issues with the system as a whole. Receipt of commentary that patients are not receiving medications, access to care or problems with programming are signs that larger issues exist. Similarly, a lack of grievances may be sign of fear of retaliation, a whole other issue that should be dealt with, as well.

Paragraph Author: Greifinger 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), 3/3/17
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; 3/3/2017
Measures of Compliance:	Medical Care: • Observation and chart review 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: As indicated above, inmates on the mental health caseload need access to the chronic care clinic. This includes inmates with chronic schizophrenia, post traumatic stress disorder, bipolar disorder, and major depression.		

Monitors' Recommendations:	<u>Medical Care:</u> 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. <u>Mental Health Care:</u> Please implement health assessment and access to adequate medical care for inmates with serious mental illness.

4. Medication Administration and Management

Paragraph Author: Greifinger 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), 3/3/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14; 7/29/16; 3/3/2017	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR);
Measures of Compliance:	Medical Care: • Inspect policies and procedures Mental Health Care: 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: The medication administration policy and procedure has been drafted. A video of medication administration has been and is used for training. Mental Health Care: CHS revised its medication administration policy. CHS does not notify the psychiatrist when a patient has refused clinically significant amounts of his or her medication.		
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. • The new policy and procedure has yet to be fully implemented. • Medication is delivered from stock and is not in patient specific form. Some medication is administered from stock bottles and other medication from stock blister cards. • Perpetual inventory is not maintained. This is risky from a diversion point of view. • Of the 10 inmates who reported taking medication at the time of intake, eight had treatment continued (the type of medication may have been different but the purpose was consistent with diagnosis) and the first dose was given within 24 hours. • The first dose of emergent medications was documented as given immediately and the first dose of other medication was administered usually at the next medication line, well within 24 hours of the order. • In the majority of charts reviewed laboratory tests were usually not completed within three days of the order. • Medications written for treatment of ongoing conditions routinely expire before the next provider appointment. Inmates are expected to submit a request to renew the medication via sick call resulting in discontinuity and delay in care.		

	• Inmates who do not want to take their prescribed medication are required to complete a refusal form and the refusal is documented on the medication administration record. Information on refusals is available to providers but is not used in any proactive way to identify and counsel inmates to improve adherence. Nurses do not refer inmates who serially refuse medication to providers for counseling or other intervention. • Privacy during medication administration is compromised at PTDC because of the physical layout of the living units as well as staff practices. • Nurses were interrupted during medication administration by inmates going to and from recreation and other unit activities. • At PTDC medication is administered through the door flap on some housing units. As such, there is no way to assure that the patient is swallowing the medication, as opposed to hoarding for self-harm or diversion. • Officers were observed to not use inmate identification cards and pictures while assisting with medication administration. Also observed were officers allowing inmates to crowd the medication cart. • The number of inmates prescribed medication for difficulty sleeping seems inordinately large compared to other correctional settings. <u>Mental Health Care:</u> 1. As indicated above, the psychiatrist is not notified when clinically significant amounts of medication are refused or are missed. This is dangerous for both the patient and for the institution. 2. Patients that collect or hoard medications as identified via 'shakedowns' are similarly not flagged and referred to mental health for evaluation. 3. Clinicians are not able to seamlessly access the medication administration record between facilities and between the electronic health record. This is particularly important when administering or ordering intramuscular medication and checking vital signs and recent pertinent laboratories.
Monitors' Recommendations:	<u>Medical Care:</u> 1. Train nurses in new medication administration policy and procedure and measure performance. 2. Minimize pre-pouring to upper tiers of segregation housing. 3. Assure that the use of stock medication for administration is legal in Florida. 4. CHS and MDCR should agree to the timing of medication administration as policy; inmate movement or other interruptions are to be minimized while the nurse is administering medication on the unit. 5. Refer patients with serial missed medications to practitioner to determine reasons and implement remedies. 6. Audit medication administration using a tool derived from the policy and report results periodically to the QI committee to ensure that actual practices are consistent with policy and procedure. 7. Implement a medication utilization project through the Pharmacy & Therapeutics sub-committee to minimize overuse of medications, e.g., medication for sleep. 8. Minimize delivery of medication through door flaps. 9. Maintain a perpetual inventory of medications. <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 a face to face contact.

Paragraph Author: Greifinger 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, 3/3/17	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; 3/3/2017
Measures of Compliance:	Medical Care: • Medical record review 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: Mental Health Care: None. This information was requested. However, CHS could not provide it.		
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. Mental Health Care: CHS reports this is not being done at this time.		
Monitor's Recommendations:	Medical Care: 1. Measure performance in this area on a regular basis and implement remedies where appropriate. Mental Health Care: Implement systems for tracking of medication dispensation. This may include finding a way to dovetail Cerner and Sapphire or your system for medication management.		

Paragraph Author: Greifinger 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, 3/3/17
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; 3/3/2017
Measures of Compliance:	Medical Care: • duplicate III.A.2.e. Mental Health Care: See III. A..2e.		
Steps taken by the County to Implement this paragraph:	Medical Care: See III. A. 2. a. 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. Mental Health Care: 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; 3/3/2017	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. Interviews with staff and inmates		
Steps taken by the County to Implement this paragraph:	Patients on Levels I and II are being seen on a regular basis by psychiatry.		
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, II and III were seen on a regular basis by psychiatry. Patients on Level IV went several months, some more than six months, without been seen by a provider at all. A review of 10 charts on Level IV demonstrated that four of the charts had not been seen by a psychiatrist in more than ninety days. This indicated that the patients either did not need to be on the mental health caseload (as their condition had stabilized) or the patient was being inappropriately managed.		
Monitor's Recommendations:	Intermittent studies should be performed to ascertain that patients are being managed at the correct level, at the correct frequency and being provided the correct level of support. For patients that are not taking medication (due to their symptomatology), other modalities of treatment may be helpful, such as group therapy, individual therapy, art therapy, etc.		

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; 3/3/2017
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:	No data was provided to document that this is occurring.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This is not occurring.		
Monitor's Recommendations:	Implement systems for tracking medication dispensation. This may include finding a way to dovetail Cerner and Sapphire or your system for medication management.		

Paragraph Author: Greifinger 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), 3/3/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/3/2017	Non-Compliance: 7/13; 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16
Measures of Compliance:	Medical Care: • Medical record review • Laboratory logs • Interview with staff Mental Health Care: 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: 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: • As described elsewhere in this report, orders for lab tests often fall through the cracks. • The laboratory process leaves opportunity for testing to be missed. The provider orders the test in the health record and the nurse prints out the order sheet and then places it in a binder in the lab room, under the tab with the date the specimen is to be collected. A medical assistant then places the patient's name on a paper log that includes patient name, date of order, date specimen obtained, date lab result is received and date provider receives the result. Upon review of the paper log, it was found to be incomplete and not reconciled. • The process to get the results to the provider for review, sign off, and adjustment of the patient's plan of care is passive. The provider must know to look for the results in the health record. As an example, a review of one patient record revealed a provider order for hemoglobin A1C and CMP on January 12, 2017. The specimen was collected on January 13, 2017. The provider saw the patient on January 17, 2017 but the lab result was not reviewed nor was it included in the documentation of the patient encounter. • Other specimens are not collected. We searched the overdue specimen collection list and overdue blood pressure orders for January 15-February 20, 2016. Eight of nine were preventable (1 collection failure; 3 relocations within MDCR; 4 practitioner input error). • Similar to ordering radiology testing, to request off-site specialty services, a form is completed and given to the same administrative assistant. Once the medical director has approved the request, it is sent to Jackson Health		

	Systems for approval and scheduling. Review of the referral tracking log kept by the administrative assistant was incomplete. There were specialty service requests as far back as October 2016 that were still pending. Random selection of patients from the list revealed the appointment date on the log did not match the date the patient was seen. Patients were found to be rescheduled, but this was not reflected on the log. Those patients listed on the log as seen did not have the disposition documented so it was unclear, without going to the patient health record, to know if there was recommendation for additional procedures or follow up appointment. Finally, the steps of the process are not in the patient's health record so the providers must contact the administrative assistant if they want to know where the specialty request is in the process. The physician that was interviewed said that when the administrative assistant goes on vacation, there is no one else in the system that can provide information about the specialty consultation process. This paper system, reliant on one individual is insufficient in a jail system of this size. <u>Mental Health Care:</u> Insufficient information was provided for this provision for a comprehensive review. Progress notes of providers receiving patients from outside hospitals did not reflect review of the outside labs or findings. Partial compliance is granted because some effort to made to check the labs, etc., but not comprehensive enough at this time.
Monitor's Recommendations:	<u>Medical Care:</u> 1. Repair the systems described in this paragraph of the CA. 2. Monitor performance and implement remedies, as appropriate. <u>Mental Health Care:</u> Timely dispensation of medications as ordered will prevent both recidivism and emergent hospitalization.

Paragraph Author: Greifinger and Ruiz	III. A. 4. f. (See 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), 3/3/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16; 3/3/2017	Non-Compliance: 7/13 (NR); 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • Lesson plans and annual training records 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: Mental Health Care: CHS provided information on nurses who attended medication administration training.		
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: Training materials for nursing were appreciated. The pre-and post-test for medication administration training was not provided. Training for CIT was also provided.		
Monitor's Recommendations:	Medical Care: N/A Mental Health Care: Continue training with staff and new staff as needed. Training should include emergency treatment administration, if this is not already included, as well as administration of restraints in a safe manner.		

5. Record Keeping

Paragraph Author: Greifinger 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, 3/3/17	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; 3/3/2017	Non-Compliance: 7/13; 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • Medical record review • Mental Health Care: 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: • Electronic health records are not centralized, complete or readily accessible by health staff. There are two electronic systems in use, Cerner and Sapphire. Information may be documented in one and not the other. For example, medication orders and the record of medication administration are in Sapphire and not in Cerner. Other orders for an inmate's treatment such as vital signs or dressing changes may be in either Cerner or Sapphire. • Not all health information is found electronically in one of the two electronic systems. For example, radiology studies are ordered on paper and scanned into the record. The form is then hand delivered to an administrative assistant who places the patient on a schedule for the radiology technician at Metro West. There is no entry in the medical record that the x-ray is scheduled so providers seeing the patient subsequent to the encounter where the original order was given have no way of knowing if the x-ray is pending or completed. An email is sent to the medical director of the facility on the day the patient is receiving the x-ray.		

	• Complex diagnostic radiological testing not available at Metro West such as CT, MRI, etc. are ordered by the provider on a paper form. The form is given to the same administrative assistant who then gives it to the facility medical director for approval. The medical director approves the test and the administrative assistant then sends it to the Jackson Health System radiology department where an ARNP reviews it and either approves or defers the test. There is no documentation in the health record about this process so again, the facility providers are blind to the process and the status of their order. • When there is a medical emergency the documentation may only be found on the Incident Addendum, which is a corrections form that is later scanned into the electronic health record. • Information that needs to be communicated to Corrections is done on paper and scanned into the health record. This includes notice of housing accommodations (lower bunk, lower tier), program adjustments (prohibitions on use of certain kinds of restraint due to a disability), medically necessary belongings (wheelchair use) etc. • Not all clinical encounters are documented in the inmate's health record. See Patient C seen by dental on 11/11/2016 but no documentation; Patient D no documentation in the health record that he was educated about how to lessen discomfort from a hernia in November 2016; Patient E was seen by a provider on 1/2/2017 after intake for high blood pressure but there is no provider note; Patient F no documentation of the removal of a Penrose drain on 9/9/2016; 160169944 inadequate documentation of emergency on 12/24 or 12/30. • CHS usually provides all necessary information on the referral form when inmates are transported out for jail for health care (15/19 off -site charts reviewed). One inmate who wrote to the Monitor was found on chart review to have been sent for specialty care on two occasions in November 2017 and no records were sent (150157919). CHS usually is provided with information from off-site specialists about the care provided and their recommendations. However, the CHS referring provider is less often aware of or contacted about these results timely and it may be several days or weeks before the recommendations are reviewed and acted upon (13/18 off-site charts). Less than half the recommendations that were followed were implemented within clinically appropriate timeframes. <u>Mental Health Care:</u> While the County has implemented an electronic medical record, opportunities for improvement continue. These include the following: 1) The medication administration remains separate from the Cerner system. This is problematic, as physicians must check a separate system to ascertain if the patient has been adherent to his or her medication. In one case, I wanted to do so and was informed this would take 24 hours "or longer." 2) Patients remain logged into the system, even after they have been discharged from the jail. In one case I was reviewing, the patient had several "pending appointments" even though he was no longer in the jail. This leads to a number of inefficiencies.
Monitors' Recommendations:	<u>Medical Care:</u> 1. Integrate the medication system with the EHR. 2. Eliminate paper systems for ordering x-rays and other diagnostics.

	3. Train and supervise staff to document encounters contemporaneously <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) 3/3/2017
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)	CHS has an electronic scheduling system. The electronic scheduling system does not facilitate the delivery of care, requiring the staff to "work-around" the system to achieve the mandated results. Having an ineffective system does not achieve compliance.		
Monitor's Recommendations:	Evaluate the electronic scheduling system for upgrading or replacing. Please provide an analysis of mental health scheduling for clinics, wait times for clinicians, and an assessment of utilization of resources. The County should assess Use of Force vis-à-vis the mental health population. Have mental health staff been adequately allocated to provide treatment to these patients? Could they be moved or utilized differently? Why or why not? These same questions were asked and data was to be produced for February 2017. For example, if the Level IV patients have not been seen by a psychiatrist in six months, are taking large amounts of sedative medications, and have not been involved in a use of force, it is possible that they do not need to be on the mental health caseload. Conversely, if the Level I and II patients are very active, have been involved in multiple uses of force, and are still non-adherent to medication, they may require additional therapeutic programming. Staff may need to be re-allocated.		

Paragraph Author: Greifinger and Ruiz	III. A. 5. c. (See 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, 3/3/17	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; 3/3/2017	Non-Compliance: 5/15 (NR); 1/16 (NR)
Measures of Compliance:	Medical Care: • duplicate III.A.5.a. 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: Greifinger 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, 3/3/17	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; 3/3/2017	Non-Compliance: 5/15 (NR); 1/16 (NR)
Measures of Compliance:	<u>Medical Care:</u> • Medical record review <u>Mental Health Care:</u> 1. Review of policy relevant to collateral information and implementation of recommended treatment. 2. Review of medical records. 3. Interview of staff and inmates.		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> <u>Mental Health Care:</u> 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> • The County still does not have a process in place to assure that external referrals are tracked, and delays are reported to appropriate personnel as alerts. • Off-site diagnostics and specialty consultation go through a utilization management process that is blind to the referring practitioner and the CHS medical director. There is no appeal mechanism and no policy. • When patients return from outside visits, including specialist appointments, ER trips, and hospitalizations, practitioners are not routinely notified. • The recommendations of outside physicians are not always followed • We reviewed 18 records of patients who had been sent to the ER for ambulatory sensitive conditions, i.e., conditions that might have been prevented by earlier intervention. Documentation of outbound and inbound progress notes in the EHR is inconsistent. There is scant documentation that clinicians see or act on ED physicians' recommendations and there is no documentation that clinicians see patients on their return from the ED. The ED visit was likely preventable through better medical care while in the custody of MDCR in 12 of the 18 cases. <u>Mental Health Care:</u> 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. Notes from the outside hospital were not incorporated into the chart and there was little evidence that the record was reviewed. Meeting minutes demonstrated		

	patients returning from State hospitals were not maintained on the basic regimen of medications they were stabilized upon while hospitalized.
Monitors' Recommendations:	<u>Medical Care:</u> 1. Patient care should be seamless between MDCR and outside resources, assuring that appointments occur as ordered, adequate information is sent with the patient, and upon return, recommendations are shared with, and acted upon by practitioners in a timely manner. 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 an oral report to their counterparts at the ER, and then set an expectation for a reciprocal communication at the time of discharge from the ER. 2. The CHS medical director should have a role in any utilization management function at JHS regarding inmate patients, including a right of timely appeal. <u>Mental Health Care:</u> Records from outside hospitals should be reviewed and incorporated into treatment notes with a thoughtful approach to treatment. Although cost may be a factor when considering psychotropic medication, patients may decompensate when switching psychotropic medications. Therefore, carefully consider all factors, such as receptor profile targets and history of response to prior medications.

6. Discharge Planning

Paragraph Author: Greifinger 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); 3/3/2017
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 1/16; 7/29/16; 3/3/2017	Non-Compliance: 3/14; 5/15 (NR)
Measures of Compliance:	Medical Care: • Medical record review • Interview 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 is in the process of updating its policy on Discharge Planning. Discharge planning occurs currently for patients that request services.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: • There are signs posted in the jail about the availability of discharge medications. • The Assistant Medical Director for MWDC reported that discharge medication is provided via two avenues; if the exact discharge date is known CHS will provide a supply of medication that the inmate can pick up as they leave jail or the inmate can call a hotline and a prescription will be written which they must pick up and then can have filled at the pharmacy of their choice. • There was no documentation in the charts reviewed of discharge planning or discharge medications provided to inmates with medical problems. • There is no connectivity between the jail management system or CHS to communicate about discharge dates or to identify those inmates who would benefit from either discharge plans or medications. Mental Health Care: No logs were submitted to confirm the percentage of the mental health caseload for whom meds were provided.		
Monitor's Recommendations:	Medical Care Implement effective discharge planning including medication and referral to community resources.		

	Mental Health Care: 1. To become compliant, the County should provide both data and analysis of its discharge planning process. Once a more active component is implemented, this should be reflected in the numbers of referrals. For example, as described above, logs should be provided that confirm that medications were signed for / dispensed. These can be used to calculate what percentage of the mental health caseload at that level utilized discharge services. Compliance will be reached at a referral and dispensed medication rate of 50% or better. 2. Referrals should include a confirmed appointment time with an available mental health provider or clinic.

Paragraph Author: Greifinger 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; 3/3/2017
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 1/16; 7/29/16; 3/3/2017	Non-Compliance: 3/14; 5/15 (NR)
Measures of Compliance:	Medical Care: • Medical record review 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 as noted by log review or other method 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: Please see III. A. 6. A. 1. Mental Health Care: Please see III. A. 6. A. 1.		
Monitor's Recommendations:	Medical Care: Please see III. A. 6. A. 1. Mental Health Care: Compliance will include providing discharge resources and bridge medications to a representative sample (greater than 50%) of the mental health caseload.		

Paragraph Author: Greifinger 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) 3/3/2017
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 1/16; 7/29/16; 3/3/2017	Non-Compliance: 3/14; 5/15 (NR)
Measures of Compliance:	Medical Care: • Medical record review Mental Health Care: 1. Policy regarding discharge planning 2. Evidence of referrals for inmates with chronic medical health problems or serious mental illness. 3. Evidence of providing a bridge supply of medications of up to 7 days to inmates upon release 4. Provision of an inmate handbook at admission indicating they may request bridge medications and community referral upon release.		
Steps taken by the County to Implement this paragraph:	Medical Care: Please see III. A. 6. A. 1. 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: 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. Mental Health Care: 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: Please see III. A. 6. A. 1. Mental Health Care:		

	1. An active system of discharge planning should be implemented for patients Levels I-II with active symptomatology. Patients with high acuity should not be expected to seek out referrals for services nor should the onus be placed on them, particularly when the patient is actively suicidal or psychotic. 2. The County should document its discharge planning efforts in the medical record as well as its individual log. Any meds that are dispensed to the patient on discharge should be logged, as well.

7. Mortality and Morbidity Reviews

Paragraph Author: Greifinger 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); 3/3/2017
Mental Health Compliance Status:	Compliance:	Partial Compliance: 3/14; 7/29/16	Non-Compliance: 7/13; 10/14 (NR); 5/15 (NR); 1/16; 3/3/2017
Measures of Compliance:	Medical Care: • Medical record review • Review of M&M and quality management committee minutes Mental Health Care, as above and: 1. Review of comprehensive mortality reviews and corrective action plans for each inmate's death 2. Review of comprehensive morbidity review and corrective action plan for all deaths of inmates with severe mental illness and/or serious suicide attempts. 3. Within 45 days of each death or serious suicide attempt, provide report for review to Monitor and United State 4. In cases where the final medical examiner report and toxicology takes longer than 45 days, a final mortality and morbidity review will be provided to the Monitor and United States upon receipt. 5. Interviews with staff. 6. Receipt of timely mortality reviews which reflect an interdisciplinary review and corrective action plan. This will include inclusion of the Chief Psychiatrist among the interdisciplinary team.		
Steps taken by the County to Implement this paragraph:	Medical Care: M&M reviews for two patients were not written prior to the tour. Two M&M reviews were written without Committee review during the tour. Mental Health Care: The County did not provide the Mental Health Monitor the case file for the deaths 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	Medical Care: The M&M reviews do not address the nature and quality of the medical/mental health care provided to the patient. The two M&M reviews written for the monitors, with no review by the M&M Committee, included three suicide attempts		

documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	where, apparently, no clinical staff asked the patients why they attempted suicide. This was not addressed in the reviews. Several prior M&Ms had somewhat improved documentation of self-critical analysis, however the remedies were mostly in-service training with no serious look at systems. There was no attempt to measure performance following the implementation of remedies. On patients who refused intervention, there was no inquiry into why there was no follow-through by the clinicians. Prior M&Ms are not updated with final medical examiner findings, including toxicology. The County is working on its Mortality and Morbidity Review policy. <u>Mental Health Care:</u> 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 and that there were no opportunities for improvement. 4. Prior M&Ms, including those dating back to 2013, were not updated. 5. M&Ms involving serious suicide attempts or patients on the mental health caseload did not include psychiatric autopsies. 6. Significant preventable morbidity could be managed via adequate and timely treatment of detoxification and seizure.
Monitors' Recommendations:	<u>Medical Care:</u> 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, including review of the medical and mental health care (through such processes as RCA); and *repairing* any system problems detected. Follow-up measurements should be performed to assure the effectiveness of the remedies. CHS and MDCR reviews should demonstrate coordination. <u>Mental Health Care:</u> 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, custody and other stakeholders.

Paragraph Author: Greifinger 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; 3/3/2017
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; 3/3/2017
Measures of Compliance:	Medical Care: • Review of M&M reports and committee minutes 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: Greifinger 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; 3/3/2017
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; 3/3/2017
Measures of Compliance:	Medical Care: • Review bi-annual reports 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 of M&M activity. 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 reports were not produced. Mental Health Care: Morbidity and Mortality reviews, Corrective Action Plans, and Quality Improvement reports were not produced.		
Monitors' Recommendations:	Medical Care: 1. Develop a policy and procedure on morbidity and mortality review and implement it. 2. Produce bi-annual reports. Mental Health Care: The County is encouraged to adopt a spirit of transparency moving forward as it works towards compliance. As morbidity and mortality begin to review cases in collaboration with its Quality Improvement Committee, focus not only on the data, but on the why and where do we go from here.		

B. MEDICAL CARE
1. Acute Care and Detoxification

Paragraph Author: Greifinger	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); 3/3/2017
Measures of Compliance:	Medical Care: • Medical record review • Inspection • Interview		
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):	• Inmates acute health needs are not always identified to provide adequate and timely acute care. While inmates may be treated for such during intake; the problem is not always listed on the problem list, follow up appointments made or ongoing treatment orders written. • Providers are not notified of abnormal vital signs, lab results, glucose monitoring, CIWA/COWS scores timely. • Access to acute care attention at intake is delayed or requires an ER visit for some conditions that could be managed on-site. • Access to acute care beds is limited by availability of beds or past practice. Inmates who should be in medical housing or the infirmary are kept in GP. • There is no review of over or under utilization of infirmary or medical housing. • There is no delineation between infirmary, observation, and medical housing beds. All patients, regardless of acuity, are admitted under the same process. The nurse conducts an assessment one time per shift, or every eight hours. Nurses that were interviewed in the medical housing unit indicated they check on the patients every two hours but nothing is documented in the health record. • There is no "leveling" of acuity, so that patients all patients get vital signs once each shift, independent of the medical need. • Some medical housing cells are off-line because there are no mattresses or pillows. These rooms could be used for patients who need physical protection, for example one patient in GP who was in a sling for an acute shoulder dislocation. • The sensors on the negative pressure cells in medical housing were defective. • Several nurses did not know which masks to use for patients housed in respiratory isolation. • Two patients with suspect tuberculosis were in rooms labeled "contact isolation," instead of "respiratory isolation." This error is highly dangerous for staff and inmate patients. • A nurse working on medical housing had acrylic nails, typically a source of intramural infection. • The door used to enter and exit the medical housing unit was not working properly and was unable to be opened via the control center. Of large concern, was that no one inside the unit, nor in the clinic directly adjacent to the		

	medical housing unit had a key to open the door. If a fire were to occur, staff and patients could easily be trapped inside this unit. • The report sheets used to pass patient plans of care from one shift to the next were inadequate. Nurses interviewed shared they report "by exception". If the oncoming nurse wants to be informed of each patient's plan of care, they are required to review each patient's health record summary. This process is too timely for the nurse to be prepared to assume responsibility for the care of each patient in the unit, prior to the departure of the off going nurse. In the event of a patient emergency, at the beginning of the shift, the nurse very likely would be assessing the patient's condition without the benefit of medical history, medications, current orders, etc. • The overall cleanliness of both units was unsatisfactory. There was mold on the spigot of the water cooler, dirt on the floors, and sinks and toilets that had hard water build up and discoloration. • Nursing staff in the infirmary reported that patients placed in the unit are under constant observation via camera, as there are no call lights available to the patients should they need to get the attention of the nurse. Observation of the desk and cameras over several days duration found several times where no one was watching the cameras. • At PTDC the examination area was filthy and had no hand towels for staff to use following hand-washing. Intoxication & Withdrawal • Observation of the booking pre-screen, intake screening, and initial encounter with the mid-level provider did not include questioning the patient on prior history of delirium tremors and/or seizure. Patients are only questioned on their drug of choice, amount used, and time of last use. Also, nurses are not informing patients that sharing present use of illegal drugs will not result in additional charges but is necessary history to have to better care for them. • Nursing staff does not autonomously place patients with history of mild to severe drug and alcohol use on a CIWA or COWS monitoring schedule. All patients felt to need monitoring are referred to the provider, often resulting in increased wait times in the lobby during peak booking times. • The electronic health record automatically assigns a series of CIWA and/or COWS monitoring exactly eight hours after the initial assessment is completed. This results in subsequent monitoring tasks falling due at all time during the shift. Ideally, all patients in the detox unit should have a complete set of vitals, including the CIWA/COWS assessment accomplished at the beginning of each shift. Because of the computer assigned monitoring times, patients are frequently awakened in the middle of the night for withdrawal assessment and refuse. • Observation of the detox unit report form and interview with nursing staff on the unit found an inadequate report of each patient's status at shift change. On the day of observation, there were 31 patients in the unit and the report sheet contained the health status of two patients. The report process should ensure that the oncoming nursing staff are made aware of each patient's vital signs, CIWA and/or COWS score, medications ordered, including time of last dose, and all other significant signs and symptoms. • The detox unit does not lend itself to adequate sight or sound of patients in withdrawal. A walk around the unit found several patients on the floor in "boats" with their heads covered and positioned behind the sink, not allowing visualization of the patients breathing status. Nursing staff report that anytime the provider orders intravenous fluids and medications, the patient is required to be transferred to the infirmary on a lower floor in the jail. • Review of ten patients' records indicated nursing staff does not notify the provider when there is a significant change in the patient's CIWA/COWS score. For example, a patient whose score jumps from 3 to 15 is indicative of progression of withdrawal, requiring notification to the provider. Nurses working on the detox unit indicate

	providers do not change the prescribed dosing from the withdrawal medication protocol sets and if a patient continues to progress they are transferred to the hospital emergency department. Additionally, chart review found that CIWA/COWS assessments are not routinely accomplished every eight hours as ordered. Assessments occur one or two hours after the initial intake assessment, and then not again for up to ten, twelve or sixteen hours later. If the patient adamantly refuses the assessment, a nursing note should be entered in the record that documents the patient's respiratory rate, presence or absence of obvious tremors, and the general presentation of the patient. • Review of the medical records of six additional patients who were on the detox unit at the time of the tour revealed only one who had "withdrawal" on the problem list.
Monitor's Recommendations:	1. Comprehensively review of the adequacy of medical housing space, processes, communicable disease risk management, utilization of space. 2. Address the deficiencies noted for Intox and Withdrawal & measure performance through focused medical record review. 3. Consider IV hydration in the dayroom on the Detox housing unit 4. Institute a MH review on all patients on the detox unit, especially those withdrawing from opioids 5. Train and supervise staff in appropriate care, including infection control. 6. Measure performance

Paragraph Author: Greifinger	III. B. 1. b. (See 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, 3/3/17	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) • duplicate III.B.1.a.		
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. & III.A.3.a.(4)		
Monitor's Recommendations:	See III. B. 1. a. & III.A.3.a.(4)		

Paragraph Author: Greifinger	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), 3/3/17
Measures of Compliance:	*The measures of compliance from the Settlement Agreement and/or Consent Agreement and/or what you will use to measure compliance* • Inspection		
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.		

2. Chronic Care

Paragraph Author: Greifinger	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), 3/3/17
Measures of Compliance:	• Policy review • Medical record review • Interview		
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):	• Generally, chronic care does not follow nationally-accepted guidelines. • Providers do not enroll inmates with chronic disease in the chronic care program at intake. • Chronic care follow up appointments are not scheduled timely and the frequency of appointments is not based upon the patient's condition. Patients whose condition is poor are seen at the same frequency interval as those whose condition is in good control. • Chronic care appointments are not schedule to coincide with the time medication needs to be renewed resulting in discontinuity of care. • Failure to provide timely, clinically appropriate chronic care results in preventable emergency room visits and hospitalization. • We reviewed the records of four patients on inhaled corticosteroids, presumably because they had moderate or severe asthma. One had mild intermittent asthma and was not a candidate for inhaled corticosteroid medication; another likely did not have asthma. None of the four patients had documentation of a measured peak expiratory flow which is a nationally-accepted practice. Two of the four patients were referred, but never had a chronic care visit. • We reviewed the care for ten patients with diabetes, including five who were insulin-dependent. Four of the latter were substantially out of control, yet there was no documented treatment plan to get them in control. Three of the five were not on aspirin prophylactically. One patient had an elevated urinary microalbumin, though he was not treated with the recommended ACE inhibitor. • Two of six patients on anticoagulant medication had poor care.		
Monitor's Recommendations:	1. Issue chronic care guidelines that are specific and that reflect nationally-accepted guidelines. Examples of these can usually be found on the NCCHC resource website. 2. Measure clinical performance as part of the quality management program, identify deficiencies, implement remedies and re-measure over time.		

Paragraph Author: Greifinger	III. B. 2. b. (See 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), 3/3/17
Measures of Compliance:	• duplicate III.B.2.a.		
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. 2. a.		
Monitor's Recommendations:	See III. B. 2. a.		

3. Use of Force Care

Paragraph Author: Greifinger 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: 3/3/17; 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: 3/3/2017	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14; 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	Medical Care: • Review of logs • Medical record review 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 Mental Health Care: The County is in the process of revising its policy on the use of clinical restraint. This policy also covers the utilization of emergency treatment orders. The policy did not mention utilization of 'observation chairs,' which were mentioned in the electronic medical record and confirmed in data submitted by MDCR.		
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 Rating is based on information provided to the monitors in July 2016. Will review along with corrections monitor on or before the next tour. Mental Health Care: Emergency Treatment Order utilization varied from 19 times per month to 37. Subsequent review of a random sample of records noted that these emergent treatment orders were accompanied by a progress note; this was an improvement over the last review. With respect to urgent transfers and emergency hospitalization, a significant proportion of the patients transferred were secondary to altered mental status related to preventable withdrawal and seizure.		

Monitor's Recommendations:	Medical Care: Mental Health Care: Restraint utilization should be kept to a minimum. I was happy to see that the County is tracking utilization of ETOs. Analysis of this data will hopefully yield information on trends and ways to minimize their use.

Paragraph Author: Greifinger	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); 3/3/2017
Measures of Compliance:	• Review of logs • Medical record review		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	• The health records of 20 inmates identified as involved in a use of force between 12/5 -15/2016 were reviewed. In half of these incidents LPNs conducted the evaluation of injury. This is likely to be outside the lawful scope of practice for LPNs in Florida. Since the purpose of these evaluations is to determine acute injury and possible cause, a registered nurse who has been trained in the assessment of trauma, mechanism of injury and sexual assault would be clinically more appropriate. • There is no evidence that nurses have received appropriate training to carry out this function. • These evaluations are conducted in a wide variety of circumstances such as a man down response to a medical emergency or after an assault by another inmate and seem to be initiated by correctional officers. Suggest establishing a clear definition of when inmates are to be evaluated for use of force and auditing actual occasions against the definition and policy. • In none of 20 incidents reviewed did health care staff suspect the possibility of staff abuse. Of all incidents tracked the last six months by the jail (9/1/2016 through 3/1/2017) there have only been two reports of suspected officer on inmate abuse submitted. In one of 20 charts reviewed in preparation for the site visit the inmate reported to a social worker after being examined by an LPN that he had been grabbed by an officer. This was not reported subsequently. • The Patient Care Services Manager at MWDC agreed that officers were present in the area at the time that nurses were evaluating inmates for use of force. This practice needs to be examined further to provide instructions so that these evaluations take place in private per the consent agreement and still provide adequate custodial supervision.		
Monitor's Recommendations:	1. Post use of force evaluation is performed within the scope of practice. 2. Train and supervise nurses for these evaluations, including proper documentation, privacy, accountability for reporting. 3. Measure clinical performance, etc.		

Paragraph Author: Greifinger	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, 3/3/17
Measures of Compliance:	• Interviews • Medical record review		
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):	Through interview and review of medical records, it is apparent that nurses' interviews are performed within earshot of custody staff, thereby preventing an adequate assessment of the cause of the injuries. Nurses in such circumstances do not document queries into the cause of the injury. On one occasion, there was potential staff on inmate abuse that was not reported.		
Monitor's Recommendations:	Recommendations from Report #3 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; 3/3/2017	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:	The County revised its policy on basic mental health. It is also conducted a pilot study to determine if its screening instrument was over-referring inmates to the mental health caseload.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The County has completed diligent efforts towards policy development.		
Monitor's Recommendations:	1. Complete revision of interagency Suicide Prevention policy. 2. Implement order to define method of differentiating constant observation from suicide precaution. 3. Design and implement process to make intake more efficient. This will include a way to easily separate and identify emergency referrals from urgent referrals not just in the EMR, but visually. 4. Perform intermittent internal reviews (audits) of intake screening for accuracy of leveling.		

	5. Differentiate suicide screen from suicide risk assessment.

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; 3/3/2017	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.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The policy states that a designated social worker or the Charge Nurse will be available to assist patients with cognitive disabilities with any health care requests. Social workers tend to be busy, as to Charge nurses. A specific designee may need to be assigned depending on the level of cognitive impairment.		
Monitor's Recommendations:	For the next tour, please provide: 1. 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) 2. Records demonstrating internal audits relative to referrals by type. 3. Complete and final policies. 4. Records demonstrating relevant staff training to the policy.		

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; 3/3/2017</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. Data was submitted. This data was provided without a context. As a result, the reader is left to interpret and create their own context. For example, as the mental health monitor, I was provided many charts in the Bi-Annual Report (which arrived timely). One of the charts is summarized below. This chart did not tell give me baseline or a context regarding what was ‘good’ or expected productivity for the psychiatrists.</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, the number of patients 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>
<tr><td></td><td>Aug</td><td>Sept</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Average</td></tr>
<tr><td>1A</td><td>29</td><td>26</td><td>28</td><td>23</td><td>25</td><td>26</td></tr>
<tr><td>1B</td><td>69</td><td>67</td><td>64</td><td>58</td><td>61</td><td>62</td></tr>
</table></td></tr>
</table>

<table>
<tr><td></td><td>
<table>
<tr><td>II</td><td>199</td><td>190</td><td>218</td><td>199</td><td>185</td><td>202</td></tr>
<tr><td>III</td><td>517</td><td>523</td><td>522</td><td>449</td><td>435</td><td>488</td></tr>
<tr><td>IV</td><td>1666</td><td>1678</td><td>1705</td><td>1705</td><td>1631</td><td>1677</td></tr>
<tr><td>Total</td><td>2480</td><td>2496</td><td>2533</td><td>2433</td><td>2338</td><td></td></tr>
</table>
Information relevant to the first half of 2016 was not provided.
</td></tr>
<tr><td>Monitor’s Recommendations:</td><td>CHS and MDCR are encouraged to continue to further tighten policy, collect data, analyze it
1. Streamline and reorganize intake.
2. Psychiatrists and ARNPs should be trained and comfortable with identifying signs and symptoms of withdrawal / dual diagnosis. Managing these patients appropriately is the crux of your system.
3. All medical staff, including mental health, should understand that vital signs are necessary.</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; 3/3/2017	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 policy for Behavioral Health Services was revised.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Bottlenecks continue to occur that demonstrate delays in access to care. For example, one of the mortality cases died due to the fact that x-ray that was ordered was not read in a timely manner. This could have lead to a diagnosis and treatment for lung cancer. Other cases demonstrated that female inmates "gave birth on the floor."		
Monitor's Recommendations:	1. Adjust and redistribute staff including nurse practitioners according to acuity and need. 2. Consider placing psychiatrist(s) at point of entry during peak flow times to eliminates back logs and reduce duplication of effort. 3. Utilize behavioral (non-pharmacologic) treatment options where possible. This will include increasing programming for Level II and III patients at Metro West.		

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; 3/3/2017	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)	Of the records reviewed, few had treatment plans. This was viewed to be the case due to the problem that many patients do not have stability in the level they achieve (i.e. mental health staff change the patient's level rapidly before the patient receives a treatment plan).		
Monitor's Recommendations:	1. Treatment plans should be individualized, and patient-centered. The treatment plan 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. 3. Patients with SMI should remain at one level long enough to obtain a treatment plan prior to being re-leveled.		

Paragraph Author: Ruiz	III. C. 2. d. Mental Health Treatment CHS shall provide each inmate on the mental health caseload who is a Level I or Level II mental health inmate and who remains in the Jail for 30 days with a written interdisciplinary treatment plan within 30 days following evaluation. CHS shall keep the treatment plan in the inmate's mental health and medical record.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 7/29/16; 3/3/2017	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. To achieve full compliance, please submit how many patients are on the mental health caseload on each level <u>and how many patients on each level receive a written interdisciplinary treatment plan within 30 days</u> in the form of an internal audit / quality improvement review / or performance plan.		

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; 3/3/2017	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. To achieve full compliance, please submit how many patients are on the mental health caseload on each level <u>and how many patients on each level receive a written interdisciplinary treatment plan within 7 days and 30 days</u> thereafter in the form of an internal audit / quality improvement review / or performance plan.		

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; 3/3/2017	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:	Please note that leveling and re-leveling continues to be problematic. (Patients cannot achieve treatment planning this way.) As this continues, CHS will need to find a way to validate its levels and maintain its patients on one level to achieve compliance moving forward.		

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: 3/3/17	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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS provided documentation indicating there has been an increase in the number of groups provided, as well as improved tracking of patients' participation in the groups. My judgement is that the work done allows for a finding of compliance. If CHS may want to differentiate the orders by a **psychiatrist** and delivered by a QMPH – that may assist in resource allocation and effective delivery of services.		
Monitor's Recommendations:	Document that the services provided align with patient needs.		

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: 3/3/2017	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.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is providing adequate mental health care to the level IV population. This psychiatric care is intermittent and ad-hoc. It would benefit less reliance on psychotropic medication and more utilization of non-pharmacodynamic approaches, including group therapy, volunteers, and exercise.		
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: 3/3/2017	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:	Mental Health: 1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies consistent with appropriate treatment in Level III, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	CHS policy 058-B was recently updated and submitted. Level III patients receive: a. Evaluation and stabilizing in the appropriate setting; a. Psychotropic medication, as clinically appropriate; b. Evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; c. 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)	As the quality improvement program develops, compliance will anticipate self-reviews of mental health care provided per level.		
Monitor's Recommendations:	1. Develop a robust quality improvement program to self-monitor. 2. Performance indicators would include wait times for psychiatry visits, psychotropic medication utilization, numbers of use of force incidents, utilization of groups, utilization of recreation time, episodes of self-harm, grievances, and adherence to medication, etc.		

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:	Partial Compliance: 7/13; 1/16; 7/29/16; 3/3/2017	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.		
Monitor's Recommendations:	Continuous quality improvement and the Director of MH should track the following: 1. Accuracy of level at booking and at treatment team (to minimize re-leveling) 2. Dispensation of critical medications 3. Bottlenecks and backlogs for provider appointments 4. 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: 3/3/2017	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 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.		
Monitor's Recommendations:	1. Provide constant observation for those patients on Level 1A with high acuity. As stated repeatedly, constant observation should be differentiated from suicide precaution and should be clearly flagged with an order. 2. Appropriate access to recreation and showers must be made available even to patients on Level 1A and Level 1B. 3. Patients on Level 1A and Level 1B should be provided access to other forms of programming to provide stimulation during the day. 4. Appropriate hygiene must be made available for menstruating females, regardless if they are 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); 3/3/17
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)	The building required is not completed. 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: 3/3/2017; 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 has been revised.		
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. Although the policy revised, no documentation was provided to demonstrate compliance with the provisions of the paragraph (e.g. internal audits or reviews).		
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; 3/3/2017	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)	Although limited non-pharmacologic treatment for Level I patients are available, patients on Level 1A and Level 1B are being seen by mental health on a regular basis.		
Monitor's Recommendations:	Address access to adequate treatment space and recreation time for the provision of both group therapy and 1:1 therapy.		

Paragraph Author: Ruiz	III. C. 2. k. Mental Health Care and Suicide Prevention: CHS shall conduct and provide to the Monitor and DOJ a documented quarterly review of a reliable and representative sample of inmate records demonstrating alignment among screening, assessment, diagnosis, counseling, medication management, and frequency of psychiatric interventions.		
Compliance Status this tour:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16; 7/29/16; 3/3/2017
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; 3/3/2017	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; 3/3/2017
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)	Suicide risk assessment should be conducted on a regular basis, as clinically indicated (e.g. someone might receive bad news, or return from ED). A review of the records did not provide evidence of adequate suicide assessment in response to triggering events. No psychological autopsies were conducted as part of the M & M review. No risk profiles were submitted.		
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. 3. The triggering events and thresholds in Appendix A include: 4. Any suicide attempt resulting in outside medical treatment 5. Any aggression to self-resulting in major injury 6. Two or more episodes of suicidal ideation/attempts within 14 consecutive days 7. Four or more episodes of suicidal ideations/attempts within 30 consecutive days		

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; 3/3/2017
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:	Patients succeeded in injuring themselves despite being on Level IA. For example, in one case, a patient swallowed a razor blade while on Level I. In another case, a patient hoarded medication and was subsequently disciplined for hoarding the medication that she used to overdose. 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, satisfactory constant observation and supervision were not documented. There was no way to establish that constant observation had been initiated in the electronic medical record.		
Monitor's Recommendations:	Provide individualized levels 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; 3/3/2017	Non-Compliance: 10/14 (NR); 5/15 (NR)
Unresolved/partially resolved issues from previous tour:	• 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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Complete revision and training on the Interagency Suicide Prevention Policy.		
Monitor's Recommendations:	Train staff to corrections-specific intake and suicide prevention policies and practices. Complete Suicide Prevention drills on site.		

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; 3/3/2017
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. The treatment plans reviewed did not contain information relevant to risk factors and preventive factors for suicide risk. This should be addressed and mitigated.		
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; 3/3/2017	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. Compliance in this provision will require proficiency in a mock drill and the ability to use the cut down tool and respond appropriately to an emergency situation involving a mental health 'man-down' drill.		

Paragraph Author: Greifinger 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: 3/3/17	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; 3/3/2017	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR)
Measures of Compliance:	<u>Medical Care:</u> • Interviews • Observation <u>Mental Health Care:</u> 1. On-site review of first aid kit and resources. 2. Review of record of education / training to CHS and officers in emergency response 3. Review of adverse events		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> <u>Mental Health Care:</u> Emergency bags were available.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care:</u> At TGK, an "crash cart" in the clinic was observed with contents labeled, cart locked and tagged with a number and evidence of every shift checks documented on the log. <u>Mental Health Care:</u> Although emergency bags were available, not all staff knew how to utilize them.		
Monitors' Recommendations:	<u>Medical Care:</u> <u>Mental Health Care:</u> All staff shall be trained in the use of emergency procedures.		

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; 3/3/2017
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:	The bi-annual report was provided. Otherwise, no reliable or representative sample of inmate records was provided specific to suicide screening.		
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 specific to suicide screening. Prior to the onsite, in preparation, I reviewed 10 records, two from each level, and their suicide screens. These records were picked by CHS. One would not be able to discern the level of acuity of the patient by reviewing the suicide screen alone had it not come labeled before-hand. In other words, the suicide screen being utilized had poor validity. A Level 1A (high acuity mental patient) suicide screen looked the same as Level IV general population screen. This was concerning.		
Monitor's Recommendations:	To achieve compliance (and decrease over-referral to their mental health caseload), CHS should: 1. Utilize a sound mental health and suicide screening instrument 2. Place trained mental health providers at intake to screen patients 3. Once screened, place solid clinicians at the second stage of intake to *evaluate* and *commence* treatment rapidly 4. if the patient is dually diagnosed or detoxing, medical or mental health should be able to immediately treat and triage as needed		

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: 3/3/2017	Partial Compliance: 7/13; 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 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)	CHS cleared a range of 65 – 73% of the mental health cases that needed to be seen for the disciplinary review process. The Biannual Report stated that in a majority of cases "mental health patients are receiving disciplinary infractions that are not associated with their mental health diagnosis and related symptoms." However, in one case reviewed (mentioned above) a woman was disciplined for hoarding the medication she utilized to overdose. In another case, a patient in segregation was involved in an altercation with an officer days after requesting assistance from mental health. The assistance from mental health never came; the patient suffered a fracture.		
Monitor's Recommendations:	Track data and conduct internal analyses 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, 3/3/2017	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)	Insufficient information was provided to find this provision in compliance. The Monitor was informed that behavioral health rounds are not occurring on a regular basis due to 'lack of staff.' Meeting minutes indicate that the County is not in compliance in terms of providing patients with special needs access to therapeutic programming and to means to communicate.		
Monitor's Recommendations:	Assign individuals with special needs and SMI to chronic care clinic. If the individual has specific issues with communication, the patient should be assigned a designated social worker or provider as needed to ascertain access to care.		

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; 3/3/2017
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, there was no way to verify via an order on any other method that patients were placed on constant observation, and if so what time and date that constant observation started or stopped.		
Monitor's Recommendations:	Suicide precaution is not constant observation and constant observation is not suicide precaution. Constant observation should have a clear start and stop time for accountability of staff and clarity of procedure.		

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; 3/3/2017	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. Mental health treatment center not established. No quarterly reports provided.		
Monitor's Recommendations:	Patients on Level 1 that are non-adherent to medication may benefit from other activities. These include recreation, showers, limited groups, reading, etc. These activities should be tailored to the individual on a case by case basis and should be written in the progress note / treatment plan.		

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; 3/3/2017	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 3. Treatment space for group therapy 4. Therapeutic programming vs volunteers		
Monitor's Recommendations:	Metro West needs a re-evaluation of its mental health caseload and the programming being offered.		

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; 3/3/2017	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 adequate 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; 3/3/2017	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:	The policy on custodial segregation is under revision.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Internal reviews indicated that inmates in custodial segregation were seen on an intermittent basis. The women fared worse in long-term segregation as per the review. No analysis or follow-up was given in the data or report to say if the finding was mitigated by referring the female patients to counseling after their time in segregation or in some other way. The Monitor was also informed that 'overflow' for custodial segregation for mental health occurs at PTDC.		
Monitor's Recommendations:	PTDC should not be utilized to house patients with severe mental illness, particularly those in custodial segregation. It is a cruel environment, even for those without SMI.		

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; 3/3/2017	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)	Data and information should be analyzed in real-time to mitigate harm to patients.		
Monitor's Recommendations:	Review and analyze data and trends relative to mental health status and length of stay of patients in custodial segregation. No patient should be placed in custodial segregation for an excessive period of time, particularly those with SMI including major depression, bipolar disorder, schizophrenia and post-traumatic stress disorder. Excessive periods of time vary by individual, but per the consent, anything longer than seven consecutive hours should be seen by QMHP and requires assessment that no contraindications exist.		

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; 3/3/2017	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, which is under revision, 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)	No internal audits or reviews were provided relative to seeing patients prior to placement in custodial segregation. It is not clear if a QMHP is evaluating the inmate prior to placement in custodial segregation or once the inmate has already been placed.		
Monitor's Recommendations:	Please provide clear documentation and an analysis of: 1. If SMI is suspected or documented, the inmate should be evaluated. The timeline for when (prior) should be clarified and the contraindications to placement in custodial segregation. 2. Disciplinary reviews should take into consideration not only whether the patient has the capacity to complete the disciplinary proceeding but whether their mental illness had anything to do with the 'charge' of which they are being accused. For example, if the patient is being charged with hoarding or stealing and that patient was intending to use that medication or used that medication for a suicide attempt, that should be taken into consideration. Conversely, if the patient is hoarding for the purposes of selling medication, that is a different intent entirely. 3. For future tours, please continue to provide: 4. Number of patients on Levels I-IV per month referred for disciplinary proceedings and placed in custodial segregation 5. Outcome of mental health review / consults prior to placement. 6. Number of patients per Level per month in custodial segregation referred to mental health care (i.e. incidence of mental health illness). 7. Outcome of mental health referral. 8. Length of placement for patients (Levels I-IV) in custodial segregation. For example, some mental health illnesses are adversely impacted by long placements in solitary confinement.		

Paragraph Author: Ruiz	III. C. 6. a. (3) Custodial Segregation If a Qualified Mental Health Professional finds that if 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; 3/3/2017	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.		
Monitor's Recommendations:	Please provide clear documentation and analysis of: 1. It is recommended that when the inmate is evaluated be clarified and the contraindications to placement in custodial segregation be outlined consistent with the CA. 2. Disciplinary reviews should take into consideration not only whether the patient has the capacity to complete the disciplinary proceeding but whether their mental illness had anything to do with the 'charge' of which they are being accused. For example, if the patient is being charged with hoarding or stealing and that patient was intending to use that medication or used that medication for a suicide attempt, that should be taken into consideration. Conversely, if the patient is hoarding for the purposes of selling medication, that is a different intent entirely. 3. For future tours, please continue to provide: 4. Number of patients on Levels I-IV per month referred for disciplinary proceedings and placed in custodial segregation 5. Outcome of mental health review / consults prior to placement. 6. Number of patients per Level per month in custodial segregation referred to mental health care (i.e. incidence of mental health illness). 7. Outcome of mental health referral. 8. Length of placement for patients (Levels I-IV) in custodial segregation. For example, some mental health illnesses are adversely impacted by long placements in solitary confinement. This should be taken into consideration.		

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; 3/3/2017
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. It is in the process of revision.		
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. In practice, these patients are being seen once weekly by a QMHP, at best, even in the case of patients that are in custodial segregation as Level 1A.		
Monitor's Recommendations:	As stated above, inmates with SMI in custodial segregation should receive rounds by a QMHP three times per week. To achieve compliance in this provision, in addition to self-audits demonstrating adherence, logs and/or data utilized to perform the self-audits will need to be submitted as well.		

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; 3/3/2017
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:	A 'Watch Tour Report' was submitted by TGK.		
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. Otherwise, insufficient information was submitted to demonstrate adherence to the Florida State guideline of one hour of out of cell recreation time per day for each inmate.		
Monitor's Recommendations:	1. Permit out of cell time and increased programming for patients with severe mental illness as per CA and Florida State guidelines. 2. For the next tour, please provide internal audits reflective of diversions from custodial segregation for patients with severe mental illness if adequate recreation, programming, and therapeutic activity cannot be offered in custodial segregation due to physical plant or other issues.		

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); 3/3/2017
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 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 written documentation was provided supporting the approval of the Facility Supervisor and Director of Mental Health Services for placement of Level 1 and Level 2 patients in custodial segregation.		
Monitor's Recommendations:	To demonstrate compliance, future tours will require the internal review and the supporting documentation demonstrating 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); 3/3/2017
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. The review of information relative to disciplinary proceedings provided indicated that even the patients that decompensated while in custodial segregation due to their mental disorder were not removed from confinement.		
monitor's Recommendations:	Provide data indicating referral for assessment and treatment prior to placement in custodial segregation. Provide data and analysis for assessment and treatment after symptoms develop during confinement.		

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); 3/3/2017
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)	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 log that was provided indicated that the patients that decompensated were not removed from custodial segregation and remained despite their symptoms. This was consistent with case review findings, as well.		
	1. All medical staff must be alert to signs and symptoms of SMI in patients in segregation, as this is a high stress environment. 2. Patients that develop signs or symptoms of SMI while in custodial segregation shall be immediately removed and referred to treatment.		

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); 3/3/2017
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)	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 log that was provided indicated that the patients that decompensated were not removed from custodial segregation and remained despite their symptoms. This was consistent with case review findings, as well.		
Monitor's Recommendations:	1. All medical staff must be alert to signs and symptoms of SMI in patients in segregation, as this is a high stress environment. 2. Patients that develop signs or symptoms of SMI while in custodial segregation shall be **immediately removed** and referred to treatment.		

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; 3/3/2017	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)	Insufficient information was provided for a comprehensive review of this provision. It remained in its current status. Sheets that were reviewed varied.		
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: Greifinger and Ruiz	III. C. 6. a. (10) Custodial Segregation 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), 3/3/17
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); 3/3/2017
Measures of Compliance:	Medical Care: • Interviews • Review of logs • Presence of logs in medical records 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: Mental Health Care: Mental health care rounds occur on a once weekly basis in custodial segregation. Medical rounds occur daily.		
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. 6. Mental Health Care: Treatment space is not available in administrative segregation for mental health.
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); 3/3/2017
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.		
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; 3/3/2017	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:	Current staffing consists of the following: • 14 Psychiatrists • 5 Clinical Psychologists • 1 Chief Nurse Officer • 2 Nurse Practitioners • 14 Social Worker The information provided verbally on-site conflicted with information provided via record review. The information above was the information provided via record review. Three vacancies remain in nursing positions.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	We were informed that mental health is fully staffed from their perspective. Anticipated difficulties with staffing moving forward will be covering shifts that occur on Wednesday through Saturday, second shift (3pm to 11pm.)		
Monitor's Recommendations:	1. Maintaining motivation in staff will be important moving forward. Efforts towards solidifying the level system and building solid caseloads may be helpful towards decreasing the burnout related to the stress of constantly 'putting out fires' rather than preventing them.		

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; 3/3/2017	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:	CHS submitted a staffing matrix in May 2015. It has not been updated or changed since then.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is adequately staffed from a psychiatric and behavioral health perspective.		
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; 3/3/2017	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:	CHS submitted a staffing matrix in May 2015. It has not been updated or changed since then.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is adequately staffed from a psychiatric and behavioral health perspective.		
Monitor's Recommendations:	New hires require corrections-specific training. The Behavioral Health Curriculum is approved pending revision.		

Paragraph Author: Ruiz	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; 3/3/2017	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:	CHS submitted a staffing matrix in May 2015. It has not been updated or changed since then.		
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. Outstanding vacancies include three nursing positions. 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 seclusion and restraint, the assessment of capacity, and games inmates play. addition, it is important that staff guard against becoming overly cynical. Thus, attitude and team-building are important.		

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: 3/3/2017	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 the Associate Director of Behavioral Health. 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. Concepcion as her supervisor. The staffing matrix that was submitted did not identify psychiatrists and the time assigned at each facility.		
Monitor's Recommendations:	The Chief Psychiatrist / Associate Director of Behavioral Health should be expected to maintain a schedule of the psychiatrists and to regularly assess patient throughput in the system so that psychiatrists are being utilized to maximize their productivity. The Chief Psychiatrist / Associate Director of Behavioral Health or their designee should be expected to oversee the morbidity and mortality reviews of all cases that involve those patients on the mental health caseload. Psychological autopsies should be assigned as appropriate and root cause analyses performed as deemed appropriate.		

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: 3/3/2017	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. Pre-and post-training tests were not submitted.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Training materials generally consist of the policy placed in a power-point format.		
Monitor's Recommendations:	For future submissions, CHS must submit all material including post-training test materials, staff matrices, and any relevant documents 30 days prior to schedule on site.		

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: 3/3/2017	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 CIT training occurred July-- December 2016.		
Monitor's Recommendations:	None		

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; 3/3/2017
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 specific information was submitted for review of this provision.		
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.		
Monitor's Recommendations:	Implement daily huddle between custody and mental health at each facility – and if necessary on each unit – to improve interagency communication and patient access to care. Specific to this provision, a policy should be implemented.		

8. Suicide Prevention Training

Paragraph Author: Ruiz	III. C. 8. a. Suicide Prevention Training The County shall ensure that all staff have the adequate knowledge, skill, and ability to address the needs of inmates at risk for suicide. The County and CHS shall continue its Correctional Crisis Intervention Training a competency-based interdisciplinary suicide prevention training program for all medical, mental health, and corrections staff. The County and CHS shall review and revise its current suicide prevention training curriculum to include the following topics, taught by medical, mental health, and corrections custodial staff: 1. suicide prevention policies and procedures; 2. the suicide screening instrument and the medical intake tool; 3. analysis of facility environments and why they may contribute to suicidal behavior; 4. potential predisposing factors to suicide; 5. high-risk suicide periods; 6. warning signs and symptoms of suicidal behavior; 7. case studies of recent suicides and serious suicide attempts; 8. mock demonstrations regarding the proper response to a suicide attempt; and 9. the proper use of emergency equipment.		
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14 3/3/2017	Non-Compliance: 7/13; 3/14; 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	Review of training logs for Correctional Crisis Intervention program for all staff Review of training materials and teaching staff for inclusion of the following items: Suicide prevention policies and procedures; The suicide screening instrument and the medical intake tool; Analysis of facility environments and why they may contribute to suicidal behavior; Potential predisposing factors to suicide; Highs risk suicide periods; Warning signs and symptoms of suicidal behavior; Case studies of recent suicides and serious suicide attempts; Mock demonstrations regarding the proper response to a suicide attempt; and The proper use of emergency equipment.		
Steps taken by the County to Implement this paragraph:	Information was provided relative to nurses that have completed suicide prevention training and officers that have completed CIT.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	An insufficient number of persons and percentage of the material required of this provision was completed to render it in full compliance. For example, no documentation was submitted that the psychiatrists or psychologists attended mandatory suicide prevention training. The suicide prevention training did not document the required mock drill element. Pre- and-post tests were not provided. These elements would be necessary to demonstrate adherence to the provision.		

Monitors' Recommendations:	1. Complete revision of Interagency Suicide Prevention Policy 2. Complete mock drill of suicide / mental health 'man-down' drill. 3. Implementation of a matrix that identifies all of the training required for each position, including contracted services. This matrix will assist MDCR in identifying what position needs training / re-certification of licensure, etc.

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; 3/3/2017	Non-Compliance: 7/13; 3/14; 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	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 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):	No documentation was provided from mental health staff regarding the requirements of this paragraph. No documentation was provided that all mh staff attended required training.		
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: 3/3/2017	Partial Compliance: 10/14	Non-Compliance: 7/13; 3/14; 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	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 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):	Documentation was provided from MDCR and medical regarding the required training. All custody staff participated as required and records were provided.		
Monitors' Recommendations:	Please provide matrix as described above.		

Paragraph Author: Ruiz	III. C. 8. d. Suicide Prevention Training CHS and the County shall ensure all correctional custodial staff are certified in cardiopulmonary resuscitation ("CPR").		
Mental Health Care: Compliance Status:	Compliance: 3/3/2017	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:			
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 above; custody staff provided documentation that staff participated in CPR training.		
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; 3/3/2017	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:			
Steps taken by the County to Implement this paragraph:	The County utilizes the Quantros system. Per this system, it had a total of 220 category E events from July to December 2016. Category E are those events that caused temporary harm. It also had 135 category F events, those events that caused temporary harm and required initial or prolonged hospitalization.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Odd trends in the data were not discussed or analyzed. For example, in Quarter 3, there were 129 category F events. In Quarter 4, there were 6 category F events. This is a striking change. How did this happen? Were they counted differently, defined differently, or did another procedure change to decrease patient morbidity?		
Monitor's Recommendations:	1. Provide analysis of risk management data. 2. Review use of force data as it relates to the mental health caseload. 3. Review suicide attempts and episodes of self-harm 4. Reviews of utilization of the emergency department should also include a review of preventable patient morbidity.		

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; 3/3/2017	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR); 1/16
Measures of Compliance:	<u>Mental Health:</u> 1. Quality / Risk Management reports, reviews and data analysis. 2. Quality Improvement minutes of monthly meetings 3. Suicide, adverse event, attempted suicide, and Quantros reports. 4. 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 a mental health screen and level system. Patients are frequently 'leveled' and re-leveled repeatedly, resulting in failure to receive an interdisciplinary assessment and risk profile.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Insufficient information was documented for adherence to this provision. The charts reviewed did not have an interdisciplinary assessment or a risk profile. At risk inmates had not been referred for discussion to professional committees (although some at-risk inmates were referred to the Baker Act).		
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; 3/3/2017	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:	As a gentle reminder, compliance with this provision will require written annual performance assessment of access to mental health care by inmates, by assessing the process for screening and assessing inmates for mental health needs. It is highly recommended that in assessing and validating your access to care (i.e. how long it takes a patient to get to the psychiatrist, the psychologist, the social worker, if urgent referrals are seen timely, if emergent referrals are seen timely), you also assess the leveling system. Again, perfection of the data is not expected: a plan to manage the findings *is*.		

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; 3/3/2017	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: 1. Review of screenings by psychiatry 2. Review of monthly Quality Meeting minutes 3. Review of suicides and adverse events 4. Review of Quantros reports. 5. Review of internal quality / risk audits		
Steps taken by the County to Implement this paragraph:	The County has hired a Quality Improvement Coordinator. 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. Issues related to the over-sensitivity of the screening tool at intake were identified as early as May 2015 and persist today. The Biannual Report contained little analysis of aggregate trends.		
Monitor's Recommendations:	Provide analysis of aggregate data and implement intervention to mitigate negative outcomes.		

D. Audits and Continuous Improvement
1. Self Audit Steps

Paragraph Author: Greifinger 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); 3/3/2017
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; 3/3/2017
Measures of Compliance:	Medical Care: • Review of Quality Improvement Plan and bi-annual evaluations • QI committee minutes • Clinical performance measurement tracked and trended over time, with remedial action timelines and periodic re-measurement • Review of grievances, responses, and data analysis Mental Health Care: 1. Review of Mental Health Review Committee minutes 2. Review of Quality Assurance Committee minutes 3. Review of any reports or analyses generated by MDCR Medical Compliance		
Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health Care: The County recently hired a Compliance Coordinator. 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: There is no written quality improvement plan, nor is there an annual evaluation. These processes are crucial for an effective quality management program. Though the QI committee meets monthly, data are not analyzed and opportunities for improvement are not discussed. There is no effective clinical performance measurement with analysis, problem identification, remedies, and re-measurement. Grievance data is not analyzed as a method to identify problems. We examined a series of recent medical care grievances. The answers were unresponsive, with little investigation and no attempt to provide explanations to inmates. Review of medical records of the inmates revealed lags in care, limited clinical assessment and examinations, medical orders without a clinical encounter, and intended orders that were either not written or written and not carried out. The problem lists of those patients were unreliable and bulky. There were scarce treatment plans for chronic disease and pain. There were many notes that were cut and pasted.		

	Mental Health Care: Although the Quality Improvement Committee is meeting regularly, there was no substantive sign that it was completing the tasks asked of it per the Consent Agreement. For example, no analysis is performed on 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. Information appears to be superficially discussed but not processed or understood on a more substantive level for decision-making as it relates to how the system runs as a whole and how to prevent problems.
Monitor's Recommendations:	Medical Care: 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. Mental Health Care: Provide data analysis and implement a performance measurement system.

Paragraph Author: Greifinger 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; 3/3/2017
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; 3/3/2017
Measures of Compliance:	Medical Care: • Review of relevant documents 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. No corrective action plans related to mental health have been submitted for review.		
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: Greifinger 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; 3/3/2017	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/3/2017	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	Medical Care: To be determined 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: Mental Health Care: The Biannual Report was submitted. It included a review of the psychotropic medications administered by the jail to the inmates, a superficial discussion of emergency room transfers, and a discussion of suicide related events.		
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 discussed the suicide related events on a quantitative basis. It provided the number of events that occurred per month and it provided the category it had placed those events. The County did not perform a more in-depth analysis. For example, in July, the number of events more than doubled any other month. No explanation or analysis was provided for this finding. Were the events categorized differently, was it an exceptionally hot month and were patients more on edge, were staff on vacation? A number of reasonable theories could apply. However, none were provided.		

Monitor's Recommendations:	Medical Care: The medical monitor will work with counsel for the Parties to revise this requirement of the CA to make it useful for all. Mental Health Care: Continue to provide the Biannual Report. The County should analyze the data collect and explain disparate findings or wide fluctuations from month to month. Trends and patterns should be examined and reported. Any plans to use the analyses on a pilot basis or practically to manage the institution may also be commented upon.

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: i. All suicide-related incidents. The report will include: ii. all suicides; iii. all serious suicide attempts; iv. list of inmates placed on suicide monitoring at all levels, including the duration of monitoring and property allowed (mattress, clothes, footwear); v. all restraint use related to a suicide attempt or precautionary measure; and vi. information on whether inmates were seen within four days after discharge from suicide monitoring.		
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 1/16; 3/3/2017	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 being 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.		
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. It did not include in the report the definition of serious suicide attempt, serious suicide attempt with intent or serious suicide attempt without intent. The report stated the majority of the suicide attempts occurred for secondary gain. Analysis and identification of trends is not occurring. Rather, committee meetings, including Morbidity and Mortality appear to be more focused on liability management than patient case, system improvement, and learning.		
Monitor's Recommendations:	Specific to suicidal prevention and analysis of suicide trends, the County should look at the data from quarter to quarter as well as from year to year. This is not occurring. Chronic clinic visits should include the major mental illnesses: major depression, bipolar disorder, chronic schizophrenia, schizoaffective disorder, and post-traumatic stress disorder.		

Paragraph Author: Ruiz	III.D.2.a. (4) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: Inmate counseling services. The report and review shall include: (4) inmates who are on the mental health caseload, classified by levels of care; (5) inmates who report having participated in general mental health/therapy counseling and group schedules, as well as any waitlists for groups; (6) inmates receiving one-to-one counseling with a psychologist, as well as any **waitlists for such counseling**; and (7) inmates receiving one-to-one counseling with a psychiatrist, as well as any **waitlists for such counseling**.		
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 3/3/2017	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 being 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 was submitted.		
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):	Between July 2016 and December 2016, the number of inmates on the mental health caseload ranged from 2338 (62%) to 2533 (64%). The largest number of patients are on Levels III and IV. The Biannual report stated that there were no wait-lists for group therapy or psychiatry time; this statement was not corroborated by data, logs, or any supporting information. The Mental Health Monitor has not been in any system, in any other setting, under any other circumstance, that did not have some sort of wait list, even as an urgent care, for psychiatry time.		
Monitor's Recommendations:	The Biannual report is a good opportunity to analyze trends in your system. Utilize this data and implement necessary changes.		

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: (8) 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; 3/3/2017	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 being submitted in a timely manner and to include accurate data supportive of its conclusions.		
Steps taken by the County to Implement this paragraph:	The County submitted a Biannual report.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	A Bi-annual report for July through December 2016 included information on the disciplinary proceeding. It gave data that QMHP 'cleared' inmates to proceed with the disciplinary process 65-73%. Further follow-up was not provided. In other words, the outcome of the proceeding was not provided. If the inmate was sentenced to segregation, this information was not collected or tracked (here). Although not necessary for this specific segment of the Consent Agreement (but necessary for a separate segment), it may be useful to track the outcome of the patients sentenced to segregation.		
Monitor's Recommendations:	For the purposes of the Bi-Annual Report, the review of the disciplinary reports should include an analysis or breakdown of incidents by type (i.e. major vs minor). For example, it may be useful to examine whether mental health inmates are more likely to be disciplined for one type of offense vs another.		

Paragraph Author: Greifinger 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; 3/3/2017	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; 3/3/2017	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Medical Care:</u> Inspection <u>Mental Health Care:</u> 1. Review of bi-annual reports 2. Review of incident reports 3. Review of inmate deaths, including those which died following transfer from MDCR to Jackson Healthcare		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> Reports are provided. <u>Mental Health Care:</u> The County submitted a Biannual report that provided data on suicide-related events. A separate request for information provided information on grievances and on reportable incidents.		
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 did not provide any substantive analysis or discussion of the inmate deaths, the medical grievances, or the suicide related events (as previously discussed). Specifically, the majority of cases were cited as "no areas of opportunity." The Mental Health Monitor has not been in any system, in any hospital, nor in any correctional system with any case that did not have *any* area of opportunity. 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. <u>Mental Health Care:</u>		

	Pursue further data analysis and identify trends.

Paragraph Author: Greifinger and Ruiz	III.D.2.b. (See also 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, 3/3/17
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; 3/3/2017
Measures of Compliance:	Medical Care: duplicate III.D.1.c. 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: Same as comments in III.D.1.c.		

IV. COMPLIANCE AND QUALITY IMPROVEMENT

Paragraph Author: Greifinger 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; 3/3/2017	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; 3/3/2017	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR);1/16
Measures of Compliance:	Medical Care: To be determined Mental Health Care: 1. Policies and procedures 2. Schedule for production, revision, etc. of written directives, logs, screening tools, handbooks, manuals, forms, etc. 3. Schedule for pre-service and in-service training 4. Lesson plans 5. Evidence of training completed and knowledge gained (e.g. pre-and post-tests) 6. Observation 7. Staff interviews.		
Steps taken by the County to Implement this paragraph:	Medical Care: This is an over-arching provision; a number of other provisions fall under its umbrella, some of which are compliant or partially compliant. For example, the County has been sending new policies and procedures to the Monitors and has developed some operational documents to implement the Consent Agreement. Mental Health Care: The County is in the process of updating policy and forms.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: See above. Mental Health The County is updating policy and forms. It needs to validate and operationalize data collection/analysis systems, intake and screening, and quality improvement.		

Monitor's Recommendations:	<u>Medical Care:</u> See various recommendations throughout this report. <u>Mental Health Care:</u> 1. Design a dashboard for quality improvement. 2. Assign individuals accountable to each specific goal on the dashboard. 3. Identify obstacles in work flow or systems of delivering care. 4. Eliminate easiest obstacles / "low hanging fruit." 5. Design pilot. (Example: intake) 6. Assess impact on dashboard. 7. Repeat.

Paragraph Author: Greifinger and Ruiz	IV. B The County and CHS shall develop and implement written Quality Improvement policies and procedures adequately 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); 3/3/2017
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); 3/3/2017
Measures of Compliance:	Medical Care: Inspection of policies and procedures. 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. Mental Health Care: The County conducts regular Quality Improvement and Mental Health Review Committee meetings.		
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: Data are not presented at the QI meetings. There is no clinical performance measurement and thereby no tracking and trending of the data. There is inadequate self-critical analysis and no meaningful provisions for follow-through on findings. There are no effective reports (with action plans and timelines) on the status of compliance for each element of the Agreement. Mental Health Care: After previously submitting a draft policy in early 2016, no further procedure or information was submitted by the County regarding this provision.		
Monitors' Recommendations:	Medical Care: 1. Please see the comments in provision III. A. 7. a. 2. CHS to finalize and implement a policy and procedure for quality management activities that include, among other things: 3. Annual QI Plan and Evaluation		

	4. Clinical performance measurement, tracked and trended over time, with quantitative and qualitative analysis of data, problem identification, remedies, action plans, timelines, and accountabilities. 5. Incorporation of M&M findings, action plans, and timelines. 6. Incorporation of grievance analysis 7. Significant findings and activities of sub-committees, such as the P&T, infection control, and U.M. 8. Status and remedial action on Consent Agreement elements, including realistic timelines 9. Training and training needs <u>Mental Health Care:</u> In collaboration with the Compliance Coordinator, the Director of Quality Improvement should outline criteria for the following: • critical incidents • serious suicide attempts with intent • serious suicide attempt without intent (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. • the policy and procedure should include a system for adequate self-critical analysis, as cited above

Paragraph Author: Greifinger 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; 3/3/2017	Partial Compliance: 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Compliance Status:	Compliance: 3/3/2017	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: • Annual review of policies and procedures for any needed changes. 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. Mental Health Care: Policy and procedure review is an ongoing process. The County continues to make strides in this effort.		
Monitor's Recommendations:	Medical Care: None. Policy review is ongoing. Mental Health Care: Please make all policies, even those under review, available to staff.		

Appendix A - Settlement Agreement							
Section	**Jul-13**	**May-14**	**Oct-14**	**May-15**	**Jan-16**	**Jul-16**	**Mar-17**
Safety and Supervision							
III.A.1.a. (1)	pc	pc	pc	nr	pc	c	c
III.A.1.a. (2)	nc	nc	pc	nr	nr	pc	pc
III.A.1.a. (3)	pc	pc	c	nr	nr	c	c
III.A.1.a. (4)	pc	pc	pc	c	nr	c	c
III.A.1.a. (5)	pc	pc	c	nr	nr	c	c
III.A.1.a. (6)	pc	c	c	nr	nr	c	c
III.A.1.a. (7)	pc	pc	c	nr	nr	c	c
III.A.1.a. (8)	nc	nc	pc	nr	c	c	c
III.A.1.a. (9)	pc	pc	pc	nr	c	c	c
III.A.1.a. (10)	pc	pc	pc	nr	nr	pc	c
III.A.1.a. (11)	pc	pc	pc	nr	nr	pc	c
Security Staffing							
III.A.2. a.	not due	pc	pc	c	nr	c	c
III.A.2. b.	nc	pc	pc	c	nr	pc	c
III.A.2.c.	not due	pc	pc	c	nr	c	c
III.A.2.d.	not audited	not due	nc	not due	c	c	c
Sexual Misconduct							
III. A.3.	pc	pc	c	nr	pc	pc	pc
Incidents and Referrals							
III. A.4 a.	pc	pc	c	nr	nr	c	c
III.A.4. b.	nc	nc	c	nr	nr	c	c
III.A.4.c.	nc	pc	pc	nr	c	c	c
III.A.4.d.	not due	nc	pc	c	nr	c	c
III.A.4.e.	pc	pc	pc	nr	nr	p	c
III.A.4.f.	pc	pc	pc	pc	c	pc	c

Use of Force by Staff							
III.A. 5 a.(1) (2) (3)	pc	pc	pc	pc	pc	pc	c
III.A.5. b.(1), (2) i., ii, iii, iv, v, vi	pc	pc	pc	pc	nr	c	c
III.A. 5. c. (1)	nc	c	pc	nr	nr	c	c
III.A. 5. c. (2)	nc	pc	pc	nr	pc	pc	c
III.A. 5. c. (3)	pc	pc	pc	c	nr	c	c
III.A. 5. c. (4)	pc	not audited	c	nr	nr	c	c
III.A. 5. c. (5)	pc	c	c	nr	nr	c	c
III.A. 5. c. (6)	nc	not audited	pc	c	nr	c	c
III.A. 5. c. (7)	pc	c	c	nr	nr	c	c
III.A. 5. c. (8)	nc	nc	c	nr	c	c	c
III.A. 5. c. (9)	nc	nc	pc	pc	c	c	c
III.A. 5. c. (10)	pc	c	c	c	nr	c	c
III.A. 5. c. (11)	nc	nc	nc	pc	nr	pc	c
III.A. 5. c. (12)	nc	nc	nc	pc	nr	pc	c
III.A. 5. c. (13)	nc	c	c	nr	nr	c	c
III.A. 5. c. (14)	nc	nc	nc	pc	nr	pc	c
III.A.5. d. (1) (2) (3) (4)	pc	pc	pc	nr	nr	pc	c
III.A.5. e. (1) (2)	nc	pc	pc	nr	nr	pc	c
Early Warning System							
III.A.6. a. (1) (2) (3) (4) (5)	nc	nc	pc	nr	c	pc	c
III.A.6.b.	nc	nc	not due	pc	c	pc	c
III.A.6.c.	nc	nc	no	pc	c	pc	c

Fire and Life Safety							
III.B.1.	pc	pc	pc	nr	nr	pc	c
III.B.2.	c	c	c	nr	nr	pc	c
III.B.3.	pc	pc	pc	nr	nr	pc	c
III.B.4.	pc	pc	pc	pc	pc	pc	c
III.B. 5.	nc	pc	pc	nr	nr	pc	c
III.B.6	nc	nc	nc	pc	nr	pc	c
Inmate Grievances							
III.C. 1.,2.,3.,4.,5.,6.	pc	pc	pc	c	nr	c	c
Audits and Continuous Improvements							
PFH III.D.1. a. b.	nc	nc	pc	nr	nr	pc	c
FLS III.D.1. a. b.	nc	nc	pc	nr	nr	pc	c
PFH III.D. 2.a. b.	not due	nc	pc	pc	pc	pc	c
Compliance and Quality Improvement							
PFH IV. A.	not due	nc	pc	nr	nr	pc	c
FLS IV. A.	not due	not audited	pc	nr	pc	pc	c
PFH IV. B.	nc	nc	pc	nr	nr	pc	c
FLS IV.B.	nc	nc	pc	nr	nr	pc	c
PFH IV.C.	not due	nc	pc	nr	c	c	c
FLS IV. C.	not due	nc	pc	nr	pc	c	c
PFH IV. D.	pc	pc	c	nr	nr	c	c
FLS IV. D.	pc	pc	pc	nr	pc	c	c

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

Appendix B Consent Agreement

History of Compliance

Consent Agreement C= Compliance; PC=Partial Compliance; NC=Non-Compliance; NR=Not Reviewed							
Section	**Jul-13**	**May-14**	**Oct-14**	**May-15**	**Jan-16**	**Jul-16**	**Mar-17**
A. Medical and Mental Health Care							
1. Intake Acreening							
III.A.1.a.	Med-PC MH -PC	Med- NR MH - NR	Med-PC MH -PC	Med - PC MH - C	Med-PC MH -PC	Med-PC MH -PC	Med-PC MH -PC
III. A. 1. b.	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C
III. A. 1. c.	MH - NC	MH - NC	MH - NC	MH - PC	MH - NC	MH - NC	MH - PC
III.A.1.d.	Med - C MH-PC	Med- NR MH - NR	Med - NC MH - NC	Med - C MH - PC	Med - C MH - NC	Med - PC MH - NC	Med - PC MH - PC
III.A.1.e.	Med- NR MH - NR	Med- NR MH - NR	Med - NC MH - PC	Med - C MH - PC	Med - PC MH- PC	Med-PC MH -PC	Med - PC MH - PC
III.A.1.f.	Med - PC MH- PC	Med- NR MH - NR	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH - PC
III.A.1.g.	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC	Med - NC MH - PC
2. Health Assessments							
III. A. 2. a.	Med- NR	Med- NR	Med- NR	Med- NR	Med- NR	Med- NR	Med - NC
III. A. 2. b.	MH - NR	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC
III. A. 2. c.	Not Yet Due	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC
III. A. 2. d.	Not Yet Due	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC
III.A.2.e.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NR	MH - C	MH - NC
III.A.2.f. (See (IIIA1a) and C. (IIIA2e))	Med - PC MH- PC	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - PC MH- PC	Med - NC MH - PC
III.A.2.g.	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - NC MH - NC	Med - NC MH - NC
3. Access to Medical and Mental Health Care							
III.A.3.a.(1)	Med - C MH - PC	Med- NR MH - NR	Med - C MH - C	Med- NR MH - NR	Med- NR MH- NR	Med - C MH - C	Med - C MH - C
III.A.3.a.(2)	Med- NR MH - PC	Med- NR MH - NR	Med - C MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - C MH - NR	Med - C MH - NC

Appendix B Consent Agreement

History of Compliance

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17
III.A.3.a.(3)	Med - PC MH- PC	Med- NR MH - NR	Med - C MH - C	Med- NR MH - NR	Med- NR MH - NR	Med - C MH C	Med - C MH - C
III.A.3.a.(4)	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - PC MH - PC
III.A.3.b.	Med - PC MH - PC	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH - NC	Med - NC MH - NC
4. Medication Administration and Management							
III.A.4.a.	Med - PC MH - PC	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - NC MH - PC
III.A.4.b(1)	Not Yet Due	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- NC	Med - PC MH - NC
III.A.4.b(2)	Not Yet Due	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - NC MH- NC	Med- NC MH -NC
III. A. 4. c.	MH - PC	MH- NR	MH- NR	MH- NR	MH- NR	MH - NC	MH- PC
III. A. 4. d.	MH - PC	MH- NR	MH- NR	MH- NR	MH- NR	MH - NC	MH- NC
IIIA.4.e.	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH - NC	Med - NC MH - PC
III.A.4.f. (See (III.A.4.a.)	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - NC MH - PC
5. Record Keeping							
III.A.5.a.	Med - PC MH - NC	Med - NR MH- PC	Med - PC MH- PC	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med-PC MH -PC
III.A.5 b.	MH - NC	MH - PC	MH - PC	MH - NR	MH - NR	MH- PC	MH - NC
III.A.5.c.(See III.A.5.a.)	Med - PC MH- PC	Med- NR MH - NR	Med-PC MH -PC	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med-PC MH -PC
III.A.5.d.	Med - PC MH- PC	Med - NR MH- NR	Med-PC MH -PC	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med-PC MH -PC

Appendix B Consent Agreement

History of Compliance

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17
6. Discharge Planning							
III.A.6.a.(1)	Med - NR MH- PC	Med - NR MH- NC	Med - PC MH - PC	Med- NR MH - NR	Med - PC MH - PC	Med - PC MH - PC	Med - NC MH - PC
III.A.6.a.(2)	Med - NR MH - PC	Med - NR MH - NC	Med - PC MH - PC	Med- NR MH - NR	Med - NC MH - PC	Med - PC MH - PC	Med - NC MH - PC
III.A.6.a.(3)	Med - NR MH- PC	Med - NR MH - NC	Med - PC MH - PC	Med- NR MH - NR	Med-PC MH -PC	Med- NR MH - NR	Med - NC MH - PC
7. Mortality and Morbidity Reviews							
III.A.7.a.	Med - PC MH - PC	Med - NR MH - PC	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - NC	Med - PC MH - PC	Med - NC MH - NC
III.A.7.b.	Med - NR MH - NC	Med - NR MH - PC	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - PC MH- NC	Med - NC MH - NC
III.A.7.c.	Med - NR MH - NC	Med - NR MH - NC	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - PC MH - NC	Med - NC MH - NC
B. Medical Care							
1. Acute Care and Detoxification							
III.B.1.a.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC
III.B.1.b. (See (III.B.1.a.)	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - PC
III.B.1.c.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC
2. Chronic Care							
III.B.2.a.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC
III.B.2.b. (See (III.B.2.a.)	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC
3. Use of Force Care							
III.B.3.a.	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - NR MH- NR	Med - NR MH- NC	Med - C MH - NC	Med-C MH -PC
III.B.3.b.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC
III.B.3.c. (1) (2) (3)	Med - NR	Med - NR	Med - PC	Med - NR	Med - NR	Med - NC	Med - NC

Appendix B Consent Agreement

History of Compliance

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17
C. Mental Health Care and Suicide Prevention							
1. Referral Process and Access to Care							
III. C. 1. a. (1) (2) (3)		MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC
III. C. 1. b.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC
2. Mental Health Treatment							
III. C. 2. a.	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 2. b.	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 2. c.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC
III. C. 2. d.	MH - PC	MH - PC	MH - PC	MH - NR	MH - NC	MH - PC	MH - PC
III. C. 2. e. (1) (2)	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC
III. C. 2. f.	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 2. g.	MH - NC	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - C
III. C. 2. g. (1)	MH - NC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - C
III. C. 2. g. (2)	MH - NC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - PC
III. C. 2. g. (3)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 2. g. (4)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C
III. C. 2. h.	MH - PC		MH - NR	MH - NR	MH - PC	MH - PC	MH - NC
III. C. 2. i.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC
III. C. 2. j.	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 2. k.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC
3. Suicide Assessment and Prevention							
III. C. 3. a. (1) (2) (3) (4) (5)	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC
III. C. 3. b.	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC
III. C. 3. c.	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC
III. C. 3. d.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 3. e.	MH - PC	MH - NC	MH - NR	MH - NR	MH - NC	MH - PC	MH - NC
III. C. 3. f.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 3. g.	Med -NR MH - NC	Med - NR MH - NC	Med - NR MH- NR	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - PC
III. C. 3. h.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC

Appendix B Consent Agreement

History of Compliance

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17
4. Review of Disciplinary Measures							
III. C. 4. a. (1) (2) and b.	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - C
5. Mental Health Care Housing							
III. C. 5. a.	MH - NC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 5. b.	MH - NC	MH - NC	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC
III. C. 5. c.	MH - NC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 5. d.	MH - NR	MH - PC	MH - PC	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 5. e.	MH - PC	MH - NC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC
6. Custodial Segregation							
III. C. 6. a. (1a)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 6. a. (1b)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 6. a. (2)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 6. a. (3)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 6. a. (4) i	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC
III. C. 6. a. (4) ii	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC
III. C. 6. a. (5)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC
III. C. 6. a. (6)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC
III. C. 6. a. (7)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC
III. C. 6. a. (8)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC
III. C. 6. a. (9)	MH - C	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 6. a.(10)	Med - NC MH - PC	Med - NR MH - NC	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - PC	Med - PC MH - PC	Med - NC MH - NC
III. C. 6. a. (11)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC
7. Staffing and Training							
III. C. 7. a.	MH - PC	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C
III. C. 7. b.	MH - NR	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C
III. C. 7. c.	MH - NC	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C
III. C. 7. d.	MH - NR	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
III. C. 7. e.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - C
III. C. 7. f.	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C
III. C. 7. g. (1)(2)(3)	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C
III. C. 7. h.	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - NC

Appendix B Consent Agreement

History of Compliance

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17
8. Suicide Prevention Training							
III. C. 8. a. (1 – 9)	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - PC
III. C. 8. b.	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - PC
III. C. 8. c.	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - C
III. C. 8. d.	MH - NC	MH - NC	MH - PC	MH - NR	MH - PC	MH - PC	MH - C
9. Risk Management							
III. C. 9. a.	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC
III. C. 9. b. (1)(2)(3)(4)	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC
III. C. 9. c. (1)(2)(3)(4)(5)	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - NC	MH - PC
III. C. 9. d. (1)(2)(3)(4)(5)(6)	MH - NR	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC
D. Audits an Continuous Improvement							
1. Self Audits							
III. D. 1. b.	Med - NR MH -PC	Med - NR MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - NC	Med - PC MH - PC	Med - NC MH - NC
III. D. 1. c.	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH- NC	Med - PC MH - NC	Med - NC MH - NC
2. Bi-annual Reports							
III. D. 2 .a. (1)(2)	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med -NC MH - NC	Med - PC MH - NC	Med - PC MH - PC
III. D. 2. a. (3)			MH - NR	MH - NR	MH - PC	MH - NC	MH - PC
III. D. 2. a. (4)			MH - NR	MH - NR	MH - NC	MH - NC	MH - PC
III. D. 2. a. (5)			MH - NR	MH - NR	MH - PC	MH - NC	MH - PC
III. D. 2. a.(6)	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - C MH - PC	Med - PC MH - PC	Med - PC MH - PC
III. D. 2. b.(See III. D. 1. c.)	Med - NR MH- NR	Med - NR MH- PC	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - PC MH - NC	Med - NC MH - NC
IV. Compliance and quality Improvement							
IV. A	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - NC	Med - PC MH - PC	Med - PC MH - PC
IV. B	Med - PC MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - PC	Med - NC MH - NC

Appendix B Consent Agreement

History of Compliance

	Med - NR MH- NR	Med - NF MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med-PC MH -PC	Med - PC MH - PC	Med - C MH - C

Yellow = Collaboration - Medical (Med) and Mental Health (MH)

Purple = Collaboration with Protection from Harm

Orange = Medical Only

Green = Mental Health Only