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. 8

January 18, 2018

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Compliance Report # 8
United States v. Miami-Dade County
December 4 - 9, 2017

This is the eighth 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. [1]

The Monitors toured the MDCR facilities during December 4 - 9, 2017. The Monitors' tour was originally scheduled for the week of September 11th and was re-scheduled due to Hurricane Irma. 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 December 22, 2018, with a requested date to return comments of January 12, 2018. The Monitors carefully reviewed all comments received and requested clarification, specifically regarding the reports and due dates included in this Compliance Report.

The Monitors acknowledge progress in many areas of work to achieve compliance, but this work is overshadowed by the twelve inmate in-custody deaths since January 2017.[2] These deaths are extremely concerning for the Defendants, the Plaintiffs and the Monitors. This unprecedented number of deaths – regardless of cause, focuses an examination of how the morbidity and mortality reviews are conducted by CHS, the assessment of the deaths by MDCR, the joint reviews, outcomes, and plans for action.

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 Maurice L. Kemp, Carlos A. Migoya, President and CEO of Jackson Health System, and Don Steigman, Chief Operating Officer, Jackson Health System for their time in meeting with the independent Monitors and their advice and actions. We also extend our thanks to the leadership teams from both organizations.

[1] A change to the monitoring team occurred in May 2017 when Amanda Ruiz, MD, Mental Health Monitor, withdrew, and was replaced by Kahlil A. Johnson M.D. Another change to the team will occur after January 1, 2018 with the retirement of Harry E. Grenawitzke. It is anticipated, as the County has achieved and maintained compliance with the six paragraphs Mr. Grenawitzke monitors, that the remaining correctional practice monitors (McCampbell and Hodge) will be able to review and assess these areas.

[2] The County asked that this Report note that the cause of deaths: three by suicide and five due to chronic illnesses. Determination of the cause of four deaths is pending.

A summary of compliance status, by paragraph, for each agreement is provided as follows:

The narratives for both the Settlement Agreement and the Consent Agreement provide the analyses of findings, work accomplished to date, and recommendations.

Report of Compliance
Settlement Agreement

Introduction

Compliance Report #8 describes Miami-Dade Corrections and Rehabilitation's (MDCR) efforts toward meeting the requirements in the Settlement Agreement. In this report, the Monitors also assessed MDCR's sustaining compliance with the Settlement Agreement, as well as examining the County's assertions regarding moving some provisions from partial to full compliance.[3]

MDCR has faced some challenges of establishing a quality improvement process, engaging in efforts to address uses of force and inmate/inmate violence, and generally using data to inform and direct leadership and management practices. In Compliance Report # 7, the Monitors and MDCR developed a plan to work toward achieving compliance with the areas noted above. This resulted in assignment of "provisional" compliance to ten (10) paragraphs. As of the tour, two (2) of those paragraphs remained in compliance.

Summary of Compliance - Settlement Agreement
As of Compliance Tour # 8

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
8	37	19	0	0	56

The Monitor notes that progress has been made in the past nine months, despite several provisions not remaining in provisional compliance as well as other changes to compliance ratings (see below discussion of "provisional" compliance). MDCR's progress is measured in a focus on identifying root causes of violence in the jail, and developing countermeasures/plans of action to address the issues. At this time, however, the Monitor finds that not substantial enough work has been done, results and findings are preliminary, and supporting organizational challenges have been identified effecting current compliance, that are discussed in the next section of this report.

[3] 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, interviewing inmates, and assessing grievance responses.

Provisional Compliance

In recognition of the commitment and work demonstrated at the February 2017 tour, the Monitor applied "provisional compliance" to ten paragraphs.[4] In acknowledging MDCR's work, with additional, significant work to be done, it was the plan that the compliance with the paragraphs would be achieved and documented prior to the next tour. While work has continued, and new initiatives begun, it is the Monitor's assessment that not all of the provisions reached full compliance as envisioned in February. The reasons for the finding, and additional recommendations are included in the body of this report. Essentially, the finding is that the work has begun, but has not resulted in the compliance required by the Settlement Agreement.

The path to achieving and maintaining compliance is never linear. These findings do not mean that the commitment waned, but rather that the final results are not, yet, achieved.

To quote, verbatim, from Compliance Report # 7: "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."

This is the work that is moving forward, but not yet concluded.

The provisions that remain, those identified in this report, are often the most difficult to achieve in a situation such as this (e.g. settlement agreements) as the final initiatives and strategies represent the deepest organizational culture challenges and changes, and the movement to the next level to reach compliance – the data driven jail. MDCR also needs to demonstrate sustainability of their work to address the core issues of the Settlement Agreement – inmate protection from harm.

[4] These paragraphs are: III.A.1.a. (11), III. A.4.a., III.A.5a. (1)-(3), III.A.5.c. (2) (i-ix), III. A. 5.c.(11), III. A.5.c. (12), III.A.5.c. (14), III D. Self-Audits 1., III D. 2.b, and IV.B.

Changes in Compliance

Compliance Report # 7 identified several provisions of the Settlement Agreement, with similar provisions in the Consent Agreement. The Monitors cautioned the County in Report 7, that the rating for compliance for these paragraphs in the Settlement Agreement would be based on the compliance rating provided for that provision in the Consent Agreement. In plain terms, if a like or similar provision is not in compliance in the Consent Agreement, it cannot be in compliance in the Settlement Agreement. The Monitors flagged this for the County in Report #7 in order to provide six months (and what turned out to be, because of Hurricane Irma, almost nine months) to assure that these shared provisions were addressed.

It is the assessment of the Monitors, even with the time passage, and admonitions to collaborate, that this objective was not reached. As such, the compliance rating for the following paragraphs in the Settlement Agreement are changed:

- IIIA.4.d – changed from compliance to partial compliance (see Consent Agreement III.B.3. b. and c.);
- III.A.5.b.(1) (i-vi), (2) – changed from compliance to partial compliance (see Consent Agreement III.B.3. b.);
- III.A.5.c. (6) - changed from compliance to partial compliance (see Consent Agreement III.B. 3. b.);
- III.A.5.c.(10) - changed from compliance to non-compliance (see Consent Agreement III.B.3.b.); and
- III.C. (1-6) - changed from compliance to partial compliance (see Consent Agreement III.A.3.a. (4)).

For both the Consent and Settlement Agreements, recommendations are provided for reaching compliance. This must be done jointly.

Protection from Harm - Remaining Challenges/Recommendations

Staffing Issues and Opportunities

The County has agreed with MDCR's staffing analysis, and allocated funding. The Monitors have also accepted MDCR's staffing plan, as required by the Settlement Agreement.[5] However, issues regarding overtime expenditures, a recent decision by the Public Employee Relations Commission (PERC) regarding the percentages of staff permitted to be off during a shift - impacting the shift relief factor, and a proposal to re-institute "roll call" time present challenges.[6] Additionally, the County

[5] Settlement Agreement, Section III. A. 2.

[6] To compute a shift relief factor (which essentially is a multiplier of the number of staff needed) the jurisdiction uses actual work hours from the agency's employees to ascertain the hours that the agency's personnel are at work in a budget year – minus hours used for, minimally: vacation time, compensatory time, sick time, family medical leave (FMLA), worker's compensation leave, leave without pay,

has engaged a consultant to review staffing, shift relief factors, and span of control in County agencies.

The Monitor will track any findings and recommendations of the County's consultant as related to the requirements of the Settlement Agreement, and look forward to learning more about this initiative.

Compliance Report # 8 provides recommendations regarding staffing related to internal investigations. These recommendations do not, necessarily, suggest that additional staff are required to address the relevant provisions of the Settlement Agreement, but rather that MDCR assess the current organizational structure to determine how to maximize staffing and supervision.

Classification

The Monitor strongly recommends that the County immediately contract with a subject matter expert to evaluate the current inmate classification processes, identify future needs, develop a validation plan (with and without the implementation of the new offender management system – see below), manage the collaboration in risk assessment for CHS and MDCR, assure that appropriate written directives and associated training materials are developed, and train/mentor staff. This recommendation is highlighted due to two findings: first, the recent recognition that the gang affiliation is, perhaps reviewed, it is not documented in the current inmate classification process; without a credible explanation of why this essential element was removed. Second, the Monitors assessed as deficient a recent County produced 45-day review of an inmate death. In this case, the inmate's arrest for domestic battery resulted in a CHS behavior health practitioner's assessment that there was not a risk for self-harm, when, almost universally, arrests for these types of charges place inmates at higher risk of self-harm. CHS and MDCR must better coordinate their risk assessments/classification findings.

Because of the critical nature of the validation of the inmate classification system (e.g. keeping inmates and staff safe) the Monitor recommends that this initial validation process be conducted in collaboration with a subject matter expert to train MDCR staff, and put into place written procedures for the future conduct of a validation study. The validation process will need to be updated/amended after the offender management system is implemented. There needs to be a process to ensure that staff who are responsible for Classification are trained as retirements are pending in the organization's leadership. During the tour, MDCR proposed a strategy for self-validation of the classification system, using what data is currently available. The Monitor and a subject matter expert provided a brief review of the proposal; which, we conclude, needs more clarification and work.

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suspension/disciplinary time, military leave, training hours, etc. Therefore, when this computation is completed, the funding authority knows the annual average hours a staff person is available to work, and hence, how many staff are required, not relying on overtime.

An agency the size of MDCR needs to, in the future, have the capacity and resources to periodically validate the classification system. Even with the capacity to this work in-house, periodically the County should engage subject matter experts to confirm the findings – given the critical nature of this process.

Inmate classification – the process, and the assurance it is appropriately separating inmates - is an important part of keeping inmates safe. If resources are needed to gain the assistance of subject matter experts, those resources should be provided.

The recommendations contained in this report are:

- The County should consider contracting with a subject matter expert to work alongside MDCR staff to create the systems and processes for validating the classification system. The work should include enhancing the capacity of MDCR to do self-validation of the system.
- As the offender management system is implemented, revise the processes for validation. Assure that staff are trained, and that there is significant leadership review and oversight of the findings and action plans, if needed.
- The County should consider a contract with a subject matter expert to periodically confirm the findings, and assure the MDCR capacity to conduct this work remains credibly in place.

Investigative Capacities and Protection from Harm

The Monitors recommend a thorough review of the processes, staffing, and supervision of internal investigations in MDCR –those involving allegations of staff misconduct, excessive uses of force, and inmate violence/critical misconduct.[7] The Monitors have observed these operations have evolved to near compliance, but now believe it is time to be more focused about to how better achieve and sustain compliance. Succinctly, MDCR needs a more robust, consistent, and thorough review of critical incidents. This is the finding contained in Compliance Report #7. What is included in the umbrella of critical incidents can be determined by MDCR, but certainly these should include, but not be limited to events where inmate/inmate violence leads to transport to an emergency department, substance overdoses, inmate altercations that involve more than two inmates, staff injuries, fires, significant contraband recoveries, and other instances in which facility security is potentially jeopardized. The object of these reviews is to determine root cause, and implement actions to prevent future harm.[8]

[7] Settlement Agreement, III. A. 5. e.

[8] The County notes that SIAB will conduct investigations of complaints involving staff misconduct including referrals from the Facility Supervisor or as determined by their review of serious incidents. The Monitor assesses that more depth in investigative capacity would be beneficial to the agency.

The Monitor urges that the following functions be reviewed to determine how to better organize and supervise, with the goal of reduction in harm and staff safety, and providing timely and meaningful information to inform leadership decisions.

- Compliance, Inspection and Accreditation Bureau (CIAB). This Bureau includes:
    - OPIM - MDCR recently established an Office of Performance Improvement and Management to conduct root cause analysis and develop countermeasures and action plans as required by the Settlement Agreement. MDCR also previewed the Rapid Response to Important Incidents and Trends enabling the facilities to address emerging critical issues. An example of Handcuffing and Escorting Procedures (undated) was provided. While a forward-thinking process, the information also needs to include how the effectiveness of the initiative will be measured, how will MDCR know the efforts worked? Additionally, how the process will flag emerging issues also needs to be identified, eventually, in policy.
    - DART - The Data Analysis and Reporting Team (DART) compiles data for all operations, and produces quarterly reports. DART, since July 1, 2017, also coordinates the Early Warning System for employees.[9] The Monitor has suggested for a number of years that the quarterly, bi-annual and annual reporting be evaluated to assure that the data has integrity and that it is meaningful to be used in leadership decisions. More about this is contained in the discussion of relevant sections of this report.
    - TAAP - MDCR implemented a force review team in 2016, Trend Analysis and Action Panning Unit (TAAP). TAAP continues to make strides to thoroughly review the circumstances surrounding uses of force, hold facility leadership accountable for paperwork, develop recommendations for training, and refer staff misconduct issues for review.
    - Regulator and Compliance Division
    - Compliance Office

- SIAB - The Security and Internal Affairs Bureau (SIAB) investigates allegations of staff misconduct, and reviews and catalogs other investigations. For example, a facility commander is responsible for reviewing a serious incident, and SIAB looks over that review, may ask additional questions, and files it. SIAB does not conduct the investigation. SIAB coordinates with the State's Attorney's Office.

[9] Settlement Agreement, paragraph III.A.6. (4) identifies "IA" as managing and administering the early warning system. The Monitors have no objection to the organizational change made by MDCR, as long as the provision of this paragraph are met.

- MDCR leadership reviews all suicides and serious suicide attempts, and develops plans to address findings.

- Program Services Division, Reentry Program Services Bureau (RPSB)

    - The inmate grievance function under the Reentry Program Services Bureau develops important information regarding inmate safety and attempts to resolve issues, often in cooperation with CHS. Inmate grievances alleging staff misconduct, inappropriate uses of force, and other potential security issues are referred for investigation.
    - The inmate disciplinary data base is also maintained by RPSB. This is also critical information which feeds back to Classification and housing decisions, and should also inform operations regarding the nature and type of inmate offenses.

The Miami Dade Police Department responds to criminal activities, including incidents of inmate/inmate violence, suicides, overdoses, etc. It is unclear to the Monitor how information developed by the Police Department related to these calls for service is integrated into findings and action plans in MDCR. While there is no reason to doubt the professionalism of the MDPD's response, MDCR is a large enough organization, with significant inmate violence issues, that warrant a more clearly focused internal investigation function, collaborating with both the MDPD and the State's Attorney's Office (SAO).

During this recent tour, it was identified that the person who coordinated gang information/intelligence was no longer doing this work, and the functions had been reduced to list-sharing. It is the Monitor's opinion that a much more robust gang/security threat group role must be part of MDCR's functions, in coordination with the Police Department and any region-wide gang initiatives. The outcome of this recommendation is that the jail needs to assess gang affiliation in classification and housing, and that incidents also be viewed with an eye toward gang involvement. Additionally, and importantly, in localities in this country coordinated jail intelligence related to gangs, and other criminal activities, are an important part of community safety.

As noted in previous Compliance Reports, the Monitor suggests that as these functions noted above are assessed, the County consider providing cross-training and certification as law enforcement officers for specifically identified posts to facilitate investigations, and relieve the Police Department of routine calls for service to the jail facilities.

The work described above must be better organized, integrated - eliminating "silos" when they are identified, assure maximum information sharing, and ultimately create a safer jail environment through use of better data in decision-making. Initiatives must be coordinated with CHS.

The Monitor looks forward to seeing changes in the coming months that will bring MDCR into compliance with the related sections of the Settlement Agreement.

Inmate Grievance Process

Although partial compliance is assessed for these provisions due to the findings of review of grievances for the Consent Agreement, MDCR has agreed that between now and May 15, 2018 additional work will be done, including, but not limited to:

- training (or re-training) correctional counselors to properly categorize the topic of the grievance;
- reduce the number of grievances categorized as "other";
- train (or re-train) staff regarding what is a substantiated or unsubstantiated grievance; improve quality control by reviewing the content of the grievance response; assess the number of grievances from the target units at Metro West where direct supervision is used and track trends; and modify the information system to support changes.
- Coordinate all initiatives with CHS.
- Update inmate education/orientation where necessary.
- Consider the efficacy and usefulness of classifying grievances as "substantiated" or "unsubstantiated", including assessing how this contributes to solving inmates' issues and providing relevant management data.

Additionally, MDCR and CHS need to demonstrate for the next tour how the data is being used to inform decisions.

On-Going Violence Reduction

MDCR is progressing in its review of incidents of uses of force and analysis of inmate/inmate violence. The work continues, and needs to be refined to meet specific provisions of the Settlement Agreement. Findings are addressed in the body of this report.

Offender Management System

MDCR is the eight largest local jail system in the United States and is working with an information system that is woefully outdated. Looking back to previous Compliance Reports, the Monitor notes that the elements of the system related to the Settlement Agreement were to be implemented by the summer of *2016*. The County chose to allow the inmate telephone vendor to provide an offender management system; however, the delays in implementation are detrimental to MDCR. This is especially true in considering the 'work arounds" that have been initiated for critical areas such as validation of the inmate classification system,

tracking and analyzing inmate grievances, and tracking and analyzing inmate disciplinary data. The Monitor urges a meaningful resolution to the current state – either requiring the current vendor to devote the resources necessary to complete this system to the satisfaction of the County, or other options, including selection of another vendor.

Compliance Management

A coordinator was hired in early 2017 by the County to oversee and coordinate the work to reach and sustain compliance. The Monitors urge more proactive and timely work in the furtherance of this objective. The Monitors have asked in this report for demonstration of sustainable work prior to the next tour. The Monitors do not want to have to judge and assess provisions solely on the basis of information and data provided while on-site, and therefore request the County's demonstration of compliance be provided no less than a month before the scheduled on-site. We also urge a review of the compliance functions and work to improve compliance. (See above discussion of Change in Compliance.)

Collaboration with CHS

The Monitors are all convinced that the leadership of CHS and MDCR are equally committed to collaboration and mutual problem-solving. This is a message and actions which are slower to seep throughout both organizations. This infusion of collaboration requires a daily effort from all the leaders.

A Model for Meaningful Progress

A collaborative initiative of CHS and MDCR, untaken at the Monitors' collective recommendation at the February tour, has been the reduction of the length of time to process inmates through booking. The findings as reported during this tour are that 70% of inmates are processed within 8 hours. While not yet to the point where all parties are satisfied, this intensive work has resulted in meaningful and significant changes impacting operations for both organizations. The Monitors urge this momentum be applied to other jointly shared and pressing issues.

Sustainability

This report provides specific requests for reports of self-audits relative to provisions of this Settlement Agreement between now and June 1, 2018 (or dates as otherwise noted). Among the documentation requested are:[10]

1. Annual review of housing plan and objective classification system (III.A.1.a. (2));

[10] Please see the full report for details.

2. Self-audit of conduct of documented and irregular rounds by staff (III.A.1.a.(3));
3. Self-audit of logs (III.A.1.a. (4));
4. Self-audit of documented half-hour welfare checks; and periodic rounds by supervisors (III.A.1.a. (6) and (7);
5. Report regarding initiatives with MDCR and CHS to address medications found in housing unit inspections and/or shakedowns (III.A.1.a. (8);
6. Self-audit of the training for officers who transfer from one facility to another (III.A.1.a.(9);
7. Self-audit of training for officers assigned to special management units (III.A.1.a.10);
8. Report of countermeasures/corrective action plans to reduce inmate violence.
9. Assessment of custody staffing sufficient to escort inmates to and from medical and mental health care units (III.A.2.b.);
10. A report of PREA compliance, completion of remedial action plans.
11. Memo to SVU regarding liaison with inmate's mental health providers and related training.
12. Updated list of training lesson plans (dates included), and a sample of those trained (III.A.4.f.);
13. Documentation of training provided to CHS staff regarding recognition of signs of injuries and sexual assault (III. A.5.c. and III.A.3.);
14. Provide the documentation regarding any pre-planned use of force occurring in the period October 1, 2017 – April 30, 2018 (III.A.5.c. (8));
15. By June 1, 2018, provide the required review and, if required a corrective action plan. (III.A.5.c.(11));
16. Provide a report to Monitors regarding designations of emergency treatment orders as uses of force, options, decision, plans of action and implementation (III. A. 5. c. (12));
17. Provide a self-assessment of the maintenance, inventory and assignment of chemical and other security equipment (III.A.5.c.(13));
18. By May 4, 2018 provide a report of the impact of countermeasures in reducing uses of force (III.A.5.c. (14));
19. By March 1, 2018, provide the results of random testing of 5% of corrections staff regarding use of force procedure; and any remedial action required (III.A.5.d.)
20. By April 1, 2018, MDCR provide the Monitor with the steps taken, or to be taken through organizational, fiscal, and human resources to address improvements in internal investigations of critical incidents. The information should include timetables, proposed or drafted policies, training initiatives, and supervision of the work (III.A.5.e. (1)(2))
21. By May 15, 2018, provide documentation regarding the revisions to the early warning system to include: (III.A.6 a. and b.)
    a. MDCR will provide a revised policy/procedure (draft is acceptable);

b. The recommendations for change to the program since moving it to the Regulatory and Compliance Division, and if those recommendations were implemented (action plans acceptable);
c. Any benchmarks or measurable objectives established for the EIS;
d. The training lesson plan(s) for facility based staff in EIS;
e. The schedule for training; and
f. Data indicating if changes to the process are achieving benchmarks or measurable objectives.

22. On or before June 1, 2018, MDCR provide the Monitor with a report determining if the EIS has been effective in identifying concerns regarding policy, training or the need for discipline. (III.A.6.c.)
23. By June 1, 2018, provide a report/update on collaborations with CHS to improve the grievance process to all the Monitors. This report may include any action plans, and the assessment of the effectiveness of short-term fixes. Provide training lesson plans and schedules for training. (III. C.)
24. By May 1, 2018 MDCR provide the Monitor with the plan to determine what data to collect, assurance of the integrity of the data, who the data will inform MDCR's management decisions, what analysis will be conducted, and how action plans/countermeasures will be developed. If a policy change is needed, the draft should be provided. If there are results, the results should be provided. (III.D.1.2.)
25. By June 1, 2018, Labor Management Unit review and assess outcomes of discipline and provide any recommendations regarding the quality and/or scope of use of force investigations/reviews. (III.A.6.)
26. 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. Provide an assessment by June 15, 2018 to all monitors. (III.A.2.b.)

For Fire/Life Safety - The Monitor recommends in order to demonstrate sustainability of compliance:

27. MDCR provide evidence to the Monitor by June 1, 2018 that the amount of time needed to complete corrective actions from the drills is reduced to 30 days or less as discussed during the tour. (III.B.4.)
28. MDCR Categorize drill conformities at least annually and provide evidence to the Monitor by June 1, 2018 that the data was incorporated into biennial and as necessary the initial fire safety training classes. III.B.4.)
29. MDCR provide evidence by June 1, 2018 of completed training for officers required to supervise inmate workers using chemicals. (III.B.5.)
30. MDCR provide evidence by June 1, 2018 of inmate worker training for using the new chemicals for housekeeping. (III.B.5.)

This request (and those for the Consent Agreement) represent a different approach by the Monitors to request that the County be more pro-active in documenting actions related to the provisions of both agreements, as well as to demonstrate the sustainability of efforts. The Monitors are willing to engage in any dialogue that is needed to clarify what constitutes substantial compliance and sustainable compliance.

Fire and Life Safety

During this tour, MDCR demonstrated and the sub-Monitor assessed that all six provisions for Fire and Life Safety remain in substantial compliance.[11] The Monitor observed continued improvement in the fire drill audits and in chemical control. The fire drill audits are excellent tools to assure policies are correctly implemented and to identify staff's abilities to respond correctly to a simulated fire or smoke event. Additional recommendations and finding are noted in the report.

Regarding chemical safety, MDCR implemented a new electronic dispensing system at all facilities. The new system, if properly used, will assure that inmates and inmate workers will only have access to cleaning and sanitizing chemicals that are properly diluted to concentrations that minimize health impacts should the chemicals be ingested or contact exposed skin. MDCR has also created a new on-line training program for proper use of the chemicals and chemical safety for sanitation staff and inmate workers.

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, 18 months, in the Settlement Agreement. The Monitors suggest a re-look at how compliance is documented, and the related responsibilities. The Monitors collectively urge the leadership of each organization to work to instill a measure of inquisitiveness and self-analysis into operational decision. Only through inculcating this into the operation will the organizations reach and sustain compliance.

[11] Settlement Agreement, Section III. B.

8th Compliance Tour - Settlement Agreement - Summary of Compliance
Tour the Week of December 4, 2017[1]

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		By June 1, 2018, provide the annual review required by this paragraph.
III.A.1.a. (3)	x			By June 1, 2018, provide an internal audit of the provisions of this paragraph.
III.A.1.a. (4)	x			By June 1, 2018, the Monitor requests an internal inspection of logs before the next tour (same recommendation as in July 2016 and February 2017 reports). If MDCR is not going to conduct an internal audit, MDCR should be prepared to provide documentation other than logs.
III.A.1.a. (5)	x			The Monitor may request proof of repairs to cameras at PTDC before July 2018 tour.
III.A.1.a. (6)	x			By June 1, 2018, MDCR provide a self-audit of this provision. If issues are identified in the self-audit, MDCR needs to demonstrate that correction action was taken.
III.A.1.a. (7)	x			By June 1, 2018, MDCR provide the Monitor with an internal inspection/audit of this provision, including a representative sample of each facility.
III.A.1.a. (8)	x			By June 1, 2018, MDCR provide the Monitor with a report to demonstrate/document collaboration with CHS regarding the medications founds in shakedowns OR as part of investigations into inmate/inmate violence or related inmate harm (e.g. suicides, overdoses).
III.A.1.a. (9)	x			By June 1, 2018, MDCR provide the Monitor with the report of a self-audit of this provision, including a representative sample of each facility.
III.A.1.a. (10)	x			By June 1, 2018, MDCR provide the Monitors with the report of a self-audit of the requirements of this paragraph, including a representative sample of each facility.
III.A.1.a. (11)		x		On or before June 1, 2018, provide a report with updates to the Monitor (see narrative in the report).
Security Staffing				
III.A.2. a.	x			By June 1, 2018, provide any related changes to policies, procedures, staffing, and/or organizational structure, if any.
III.A.2. b.	x			Develop internal measures (recordkeeping, problem identification, action plans if necessary), in addition to MAC and "mini"-MAC meetings to address this

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

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
				paragraph. 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 paragraph. Provide an assessment by June 15, 2018 to all monitors.
III.A.2.c.	x			
III.A.2.d.	x			See III.A.2.a. See also CA III.C.7.
Sexual Misconduct				
III. A.3.		x		By June 1, 2018 MDCR provide the Monitor with the update of compliance with PREA standards; including documentation that compliance was achieved.
Incident and Referrals				
III. A.4 a.	x			
III.A.4. b.	x			
III.A.4.c.	x			
III.A.4.d.		x		CA provision III. B. 3. b. and c. are in partial compliance. As noticed in Compliance Report # 7 – this provision is now in partial compliance.
III.A.4.e.	x			
III.A.4.f.	x			By June 1, 2018, MDCR provide to the Monitor an updated list of training lesson plans and a sample of the names trained will be needed to document on-going compliance.
Use of Force				
III.A. 5 a.(1) (2) (3)		x		
III.A.5. b. (1), i., ii, iii, iv, v, vi (2)		x		CA provision III.B.3.b.and c. are in partial compliance. As noticed in Compliance Report # 7 – this provision is now in partial compliance.
III.A. 5. c. (1)	x			
III.A. 5. c. (2)		x		See notes and Settlement Agreement III.A.5.c.(1)
III.A. 5. c. (3)	x			
III.A. 5. c. (4)	x			See recommendation for paragraphs III.A.2.a. and III.4. a.
III.A. 5. c. (5)	x			
III.A. 5. c. (6)		x		CA provision III. B. 3. b. and c. are in partial compliance. As noticed in Compliance Report # 7 – this provision is now in partial compliance.
III.A. 5. c. (7)	x			
III.A. 5. c. (8)	x			By June 1, 2018, provide the documentation regarding any pre-planned use of force occurring in the period October 1, 2017 – April 30, 2018.
III.A. 5. c. (9)	x			
III.A. 5. c. (10)		x		CA provision III. B. 3. b. and c. are in partial compliance. As noticed in Compliance Report # 7 – this provision is now in partial compliance.
III.A. 5. c. (11)		x		By June 1, 2018, provide the required review and, if required a corrective action plan.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
III.A. 5. c. (12)		x		By June 1, 2018, provide a report on meetings/deliberations regarding definitions about Emergency Treatment Orders (ETO) and uses of force. See the narrative for more specific information. See also CA III.B.3.
III.A. 5. c. (13)	x			By June 1, 2018, MDCR provide the Monitor with a self-audit of this provision, included in the sample all facilities.
III.A. 5. c. (14)		x		No later than May 4, 2018, provide the Monitor the materials noted in the protection from harm measures of compliance.
III.A.5. d. (1) (2) (3) (4)		x		By March 1, 2018, MDCR provide the Monitor with an update of the evidence that MDCR is randomly testing at least 5% of correctional officer staff annually.
III.A.5. e. (1) (2)		x		By April 1, 2018, MDCR provide the Monitor with the steps taken, or to be taken through organizational, fiscal, and human resources to address improvements in internal investigations of critical incidents. The information should include timetables, proposed or drafted policies, training initiatives, and supervision of the work.
Early Warning System (EWS)				
III.A.6. a. (1) (2) (3) (4) (5)	x			1. By May 15, 2018 address all the requirements noted in the narrative to this paragraph. If these requirements are not met by the July tour, this paragraph will be in partial compliance. 2. By June 1, 2018, Labor Management Unit review and assess outcomes of discipline and provide any recommendations regarding the quality and/or scope of use of force investigations/reviews.
III.A.6.b.	x			
III.A.6.c.		x		On or before June 1, 2018, MDCR provide the Monitor with a report determining if the EWS has been effective in identifying concerns regarding policy, training or the need for discipline.
Fire and Life Safety				
III.B.1.	x			
III.B.2.	x			
III.B.3.	x			
III.B.4.	x			1. Provide evidence to the Monitor by June 1, 2018 that the amount of time needed to complete corrective actions from the drills is reduced to 30 days or less as discussed during the tour. 2. Categorize drill conformities at least annually and provide evidence to the Monitor by June 1, 2018 that the data was incorporated into biennial and as necessary the initial fire safety training classes.
III.B. 5.	x			1. Provide evidence by June 1, 2018 of completed training for officers required to supervise inmate workers using chemicals.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
				2. Provide evidence by June 1, 2018 of inmate worker training for using the new chemicals for housekeeping.
III.B.6	x			
Inmate Grievances				
III.C. 1.,2.,3.,4.,5.,6.		x		1. By June 1, 2018, provide a report/update on collaborations with CHS to improve the grievance process to all the Monitors. This report may include any action plans, and the assessment of the effectiveness of short-term fixes. Provide training lesson plans and schedules for training. 2. Consent Agreement III. A. 3. a.(4) s in partial compliance. As noticed in Compliance Report # 7 – this provision is now in partial compliance.
Audits and Continuous Improvements				
III.D.1. a. b.		x		By May 1, 2018 MDCR provide the Monitor with the plan to determine what data to collect, assurance of the integrity of the data, who the data will inform MDCR's management decisions, what analysis will be conducted, and how action plans/countermeasures will be developed. If a policy change is needed, the draft should be provided. If there are results, the results should be provided.
III.D. 2. a. b.		x		See recommendations and timetable for III.D.1. a. b.
Compliance and Quality Improvement				
IV. A.	x			
IV. B.		x		
IV. C.	x			
IV. D.	x			Provisional compliance based on meeting the requirements and deadlines contained in this report.

Compliance Report - Settlement Agreement
Findings – Tour Week of December 4, 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: 12/7/17, 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)	As noted in Compliance Report # 7, the Monitor remains concerned that MDCR improve the analysis of data, as well as development of plans of action to address any identified deficiencies. The policies and procedures required by this paragraph are completed. See III.D. and IV. The Monitor's review of a sample of use of force videos and reports identifies additional issues not surfaced by the facility commander or TAAP.			
Monitor's Recommendations:	1. Use of the data to develop and implement strategies to lower the uses of force as developed into countermeasures and action plans; and demonstrated reductions from the application and evaluation of these work products. 2. Separate the data to identify the "uses of force" related to involuntary medication administration. **See Recommendations at III.A.5.c.12.**			

Paragraph	III. A. 1. Safety and Supervision: (2) Within 90 days of the Effective Date, conduct an inmate bed and classification analysis to ensure the Jail has adequate beds for maximum security and disciplinary segregation inmates. Within 90 days thereafter, MDCR will implement a plan to address the results of the analysis. The Monitor will conduct an annual review to determine whether MDCR's objective classification system continues to accomplish the goal of housing inmates based on level of risk and supervision needs.			
Compliance Status:	Compliance:	Partial Compliance: 12/7/17, 3/3/17, 10/24/14, 7/29/16	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	See below.			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Completion of a bed and classification analysis. 2. Post-study housing plan. 3. Annual report by Monitor of the objective classification system and housing plan. 4. Data provided by MDCR regarding outcomes/impact of classification system.			
Steps taken by the County to Implement this paragraph:	As noted in Compliance Report # 7, MDCR continues to implement the new offender management system. Implementation is now years behind schedule, which impacts MDCR's ability to validate the inmate classification system.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	During the tour, MDCR proposed a strategy for self-validation of the classification system, using what data is currently available. The Monitor and a subject matter expert provided a brief review of the proposal; which, we conclude, needs more clarification and work. An agency the size of MDCR needs to, in the future, have the capacity and resources to validate the classification system periodically. Because of the critical nature of this validation (e.g. keeping inmates and staff safe) the Monitor recommends that this initial validation process be conducted in collaboration with a subject matter expert. This contract with a subject matter expert should serve as a means to train MDCR staff, and put into place written procedures for the future conduct of a validation study. The validation process will need to be updated/amended after the offender management system is implemented. There needs to be a process to ensure that staff who are responsible for Classification are trained in the future. Even with the capacity do this work in-house, periodically the County should engage subject matter experts to confirm the findings – given the critical nature of this process. This is an important part of keeping inmates safe. If resources are needed to gain the assistance of subject matter experts, those resources should be provided.			
Monitor's Recommendations:	1. The County should consider contracting with a subject matter expert to work alongside MDCR staff to create the systems and processes for validating the classification system. The work should include enhancing the capacity of MDCR to do self-validation of the system. 2. As the offender management system is implemented, revise the processes for validation. Assure that staff are trained, and that there is significant leadership review and oversight of the findings and action plans, if needed. 3. The County should consider a contract with a subject matter expert to periodically to confirm the findings, and assure the MDCR capacity to conduct this work remains credibly in place.			

Paragraph	III. A. 1. Safety and Supervision: (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: 12/7/17, 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:	Protection from Harm: 1. Policies and procedures requiring conduct of rounds. 2. Review of housing unit logs. 3. Review of staffing in housing units through observation and logs. 4. Interviews with inmates, employees.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The sub-Monitor who walked through the facilities reviewed logs. No issues or concerns at this time. MDCR needs to document that its internal inspections processes identify any issues with this paragraph. Additionally, if internal investigations conclude that staff rounds are not being done as per policy, a record of employee correction (if warranted) along with an action plan is required.			
Monitor's Recommendations:	1. By June 1, 2018, provide an internal audit of the provisions of this paragraph.			

Paragraph	III. A. 1. Safety and Supervision: (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: 12/10/17, 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. By June 1, 2018, the Monitor requests an internal inspection of logs before the next tour (same recommendation as in July 2016 and February 2017 reports). If MDCR is not going to conduct an internal audit, MDCR should be prepared to provide documentation or analyses other than just providing unanalyzed logs.			

Paragraph	III. A. 1. Safety and Supervision: (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.			
Compliance Status:	Compliance: 12/10/17, 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:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Re-classification screening documentation for inmates moved to maximum security housing that does not have direct supervision or video monitoring. 2. Plan to increase video surveillance and recording capacity; implementation dates; contracts; evidence of completion on required dates; plan of action if dates specified in the Settlement Agreement for completion not met.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Monitor's review of TAAP reports have not revealed any missing video except in areas where video is not expected (e.g. courts).			
Monitor's Recommendations:	No further recommendations. Monitor may request proof of repairs to cameras at PTDC prior to the next tour.			

Paragraph	III. A. 1. Safety and Supervision: (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: 12/10/17, 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)	No logs were requested for this tour. However, an internal audit is requested prior to the July 2018 tour.			
Monitor's Recommendations:	1. By June 1, 2018, MDCR provide a self-audit of this provision. If issues are identified in the self-audit, MDCR needs to demonstrate that correction action was taken.			

Paragraph	III. A. 1. Safety and Supervision: (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: 12/10/17, 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)	Logs were not requested for this tour.			
Monitor's Recommendations:	1. By June 1, 2018, MDCR provide the Monitor with an internal inspection/audit of this provision, including a representative sample of each facility.			

Paragraph	III. A. 1. Safety and Supervision: (8) MDCR shall maintain a policy ensuring that security staff conduct sufficient searches of cells to ensure that inmates do not have access to dangerous contraband, including at least the following: i. Random daily visual inspections of four to six cells per housing area or cellblock; ii. Random daily inspections of common areas of the housing units; iii. Regular daily searches of intake cells; and iv. Periodic large scale searches of entire housing units.			
Compliance Status:	Compliance: 12/10/17, 3/3/17, 7/29/16, 1/8/16	Partial Compliance: 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 5/15.
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding staff searches of inmate cells and living areas, meeting language in this Settlement Agreement. 2. Shakedown logs/records. 3. Operational plans for large scale searches; and post search evaluations/management reviews. 4. Reports provided by MDCR regarding contraband and shakedowns.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Results of facility shakedowns were provided. A concern: use of the data to drive security operations. For example, the findings of medication have not generated a corrective action plan. Better analysis of data is needed. Additionally, if internal review of incidents identifies incomplete or missing shakedowns, the corrective action plans are expected.			
Monitor's Recommendations:	1. Provide a more robust review and analysis of items found in shakedowns. Provide action plans as dictated by the data. Focus on identifying the source(s) of contraband. Don't just provide the reports; include an analysis, findings, and any recommendations/plans of action/countermeasures. 2. By June 1, 2018, MDCR provide the Monitor with a report to demonstrate/document collaboration with CHS regarding the medications founds in shakedowns OR as part of investigations into inmate/inmate violence or related inmate harm (e.g. suicides, overdoses).			

Paragraph	III. A. 1. Safety and Supervision: (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: 12/10/17, 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 reports: 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:	1. By June 1, 2018, MDCR provide the Monitor with the report of a self-audit of this provision, including a representative sample of each facility.			

Paragraph	III. A. 1. Safety and Supervision: (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: 12/10/17, 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)	Specific training records were not reviewed with tour.			
Monitors' Recommendations:	1. Continue to provide CIT and other enhanced mental health training to custodial staff. 2. By June 1, 2018, MDCR provide the Monitors with the report of a self-audit of the requirements of this paragraph, including a representative sample of each facility.			

Paragraph	III. A. 1. Safety and Supervision: (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: 12/7/17; 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)	• Provisional compliance was granted in Compliance Report # 7 pending MDCR reaching commendable goals in organizing the efforts to address this paragraph. • MDCR has made significant and important progress in setting up systems to focus on inmate-on-inmate violence, while the trends have somewhat stabilized; these trends are not for a sufficiently long period of time (more than a few months) to allow conclusions to be reliably drawn that the strategies are successful or sustainable. MDCR is commended for intense efforts to develop countermeasures for inmate violence, including the inclusive nature of the initiative. The countermeasure strategies have only been in place at Metro West since July, although MDCR is committed to expanding these strategies to other facilities. Additionally, some critical elements were missing from the strategies, including examining the impact of gang affiliation on inmate/inmate violence. The early data is quite encouraging; but the plans to expand the initiative to beyond the current seven units at Metro West are pending. • MDCR has indicated it is committed to accomplishing the Monitor's recommendations to reduce the number of review of inmate/inmate violence and uses of force for which there is no specific cause of the event determined. While not all these events will have clear causes; more investigative effort needs to be placed in activities such as inmate interviews, to find ways to resolve the violence. • As this initiative is clarified, expanded, and institutionalized, the related policies need to be modified, as well as assuring sufficient staffing is devoted. There needs to be more collaboration between: Data Analysis and Reporting Team (DART), TAAP, SIAB, the pending initiatives regarding gang/security threat groups, the grievance process, and enhanced internal investigations. The County should consider if reorganization of these initiatives is necessary.			
Monitor's Recommendations:	1. Amend the policy as needed. 2. Refine the countermeasure initiatives. 3. Provide for expansion of the initiatives at MW, including resources for training, counselor resources, corporals as coaches, reinstitute direct supervision principles, more robust investigation of serious incidents, and development of benchmarks.			

	4. Continue to decrease the finding of "undetermined" for the reason for inmate/inmate violence. 5. On or before June 1, 2018, provide a report with updates to the Monitor that includes, but is not limited to: countermeasures/action plans, data documenting results, mid-course corrections, lesson learned, sustainable elements, and a time table for expansion, as needed.

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: 12/10/17, 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)	The County has agreed to fund MDCR's budget; but not all funded positions have been authorized to be filled. This is because of the need to address overtime, a plan to reinstitute a roll call period for each shift, and an undetermined fiscal impact of a recent PERC decision. The County has worked with MDCR to fund critical positions. The County has also engaged a consultant to review staffing, relief factors, and span of control for all County agencies. This work has not yet been provided for agency-level review and requires attention to determine if the underlying assumptions and comparisons made by the consultant are valid for MDCR.			
Monitor's Recommendations:	1. Continue to work with the County regarding filling vacancies for critical positions. 2. Review the County's consultant's recommendations, and underlying assumptions that may impact staffing and the requirements of this provision. 3. Work with the County to address staffing considerations included in this report (e.g. investigations, gang). This does not infer necessarily additional staff, and may involve deployment of staff. 4. By June 1, 2018, provide any related changes to policies, procedures, staffing, and/or organizational structure, if any.			

Paragraph Coordinate with Drs. Johnson 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: 12/7/17, 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. Johnson 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. Johnson 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)	Information was discussed at PTDC that some inmate group counseling sessions were delayed due to what was attributed to custody staff. This is above what is addressed in the SA regarding moving inmates to and from medical and mental health care units. Materials were requested during the last tour which were not provided – see below. Please provide by February 1, 2018. These schedules were provided post-tour, but no assessment regarding adequacy of staffing was made by CHS or MDCR. If documentation is not provided in the July tour, this paragraphs risks being found in partial compliance.			
Monitors' Recommendations:	Protection from Harm/Mental Health (from last Compliance Report). 1. Assess staffing per this paragraph. 2. 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. Provide an assessment by June 15, 2018 to all monitors.			

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: 12/10/17, 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)	Documentation was provided regarding the FY 2017-2018 hiring plan showing that the County is permitting MDCR to hire to keep pace with attrition of sworn/certified staff. The plan extends through August 2018.			
Monitor's Recommendations:	No further recommendations. The hiring will be assessed at the next tour.			

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: 12/7/17, 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)	MDCR does a very credible job of assessing staffing every 180 days.		
Monitor's Recommendations:	See III.A.2.a., above.		

III.A.3. Sexual Misconduct

Paragraph Coordinate with Drs. Johnson 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: 12/7/17, 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 results based on self-audit.		
Steps taken by the County to Implement this paragraph:	A second PREA audit was conducted in July 2017. Corrective action plans were required, which will not be fully assessed and evaluated until early 2018.		
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR is preparing the remedial plans to address issues identified in the audit of July 2017.		
Monitors' Recommendations:	1. Complete remedial action plans. 2. As included in the previous compliance report, assure that MDPD's 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. By June 1, 2018 MDCR provide the Monitor with the update of compliance with PREA standards; including documentation that compliance was achieved.		

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: 12/7/17, 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 is in compliance with this paragraph by documenting the incidents. However, what is critically missing is the review of each incidents at a depth with a goal of avoiding the incident from happening again and preventing future inmate harm. Additionally, collaboration between MDCR and CHS on suicide prevention/morbidity and mortality reviews could be enhanced.			
Monitor's Recommendations:	1. See recommendations in the introduction to this Compliance Report regarding the need to establish the capacity and expertise to conduct credible internal reviews of critical incidents. 2. See also III.A.2.a.			

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: 12/7/17, 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)	Review of morbidity and mortality reviews, as well as MDCR's administrative reviews demonstrate compliance with this paragraph.			
Monitor's Recommendations:	Nothing further at this time.			

Paragraph	4. Incidents and Referrals c. MDCR shall employ a system to track, analyze for trends, and take corrective action regarding all reportable incidents. The system should include at least the following information: 1. unique tracking number; 2. inmate(s) name; 3. housing classification; 4. date and time; 5. type of incident; 6. any injuries to staff or inmate; 7. any medical care; 8. primary and secondary staff involved; 9. reviewing supervisor; 10. any external reviews and results; 11. corrective action taken; and 12. administrative sign-off.		
Compliance Status:	Compliance: 12/7/17, 3/3/17, 7/29/16, 1/8/16	Partial Compliance: 5/15/15; 10/24/14; 3/28/14	Non-Compliance: 7/19/13
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures to track, analyze data, develop corrective action plans, as needed for all reportable incidents. 2. Definition of reportable incidents. 3. Review of reports, analysis, corrective action plans. 4. Review of elements in database. 5. Review of incident reports 6. Review of any external reviews/results. 7. Review of corrective action plan, if any. 8. Review of data/reports generated from the information in the system.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The offender management system (OMS) is still not being implemented based on the initial vendor plan. The current system supports the requirements of this paragraph.		
Monitor's Recommendations:	No recommendations at this time.		

<table>
<tr><td>Paragraph
Coordinate with Dr. Johnson
See Also Consent III.A.3.(4)</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: 12/7/17, 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.3.(4) 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:	Protection from Harm/Mental Health: 1. MDCR 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 self-audit of this provision prior to the Monitors next tour, including any 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: 12/7/17, 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)	MDCR is revising lesson plans to assure that phrases such as "guided to the floor" etc. are removed. The Monitor will continue to review use of force reports as part of a sampling of incidents.			
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.			

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: 12/7/17, 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)	Training lesson plans were not altered since the previous tour. Going forward self-review is required, as well as corrections were needed.		
Monitor's Recommendations:	1. By June 1, 2018, MDCR provide to the Monitor an updated list of training lesson plans and a sample of the names 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: 12/7/17, 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)	As noted in Compliance Report #7, to maintain provisional compliance required a robust plan of action to address uses of force. There are not allegations of excessive uses of force; but rather the trend continues to rise (454 in CY 2014, 467 in CY 2015, 646 in CY 2016, and an annualized number of more than 700 incidents). Approximately 41% of these uses of force are attributed to stopping inmate fights; and 34% for physically restraining an inmate for medication administration. The change to partial compliance is made because no specific plans of action were developed in a timely fashion, nor is there any data at the time of the tour, to determine if any of the efforts, particularly targeted to Metro West, are successful. To that end, a plan reduction inmate/inmate violence is underway; and review of restraining inmates for medical reason requires review (for example, how the inmate arrived in the condition requiring this type of intervention).		
Monitor's Recommendations:	1. Develop facility-specific plans to address the increases in uses of force (and inmate/inmate violence)		

	2. Provide training to all staff working with inmates (all levels) on the mental health caseload. 3. Continue re-envisioning Metro West to its original direct supervision design; develop that plan as well as what skills and strategies can be expanded. 4. Work with CHS to review when "uses of force" are needed for administration of medical care and/or in the clinic setting.

<table>
<tr><td>Paragraph
See Consent Agreement III.B.3.c.</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: 12/7/17, 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>
</table>

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. (c) is noted in partial compliance by the medical/mental health Monitors. As indicated in Compliance Report # 7, this is the reason this was moved to Partial Compliance.**
Monitors' Recommendations:	1. Provide training to all staff working with all levels of inmates on the mental health caseload. 2. Continue to document discussions in MAC and mini-MAC meetings.

Paragraph	III. A. 5. Use of Force by Staff c. Use of Force Reports (1) MDCR shall develop and implement a policy to ensure that staff adequately and promptly report all uses of force within 24 hours of the force.		
Compliance Status this tour:	Compliance: 12/7/17, 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> a. Policies and procedures regarding reporting of uses of force; definitions; reporting formats; time requirements. b. Review of incident reports. c. Review of investigations into uses of force. d. 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:	No recommendations at this time other than to consider the TAAP findings when MDCR conducts the annual evaluation of the policy.		

<table>
<tr><td>Paragraph</td><td colspan="4">III.A. 5.c.
(2) MDCR shall ensure that use of force reports:
i. are written in specific terms and in narrative form to capture the details of the incident in accordance with its policies;
ii. describe, in factual terms, the type and amount of force used and precise actions taken in a particular incident, avoiding use of vague or conclusory descriptions for describing force;
iii. contain an accurate account of the events leading to the use of force incident;
iv. include a description of any weapon or instrument(s) of restraint used, and the manner in which it was used;
v. are accompanied with any inmate disciplinary report that prompted the use of force incident;
vi. state the nature and extent of injuries sustained both by the inmate and staff member
vii. contain the date and time any medical attention was actually provided;
viii. include inmate account of the incident; and
ix. note whether a use of force was videotaped, and if not, explain why it was not videotaped.</td></tr>
<tr><td>Protection from Harm: Compliance Status:</td><td>Compliance: 3/3/17</td><td>Partial Compliance: 12/17/17, 7/29/16, 1/8/16, 10/24/14, 3/28/14</td><td>Non-Compliance: 7/19/13</td><td>Other: Other: Not reviewed per MDCR 5/15</td></tr>
<tr><td>Unresolved/partially resolved issues from previous tour:</td><td colspan="4"></td></tr>
<tr><td>Measures of Compliance:</td><td colspan="4"><u>Protection from Harm:</u>
1. Policies and procedures regarding use of force reports; specifications for reporting.
2. Review of incident reports.
3. Review of investigations.
4. Review of inmate disciplinary reports.
5. Review of lesson plans.
6. Review of Medical Care/mental health records regarding injuries, including any required off-site hospitalizations.
7. Review of sample of staff workers' compensation claim relating to uses of force, inmate/inmate altercations.
8. Remedial, corrective action if necessary.
9. Review of digitally recorded incidents.
10. Review of MDCR Inmate Violence Report</td></tr>
<tr><td>Steps taken by the County to Implement this paragraph:</td><td colspan="4"></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">As noted in Compliance Report # 7 – provisional compliance was provided because of the on-going efforts to address the specific provisions of the paragraph. However, review of use of force reports show that the victim statements were not consistently obtained.

Also, as noted in the two previous compliance reports, work that remains to be done is:
• Gathering statement from the inmate victim(s) – it is unacceptable that the inmate victim was unavailable at the time of the initial review either – follow-up can be done; or that the inmate's injuries prevented a statement; or that an inmate's mental health status prevented a statement.</td></tr>
</table>

	• Gathering statements from inmate witnesses (not all inmates in the immediate proximity of the incident can be asleep or in the bathroom); • Assess the adequacy of the CHS' evaluation of inmate's injuries.
Monitors' Recommendations:	**1. <u>This is a repeat of the recommendation from Compliance Report # 7</u> - 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.**

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: 12/10/17, 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 Monitor's review of use of force packages confirms that the facility administrator reviews the incident within three days. The quality of the reviews is uneven in terms of depth; and the TAAP unit (and the Monitor) find issues not specifically addressed in the review. As with reviews of incidents (not required by the Settlement Agreement) but related to inmate harm (e.g. inmate/inmate assaults), MDCR needs to provide more direction on writing these reviews, training, and more intense review.			
Monitor's Recommendations:	1. Provide any updated policy, directive, and/or training for facility leadership to improve reviews prior to the next tour.			

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: 12/7/17, 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)	The Monitor reviewed a sample of TAAP reports, and confirms compliance.			
Monitor's Recommendations:	See recommendation for paragraphs III.A.2.a. and III.4.a.			

Paragraph	III. A. 5.c. **(See also CA III. B. 3)** (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: 12/7/17, 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. b. is noted in partial compliance by the medical/mental health Monitors.** The Monitor reviewed a sample of TAAP reports, and confirms compliance. There is no pattern of inappropriate or excessive uses of force.			
Monitors' Recommendations:	1. Coordinate with CHS regarding the similar paragraph in the Consent Agreement. Provide evidence of this collaboration and any action plans prior to the next tour.			

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: 12/7/17, 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)	A sample of TAAP reports were reviewed documenting continual compliance. There are important underlying issues about the training of CHS providers. **NOTE: A related provision in the Consent Agreement, III.B.3. b. 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. Documentation of this training must be provided prior to July 2018 tour. 2. Coordinate with CHS regarding the similar paragraph in the Consent Agreement. Provide evidence of this collaboration and any action plans. Provide by June 1, 2018.			

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: 12/7/17, 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)	The Monitors reviewed use of force packages prepared by TAAP. All contained photos.			
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: 12/10/17, 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:	Protection from Harm: 1. Policies and procedures regarding use of force; supervisory presence; location of recording equipment; supervision of recording equipment (batteries charged, repairs needed, etc.) 2. Policies and procedures regarding digitally recording incidents; training for users; instructions. 3. Review of incident reports; including exceptions in which digital recordings not made. 4. Review of investigations; review of digitally recorded incidents. 5. Review of remedial or corrective actions, if any. 6. Interview with IAB staff.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	No reports of planned uses of force were reviewed during the interim period.			
Monitor's Recommendations:	1. By June 1, 2018, provide the documentation regarding any pre-planned use of force occurring in the period October 1, 2017 – April 30, 2018.			

Paragraph	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: 12/7/17, 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:	<u>Protection from Harm:</u> 1. Personnel policies and procedures regarding employee discipline; relevant portions of CBAs. 2. Employee disciplinary reports; investigations. 3. Employee disciplinary sanctions. 4. Records of hearings, including arbitration hearings, if any. 5. Documentation of terminations for cause.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Monitor is concerned about the length of time between an incident where staff misconduct is potentially founded, and the disciplinary process – which is taking more than six months (based on the six reviews conducted by the Monitor for the first quarter of 2017). The reasons for the delays should be evaluated and changes made where necessary. The Monitor did not meet with the SAO this tour, but invited any comments or concerns; none were reported.		
Monitor's Recommendations:	1. Track internal disciplinary in terms of timeliness; any documentation regarding this review should be provided to the Monitor ahead of the July 2018 tour. 2. Track referrals to the SAO, time for review in the SAO, 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, 12/7/17	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 review of TAAP reports shows that inmates are referred to medical care even if there are no apparent injuries, or no complaints by the inmates involved. **NOTE that Consent III.B.3.b. is in partial compliance.**			
Monitors' Recommendations:	1. Coordinate with CHS regarding the similar paragraph in the Consent Agreement. Provide evidence of this collaboration and any action plans prior to the July 2018 tour.			

Paragraph	III. A. 5.c. (See CA III.B.3.) (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: 12/7/17, 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)	TAAP reviews all incidents, so this constitutes 100% sample. What was not provided was "review for trends and implement appropriate corrective action all uses of force that required outside emergency medical treatment."			
Monitor's Recommendations:	1. Assure that the annual and/or quarterly reports note any findings and if required, action plans. 2. By June 1, 2018, provide the required review and, if required a corrective action plan.			

Paragraph	III.A.5.c. (See CA III.B.3.) (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: 12/10/17, 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:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR continues to work on countermeasures and plans of action. These are not yet sufficient, in the view of the Monitor, to insure protection from future harm. Note: MDCR was advised in Compliance Report #7 that in order for this paragraph to remain in compliance at the time of the next tour, there must be credible action plans provided. The Monitors find that one broad issue is that every time an Emergency Treatment Order (ETO) is needed/entered to medicate a patient who is agitated due to mental illness the officers are refusing, according to CHS, to assist with the administration of the medication unless the Psychiatrist/Psych NP writes another order authorizing use of force). MDCR is then classifying each ETO as a use of force, even when the patient voluntarily complied in this instance, without force. This process seems to inflate the numbers for Level 1/2 mental health patients. NOTE: that CA III.B.3. b. is in partial compliance.			
Monitor's Recommendations:	1. Analyze the data in the quarterly reports. 2. Develop plans of action/countermeasures as needed. 3. Coordinate with CHS regarding the similar paragraph in the Consent Agreement. Review and amend or consolidate as necessary: CHS has an Involuntary Medication Policy; A Clinical Restraint Policy (CHS - 068); and MDCR has a Response to Resistance Policy (DSOP 11-041 Response to Resistance Policy) which is referenced in CHS' Clinical Restraint Policy. 4. The Monitors highly encourage the County to consider the following: a. Change the understanding that MDCR's assistance to CHS with Emergency Treatment Orders (ETOs) will not necessarily be classified as a use of force. Devise or develop another system to capture this data. Improve the			

	current data capture to more explicitly identify these circumstances, identify trends, and develop alternatives, if needed. b. Examine a sample of incidents to determine why an ETO was necessary. Develop collaborative plans of action, in necessary. c. Evaluate the process currently used in these circumstances, to assess if an order from the Psychiatrist/Psych NP to use force is necessary, and if so, why? d. Change the classification of ETOs to something other than a use of force to indicate the difference. If the event becomes a use of force, the classification can be appropriate amended. e. Provide a report on meetings/deliberations on these matters (noted above), along with any plan of action to the Mental Health and Corrections Monitors by **June 1, 2018.**

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: 12/7/17, 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)	This provision was not evaluated by the Monitor this tour.			
Monitor's Recommendations:	1. By June 1, 2018, MDCR provide the Monitor with a self-audit of this provision, included in the sample all facilities.			

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: 12/7/17, 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 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 continues to work on countermeasures and plans of action. These are not yet sufficient, in the view of the Monitor, to insure protection from future harm. MDCR has developed countermeasures, which have been started at Metro West in July. The countermeasures are showing promising data, in limited implementation. Note: MDCR was advised in Compliance Report #7 that in order for this paragraph to remain in compliance at the time of the next tour, there must be credible action plans provided.			
Monitor's Recommendations:	1. Provide any updates to the QA/QI policies. 2. Provide action plans/countermeasures. 3. Provide the data evaluating the effectiveness of countermeasures. 4. Provide the plan for expansion of direct supervision throughout Metro West, with the schedule, training schedule, and other fiscal related items that inhibit or enhance increased safety (e.g. correctional counselor vacancies, training schedule, training for trainers, "coach/mentor" training for corporals). 5. At a minimum identify the objective measures of success for the pilot and the facility-wide roll out of the initiative. 6. No later than May 4, 2018, provide the Monitor the materials noted in 1—5, above.			

<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: 12/7/17, 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>
D. Policies and procedures regarding training.
E. 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.
F. Training schedules.
G. Documentation of provision of updates to supervisors; sign-offs, etc.
H. Reports of random interviews.
I. Observation and interviews.
J. 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 was not provided that 5% of correctional officer staff were tested annually to determine their knowledge of use of force policies, etc. The recommendations in Compliance Report # 7 requested an update that the testing was completed, and the results, including any need for remediation of staff who did not receive a passing score.</td></tr>
<tr><td>Monitor's Recommendations:</td><td colspan="4">1. By March 1, 2018, MDCR provide the Monitor with an update of the evidence that MDCR is randomly testing at least 5% of correctional officer staff annually.
2. If any 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: 12/7/17, 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)	As SA III. A. c. (2) is in partial compliance, this paragraph in in partial compliance. Internal investigations of inmate/inmate assaults and other critical issues require attention. This paragraph addresses uses of force investigations, and inmate safety will be enhanced with updated strategies regarding incidents.
Monitor's Recommendations:	1. Update of SIAB standard operating procedures to assure more aggressive oversight of review conducted at the facility-level. 2. Document the legal basis for MDCR's initiation/conduct of investigations that may/could result in criminal charges. 3. Evaluate the efficacy of cross certifying investigative staff, training, and oversight to improve internal investigations. 4. By April 1, 2018, MDCR provide the Monitor with the steps taken, or to be taken through organizational, fiscal, and human resources to address improvements in internal investigations of critical incidents. The information should include timetables, proposed or drafted policies, training initiatives, and supervision of the work.

III. A.6. Early Warning System

Paragraph	III. A. 6. Early Warning System a. Implementation (1) MDCR will develop and implement an Early Warning System ("EWS") that will document and track correctional officers who are involved in use of force incidents and any grievances, complaints, dispositions, and corrective actions related to the inappropriate or excessive use of force. All appropriate supervisors and investigative staff shall have access to this information and monitor the occurrences. (2) At a minimum, the protocol for using the EWS shall include the following components: data storage, data retrieval, reporting, data analysis, pattern identification, supervisory assessment, supervisory intervention, documentation, and audit. (3) MDCR Jail facilities' senior management shall use information from the EWS to improve quality management practices, identify patterns and trends, and take necessary corrective action both on an individual and systemic level. (4) IA will manage and administer the EWS. IA will conduct quarterly audits of the EWS to ensure that analysis and intervention is taken according to the process described below. (5) The EWS will *analyze the data according to the following criteria:* i. number of incidents for each data category by individual officer and by all officers in a housing unit; ii. average level of activity for each data category by individual officer and by all officers in a housing unit; iii. identification of patterns of activity for each data category by individual officer and by all officers in a housing unit; and iv. identification of any patterns by inmate (either involvement in incidents or filing of grievances).			
Compliance Status:	Compliance: 12/7/17, 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 the County's representations, and the factual basis for finding(s)	The responsibility for the EIS has been moved from SIAB to Regulatory and Compliance Division on July 1, 2017. With that move, deficiencies were identified in terms of action on notifications. The need for training of facility commanders was identified as critical to making the system effective. To remain in compliance during the July 2018 tour the following actions are required by May 15, 2018: • MDCR will provide a revised policy/procedure (draft is acceptable); • The recommendations for change to the program since moving it to the Regulatory and Compliance Division, and if those recommendations were implemented (action plans acceptable); • Any benchmarks or measurable objectives established for the EIS; • The training lesson plan(s) for facility based staff in EIS; • The schedule for training; and • Data indicating if changes to the process are achieving benchmarks or measurable objectives. Additionally, a review of the reporting (annual) is suggested to determine how this information (along with quarterly) reporting is linked to keeping inmates safe. MDCR provided a list of 22 names of officers who are pending disciplinary action as a result of uses of force from the period January 1 – September 30, 2017. Looking at the first quarter of 2017 (N=10), two remain pending, 5 are pending appeal, one resulted in a written reprimand, and 3 were rescinded. For the second quarter (N=8), three reduced1 - /5-day suspension/2 termination; three rescinded, one retired, and one pending. The Monitor suggests that the timeliness of discipline needs to be explored, as well as documentation of the actions taken and appeals. The Labor Management Unit is urged to take this review and provide for feedback to the those conducting use of force reviews to assess if the quality of the investigation influenced the eventual outcome of employee discipline.
Monitor's Recommendations:	1. See above, the requirements for maintaining compliance. 2. By June 1, 2018, Labor Management Unit review and assess outcomes of discipline and provide any recommendations regarding the quality and/or scope of use of force investigations/reviews. 3. See also III.A.6.c.

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: 12/7/17, 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)	The list was provided; however, the effectiveness of the process is being evaluated. See III.A.6. a. (1)- (5)		
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: 12/7/17, 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 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)	Three quarterly reviews were provided; but not an annual review.		
Monitor's Recommendations:	1. On or before June 1, 2018, MDCR provide the Monitor with a report determining if the EWS has been effective in identifying concerns regarding policy, training or the need for discipline. 2. 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 1. Necessary fire and life safety equipment shall be properly maintained and inspected at least monthly. MDCR shall document these inspections.			
Compliance Status:	Compliance: 12/7/17; 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 implemented reauthorized policy, DSOP 10-022, entitled "Fire Response and Prevention Plan" effective 10/24/16.			
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 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 is 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. MDCR provided copies of the monthly Fire Extinguisher Inventory Inspection report for Boot Camp, MWDC, PTDC and TGK for July, August, and September 2017. The inventory and report identify all fire extinguishers by location and by a unique identifier. The inventory includes all extinguishers in storage at each facility and any extinguishers in storage needing repairs. The report documents when faulty equipment has been replaced. The reports are complete and signed. Under a contract, all fire extinguishers are inspected and recharged every three years for all facilities. MDCR provided requested copies of the monthly fire inspection reports for July, August, and September 2017 for each facility along with a monthly summary report highlighting common violations found for the month and tracking of all			

	FMB Service Tickets. The reports are complete and include photos of all identified non-conformities, along with follow-up photos showing that repairs were completed and closing of that month's inspection. When a repair has not been completed, the report narrative includes FMB's reason repairs could not be completed (typically waiting for parts or the repair is part of a longer-term capital project). In those instances, the following month's report continues to carry the existing non-conformity until repairs are completed.
Monitor's Recommendations:	No additional recommendations.

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:12/7/17; 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:	<u>Fire and Life Safety:</u> 1. Development of either a MDCR or facility specific policy mandating at least an annual inspection of all fire alarms and sprinkler systems. The policy needs to include assurance of installation in accordance with all applicable fire codes and require effective repairs for any deficiency found. All policies and procedure are to be reviewed and updated as necessary at least annually on a schedule. 2. Establishment and implementation of a written contract with a company licensed to conduct the inspection, and make repairs. 3. Copies of the annual inspection reports and corrective actions taken for all non-conformances.			
Steps taken by the County to Implement this paragraph:	MDCR continues to implement a "Fire Safety Inspection Interval Schedule" as an attachment to DSOP 10-022. Miami-Dade County maintains a current contract with Florida Fire Alarm, Inc. for fire alarm testing (Contract No #6694-0/18 (primary vendor) and Metro Dade Security System, Inc. (secondary vendor). MDCR also maintains a contract with National Fire Protection, LLC (NFP) (primary vendor) and McGilvary Mechanical, LLC (secondary vendor) 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)	MDCR provided copies of: • the 2017 completed Fire Alarm System inspection for Boot Camp (3/02/17); for MDWC (3/24/17); for PTDC (3/17/17); and TGKCC (5/13/17) by Florida Fire Alarm, Inc. (TTC continues to be closed). • the sprinkler system completed inspections for MWDC (3/29/17); PTDC (3/30/17); TGKCC (3/29/17) by National Fire Protection LLC. • Evidence from NFP that corrections were completed for the non-conformities identified at PTDC. NFP also provided MDCR with proposals to conduct the five-year internal fire sprinkler inspections for MWDC, PTDC, and TGK. • the 2017 Miami-Dade County Fire Rescue inspection for Boot Camp (11/3/17), MWDC (9/26/17) and TGK (9/26/17). • the 2017 inspection for PTDC (4/26/17) completed by the City of Miami Fire-Rescue Department. All facilities passed their inspections and were approved.			
Monitor's Recommendations:	No additional recommendations.			

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: 12/7/17; 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):	None			
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:	MDCR continues to follow DSOP Policy 11-023 "Key Control" reauthorized 11/4/16. The revision establishes one policy for all facilities and eliminated past practice for a separate emergency key control policy for each facility.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	At this tour, the Monitor reviewed emergency key location, documentation of completed inspections and a daily shift inventory showing the red box glass had not been broken for MWDC, PTDC, and TGK. MDCR requires incident reports be completed for any missing, or broken keys. There were none this year. Key control officers test emergency keys with the appropriate lock at least quarterly and documenting the testing in each facility's electronic key control log. This provision remains in compliance.			
Monitor's Recommendations:	No additional recommendations.			

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: 12/7/17; 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:	Fire and Life Safety: 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:	MDCR revised DSOP 10-022, "Fire Response and Prevention Plan" effective 10/24/16. Section XII states, "The CIAB Captain or Department Safety Officer (DSO) shall ensure that all fire drills are documented on the Fire Drill Report to ensure effective staff response to a fire emergency." Fire Drills are comprised of four levels as shown on the Fire Drill Level Overview Sheet. MDCR revised DSOP Policy 10-006 "Emergency Procedures RE: Evacuation" effective 10/24/16.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Prior to this tour MDCR provided a copy of the fire drill schedule for 2018, along with copies of the monthly fire drill audit report for May 2017. At the tour MDCR submitted the audit reports for July, August, and September 2017 for review. In the four monthly reviews provided by MDCR, they demonstrated, with one exception each facility completed a minimum of three drills. MWDC completed only two in September. TGK conducted extra follow-up drills during July and August. The audit reports of the drills continue to improve and facilities continue to be more self-critical in identifying errors in staff response to the exercise. The audit reports included all evidence of corrective actions taken as a result of the non-conformances identified. As noted in the previous compliance reports, the Monitors believes that the time to complete the process is too long. For example, the May audit report was not completed until late July. The entire process should be completed in 30 day		

	or less so the lessons learned from the drill remain relevant to the participants. The audit is an excellent process to assure management that the drills are effective and changes to policies and/or training modules are made as needed.
Monitor's Recommendations:	1. Provide evidence to the Monitor by June 1, 2018 that the amount of time needed to complete corrective actions from the drills is reduced to 30 days or less as discussed during the tour. 2. Categorize drill conformities at least annually and provide evidence to the Monitor by June 1, 2018 that the data was incorporated into biennial and as necessary the initial fire safety training classes. 3. The Monitor suggests that as best practices: a. The facility FSSO to should conduct an initial post drill assessment to determine the root cause of any identified non-conformances to policies and procedures and submit to CIAB the appropriate corrective action steps needed to prevent the issue from re-occurring. It is CIAB's responsibility to review and either revise, reject, or accept the corrective actions proposed. b. The Monitor recommends that CIAB categorize all the non-conformances identified during the drills for the year and identify the most frequently occurring issues and use it to modify either or both the two-hour biennial refresher training and the initial eight-hour initial fire safety training for new staff. Following the discussion during the tour CIAB did provide the Monitor a six-month summary of common areas of concerns from the drills for each facility. c. The fire safety trainers' assessment of training issues that should be used to improve training or policies. d. MDCR should consider developing a process to record which officers have participated in drills and use the data when scheduling drills to get more staff participating in drills over time.

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: 12/7/17; 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 and implemented DSOP 10-010 "Chemical Control" authorized on 11/4/16. MDCR has developed an eight-hour lesson plan dated 10/26/16 for chemical control based on the policy and procedures that is used to train Facility Safety and Sanitation Officers (FSSOs) and MDCR employees permanently assigned to facility sanitation units. Additionally, MDCR required as part of the contract with their new chemical provider, an on-line training program for chemical safety, use of the PRIDE products. They have also established and maintain chemical control inventory logs and chemical 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)	Prior to this tour MDCR installed new electronic dispensing systems for all housing units at Boot Camp, MWDC and PTDC. The same system is scheduled to be installed at TGK in the next quarter once they have used the remaining chemicals from the previous provider. MDCR provided examples of the inventories on the decontamination cart, spill kit inventories, and chemical inventory/issuance logs for Boot Camp, MWDC, PTDC and TGK. During this tour, the Monitor reviewed the chemical logs and storage rooms for MWDC, PTDC, and TGK. At each facility, the FSSOs were completing, signing and maintaining the chemical inventory and distribution logs correctly. The chemical storage rooms are organized well and secured, limiting access to only staff. Inmate workers are allowed to handle/use only 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. The FSSO's explained the chemical distribution and storage process for their respective facility. The Monitor also observed inmate workers using chemicals and only diluted chemical working containers that were properly labeled and stored in either the chemical storeroom or in secure control rooms.			

	This paragraph continues to be substantially compliant.
Monitor's Recommendations:	3. Provide evidence by June 1, 2018 of completed training for officers required to supervise inmate workers using chemicals. 4. Provide evidence by June 1, 2018 of inmate worker training for using the new chemicals 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: 12/7/17; 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 developed and implemented an eight-hour lesson plan reviewed by the Monitor for initial fire and life safety training for current and newly hired MDCR correctional employees. The training was developed in accordance with the current edition of DSOP Policy 10-022 (Fire Response and Prevention Plan) and DSOP Policy 10-006, (Emergency Procedures RE: Evacuation. DSOP Policy 10-022 establishes that the CIAB Captain, in conjunction with the Training Bureau Supervisor are responsible for ensuring that there is fire safety training that includes fire watch training Currently MDCR has 2041 sworn staff. They have developed a schedule demonstrating that all staff will complete initial training by mid-2018. The database shows the schedule for what year officers must also complete the biennial training program.			
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. Fifty officer completed training in 2015; 496 completed training in 2016 and 820 officers have completed training to date in 2017. It is planned that the remaining staff plus 2018 new hires will complete training by mid-2018. MDCR provided evidence of 41 officers that continue to be employed by MDCR who completed the initial training in 2015 have completed biennial refresher training in 2017. The remaining 460 of the 496 employees that completed the initial training in 2016 are scheduled to receive the on-line refresher training in 2018. MDCR provided a current copy of the training database report maintained to track progress in training.			
Recommendations:	1. As best practice the Monitor recommends: a. MDCR 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 document the training.			

	b. As the medical personnel working in MDCR are part of the response team, training should be provided. Training should also be included for Facility Maintenance Bureau who are part of a response such as mechanical system workers, electricians, and plumbers. The training process for both CHS and Maintenance should be documented.

III. C. Inmate Grievances

<table>
<tr><td>Paragraph
<u>Coordinate with Drs. Johnson and Greifinger</u>
<u>See also Consent Agreement III.A.3.a.(4) and III.D. 1.b.</u></td><td colspan="4">III. C. Inmate Grievances
MDCR shall provide inmates with an updated and recent inmate handbook and ensure that inmates have a mechanism to express their grievances and resolve disputes. MDCR shall, at a minimum:
1. Ensure that each grievance receives follow-up within 20 days, including responding to the grievant in writing, and tracking implementation of resolutions.
2. Ensure the grievance process allows grievances to be filed and accessed confidentially, without the intervention of a correctional officer.
3. Ensure that grievance forms are available on all units and are available in English, Spanish, and Creole. MDCR shall ensure that illiterate inmates, inmates who speak other languages, and inmates who have physical or cognitive disabilities have an adequate opportunity to access the grievance system.
4. Ensure priority review for inmate grievances identified as emergency medical or mental health care or alleging excessive use of force.
5. Ensure management review of inmate grievances alleging excessive or inappropriate uses of force includes a review of any medical documentation of inmate injuries.
6. A member of MDCR Jail facilities' management staff shall review the grievance tracking system quarterly to identify trends and systemic areas of concerns. These reviews and any recommendations will be documented and provided to the Monitor and the United States.</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: 12/7/17, 10/24/14, 3/28/14, 7/19/13</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"><u>Protection from Harm:</u>
1. Policies and procedures regarding inmate grievances per the specifications above.
2. Updated inmate handbook.
3. Review of grievance forms (Creole, English, Spanish)
4. Review of procedures for LEP inmates, and illiterate inmates.
5. Review of a sample of grievances.
6. Observation of grievances boxes and processing of grievances.
7. Interview with inmates.
8. Evidence of referral of grievances alleging use of force; sexual assault.
9. Quarterly tracking/data reporting; recommendations, if needed.
10. Documentation of collaboration between security and medical/mental health regarding inmate grievances.
11. Quarterly report of trends, by facility; corrective action plans, if any.
<u>Medical Care</u>:
• Review of Quality Improvement Plan and bi-annual evaluations
• QI committee minutes</td></tr>
</table>

	• 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)	This paragraph is in partial compliance specifically for sub-paragraphs 5. and 6., above. The Monitor's assessment of the grievance data for the last several years expressed concern about the number of grievances classified as "other". There is no evidence that the information gained from grievances is used for management purposes. Additionally, review of a sample of grievances during the tour indicated issues with the accuracy of the classification as substantiated or unsubstantiated. In reviewing CHS' response to grievances, while the information provided might be correct as far as it went, it did not address or solve the inmate's problem. During the tour, the Monitor requested and was provided an action plan to address the deficiencies noted in the on-site review. This included: training (or re-training) correctional counselors to properly categorize the topic of the grievance; reduce the number of grievances categorized as "other"; train (or re-train) staff regarding what is a substantiated or unsubstantiated grievance; improve quality control by reviewing the content of the grievance response; assess the number of grievances from the target units at Metro West where direct supervision is used and track trends; and modify the information system to support changes. **These initiatives must be undertaken with CHS.** Update inmate education/orientation where necessary. There is evidence that grievances reflecting allegations of uses of force are referred for investigation. The Monitors (all Monitors) urge the County to consider the efficacy of classifying grievances as "substantiated" or "unsubstantiated", including assessing how this contributes to solving inmates' issues and providing relevant management data. **NOTE that <u>CA III. A. 3. (4)</u> is in non-compliance**
Monitors' Recommendations:	1. See above recommendations, including assessment of the value of classifying incidents as "substantiated" or "unsubstantiated". 2. By **<u>June 1, 2017</u>**, provide a report/update on collaborations with CHS to improve the grievance process to all the Monitors. This report may include any action plans, and the assessment of the effectiveness of short-term fixes. Provide training lesson plans and schedules for training. 3. Revise the policy/procedures as needed.

III. D. Audits and Continuous Improvement

Paragraph Coordinate with Grenawitzke	III. D. Self Audits 1. Self Audits MDCR shall undertake measures on its own initiative to address inmates' constitutional rights or the risk of constitutional violations. The Agreement is designed to encourage MDCR Jail facilities to self-monitor and to take corrective action to ensure compliance with constitutional mandates in addition to the review and assessment of technical provisions of the Agreement. a. On at least a quarterly basis, command staff shall review data concerning inmate safety and security to identify and address potential patterns or trends resulting in harm to inmates in the areas of supervision, staffing, incident reporting, referrals, investigations, classification, and grievances. The review shall include the following information: (1) documented or known injuries requiring more than basic first aid; (2) injuries involving fractures or head trauma; (3) injuries of suspicious nature (including black eyes, injuries to the mouth, injuries to the genitals, etc.); (4) injuries that require treatment at outside hospitals; (5) self-injurious behavior, including suicide and suicide attempts; (6) inmate assaults; an (7) allegations of employee negligence or misconduct. b. MDCR shall develop and implement corrective action plans within 60 days of each quarterly review, including changes to policy and changes to and additional training.			
Protection from Harm: Compliance Status:	Compliance: 3/3/17	Partial Compliance: 12/7/17, 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: 12/7/17, 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 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:			

	5. 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. 6. 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: As noted as theme throughout this report, MDCR collects data, but there is insufficient analysis of the data. There is also no determination if the data is used to make decisions. The Provisions for Audits and Continuous Improvements and Compliance and Quality Improvement are for the County, MDCR, and CHS, not the monitors. The Monitor's comments regarding reporting are at least three years old, and have not been addressed. Fire and Life Safety: MDCR is completing audit reports monthly for fire drills. See Provision III.B.4. above.
Monitors' Recommendations:	Protection from Harm: 1. By May 1, 2018 MDCR provide the Monitor with the plan to determine what data to collect, assurance of the integrity of the data, who the data will inform MDCR's management decisions, what analysis will be conducted, and how action plans/countermeasures will be developed. If a policy change is needed, the draft should be provided. If there are results, the results should be provided. Fire and Life Safety: No recommendations at this time.

<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.
b. 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>Protection from Harm: Compliance Status:</td><td>Compliance: 3/3/17</td><td>Partial Compliance: 12/7/17, 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></td></tr>
</table>

	1. Policies and procedures regarding self-audits. 2. Bi-Annual Reports. 3. Corrective action plans, if needed. 4. Evidence of implementation of corrective action plans, if any.
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: The theme throughout this report is for data to be collected, then analyzed for some management purpose. The second paragraph of this requirement is not yet met.
Monitor's Recommendations:	Protection from Harm: See all recommendations and dates for III. D. 1. a. b.

IV. Compliance and Quality Improvement

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: 12/7/17, 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: 12/7/17, 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:				

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: Any revisions to new policies have been provided to the Monitor in a timely manner. Fire and Life Safety: MDCR has provided drafts of policies and copies of training plans in 2016. There were none provided for 2017. MDCR provided evidence of completed training for both fire safety and chemical control. While not all the training of current officers is completed, the Monitor believes that based on the documentation provided for this tour, it will be completed in 2018. The provision is substantially compliant.
Monitor's Recommendations:	No further recommendations 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: 12/7/17, 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: 12/7/17, 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:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Protection from Harm: MDCR collects data. There is improving, but still inadequate analysis of the data, nor development of corrective action plans/countermeasures where indicated. These initiatives are evolving, and will gain compliance with the provision when fully implemented. The amount of time and human resources spent on collecting data, and formatting it into quarterly reports is substantial; but in the view of the Monitors, does not yield a sufficient return on investment. The Monitors have been providing comments on the usefulness of the data in the quarterly reports for several years, and no amendments have been made. Importantly, this data is for the use of the County; not the Monitors. The Monitors recommend a complete review and overhaul of the system, clarity of why data is collected and how it is used. Fire and Life Safety: MDCR has developed and implemented an audit process for all fire drill conducted at all facilities. The audit process establishes a corrective action process that includes documentation to demonstrate that all corrective actions are completed. See III.B.4.			

	MDCR has also developed monthly fire and life safety inspections to require photos of violations identified during the inspections, along with photos documenting the corrective actions taken to complete the corrective action process. The provision is substantially compliant for the fire/life safety provisions of the Settlement Agreement.
Monitor's Recommendations:	Protection from Harm: 1. Assess the quarterly and annual reports for utility to the County. Determine how the data is used in decision-making, and amend accordingly. Assess the human resources used in this work compared to the return on investment. 2. Coordinate this assessment with CHS' data keeping and QA/QI processes. Determine what data can be jointly collected, analyzed, and how plans of action/countermeasures are developed, implemented and assessed for effectiveness. 3. See recommendations for III.D.1.a.b. Fire and Life Safety: No further recommendations.

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: 12/7/17, 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: 12/7/17, 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:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	A memorandum from the Director was provided attesting to the annual review of policies and procedures.		
Monitor's Recommendations:	No further recommendations.		

Paragraph Coordinate with Grenawitzke	V. 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: 12/7/17, 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: 12/7/17, 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:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	There are a series of time sensitive recommendations in this Compliance Report. If these elements are not provided timely, then this paragraph will be in non-compliance with the next tour.			
Monitor's Recommendations:	1. MDCR's production of required reports will dictate if this provision remains in compliance during the next tour. Attention to these reports is necessary.			

Compliance Report # 8

Consent Agreement - Medical and Mental Health Care

Report of Compliance Tour, December 4 – 7, 2017

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

Consent Agreement – Compliance Report # 8 - Status of Compliance[1]

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[2]
5	4	50	61	0	115
6	10	65	40	0	115
7	16	51	48	0	115
8	29	70	16	0	115[3]

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. Johnson was clear in his 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.

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

[2] Joint reporting paragraphs removed.

[3] 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 second 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.

Since Compliance Tour #7, CHS has made some demonstrable improvements in some of the required medical areas: intake screening, access timeliness, medication administration and management, medical record keeping, acute care and detoxification/withdrawal.
Morbidity and mortality reviews are more specific than previously, but the findings and corrective action plans are not integrated into the quality management program. CHS has developed chronic care guidelines, but performance is poor, and analysis and corrective action plans remain somewhat weak. Answers to grievances are unresponsive. Care surrounding use of force is poorly documented. The biannual report has data that is insufficiently analyzed to tell a story. Though CHS initiated health assessments several months ago, there has been insignificant progress, as measured through focused review of medical records. Discharge planning has not improved.

The current peer review program is poorly conceived and ineffective.

The implementation of an effective quality management program has assisted the CHS management and clinical leadership teams to identify opportunities for improvement; develop action plans with clear accountabilities for specific personnel. The reliability of measurement is good, except for the reliability of the chronic disease measures. Grievances are not analyzed with a focus on identifying opportunities for improvement. 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, 53% of patients in the jails are on the mental health caseload. This number is high when compared to other correctional facilities, both large and small. Screening has improved with analysis of transfers to the emergency department to improve the appropriateness of transfers. Due to improvements in the detox program, there were fewer transfers to the emergency department due to seizures.

However, persons on the mental health caseload, especially those on Level 1 and 2, continue to be a statistically significant percentage of the those involved in uses of force. Upon deeper analysis, it was discovered that MDCR classifies any patient who receives an emergency treatment order (ETO) as a use of force, even when force was not needed. MDCR is also requiring the Qualified Mental Health Professional (QMHP, which is a psychiatrist or advance practice registered nurse[APRN]) to write an order authorizing use of force. It is outside the practice parameters of a QMHP to authorize use of force in an order and I recommend that this requirement be stopped immediately. Also, only classifying ETOs that actually required a use of force as RTRs will provide a clearer understanding of actual uses of force with mental health patients.

Inaccurate Leveling, Suicide Classification, and Preventable Morbidity and Mortality

Despite the majority of classifications of mental health level of care being appropriate, there were two deaths by suicide that may have been prevented had the patients been appropriately leveled. Early analysis by CHS of how this occurred indicated that mental health staff were not following the leveling guidelines despite having access to all relevant information needed to have appropriately leveled the patients. CHS indicated that staff reported using their "clinical judgment" rather than following the guidelines, which lead to the errors. This indicates a need for staff to be retrained on the leveling process to avoid future preventable mortalities. Had the individuals of committed suicide been leveled appropriately, they would have been housed at a higher level of care (e.g., level 1) and their chance of completed suicide would have presumably decreased.

Similarly, analysis of Deliberate Self-Harm (DSH) incidents indicates a need for a more specific, evidence-based definition for acts of self-harm (e.g., Non-Suicidal Self- Injury [NSSI]) to appropriately differentiate them from of suicide attempts.
Appropriate classification of NSSI and suicide attempts will allow for analysis and

targeted improvements in CHS' response to these incidents. Improved analysis and targeted improvements could lead to a reduction in these events and therefore a reduction in preventable morbidity and mortality resulting from these events. 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

Coordination with MDCR and hence patient outcomes has significantly improved since the last tour. MDCR was aware and conversant about the daily schedules for the delivery of services to each housing unit in which Level 1 and 2 inmates are held. They were also aware of the schedule for units housing Level 3 and 4 inmates at the Metro West facility as well. MDCR was aware of, but not be limited to, 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). Furthermore, CHS Mental Health staff repeatedly expressed adequate staffing of housing units. Both CHS and reported improved communication regarding patient care.

The Monitors will continue to review this recommendation for evidence of ongoing coordination with MDCR to ensure this issue continues to be prioritized and addressed.

Next Steps

In addition to the recommendations contained in the report, the following are additional requests for information and demonstration of compliance and sustainability. These are due before the tour:[1]

31. By February 1, 2018, report on the recommendations contained regarding this paragraph. (III.A.1.a.)
32. By March 1, 2018 identify the clinical performance measures, and update quarterly. (III.A.1.e.)
33. By May 1, 2018, assure all incoming and current patient care meets requirements. Provide documentation of such by this date. (III.A.2.a.)
34. By May 1, 2018 provide documentation of compliance with this paragraph

[1] Sequential numbering from reports required as part of the Settlement Agreement Compliance Report #8 (above).

and recommendations. (III.A.2.c.)
35. By February 1, 2018, provide report on clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time. (III.A.2.e.)
36. By February 1, 2018, provide report on clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time. (III.A.2.f.)
37. By February 1, 2018, provide report on clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time. (III.A.2.g.)
38. By February 1, 2018, provide documentation of process and outcomes for delivery of care. (IIII.A.3. a. (4))
39. By April 1, 2018 provide process information and outcomes for recommendations. (III.A.4.a.)
40. By February 1, 2017 address the systems issues of this requirement; provide evidence/documentation of outcome of remedies, including action plans. (III.A.4.e.)
41. By April 1, 2018, demonstrate compliance with recommendations. (III.A.5.a.)
42. By March 1, 2018, provide a written evaluation of the electronic scheduling system, and plan for expeditious achievement with the requirements of this paragraph. (III.A.5.b.)
43. By April 1, 2018, provide a report on the adoption of recommendations and compliance with the paragraph. (III.A.5.d.)
44. By June 1, 2018 provide a report regarding compliance with this paragraph. (III.A.6.)
45. By March 1, 2018, demonstrate compliance with these recommendations. (III.A.7.a.)
46. By February 1, 2018, provide data for July – December 2017. (III.A.7.c.)
47. By February 1, 2018, provide performance measures. (III.B.1.)
48. By February 1, 2018, provide report regarding the recommendations. (III.B.2.)
49. By April 1, 2018, provide a report regarding the CHS' and MDCR's compliance with this requirement. (III.B.3.a.)
50. By April 1, 2018 provide a report regarding the recommendations and documentation. (III.B.3.b.)
51. By April 1, 2018 provide a report regarding assessment and implementation of recommendations. (III.B.3.c.)
52. By June 1, 2018, document development of a dev process to self-monitor this provision and have it available for review for the next site visit. See recommendations. (III.C.2.e)
53. By June 1, 2018, provide report on CHS' validation of leveling. (III.C.2.f.)
54. By June 1, 2018, provide evidence of the use of the quality improvement program and ability to self-monitor, including description of performance indicators. (III.C.2.g.(2))
55. By June 1, 2018, respond to the recommendations from this and Compliance Report #7. (III.C.6.a. (2))
56. By June 1, 2018, provide documentation regarding compliance with this paragraph. (III.C.6.a.(6))
57. By June 1, 2018, provide the data to track this provision and perform audits

demonstrating adherence, and include analysis of any information specific to the timely referral of patients for SMI during custodial segregation (and assessment by a QMHP). (III.C.6.a. (11))

58. By March 1, 2018, provide clearer a clearer staffing matrix that addresses the concerns noted in the narrative. (III.C.7.a.)
59. By June 1, 2018, demonstrate that new hires require corrections-specific training. (III.C.7.b.)
60. By June 1, 2018, please provide updated staffing analyses per this provision in the future. Please provide all data requested prior to the tour (e.g., FTEs). (III.C.7.d.)
61. By June 1, 2018, 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. (III.C.7.h.)
62. By June 1, 2018, provide a self-audit of this provision. (III.C.8.d.)
63. By June 1, 2018, provide more in-depth analysis of risk management data. (III.c.9.a)
64. By June 1, 2018, provide risk management specific data analysis and associated interventions to prevent or minimize harm to inmates. (III.c.9.b.)
65. By June 1, 2018, provide evidence of written annual performance assessments and presentation its findings to the Interdisciplinary Team regarding the following: Quality of nursing services regarding inmate assessments and dispositions, and access to mental health care by inmates, by assessing the process for screening and assessing inmates for mental health needs. (III.C.9.c.)
66. By April 1, 2018 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. (III.D.1.b.)
67. By June 1, 2018, develop a biannual report that describes findings from clinical performance measurement, M&M reviews, grievances, etc. with consolidated action plans and trended date. The second biannual review of each calendar year could serve as an evaluation of the quality management program. It can serve as a stepping off point for the next year's annual QI Plan. (III.D.2.a.)
68. By May 1, 2018, provide a report responsive to all the requirements of this provision. (III.D.2.a.(6)

This request (and those in the Settlement Agreement) represent a different approach by the Monitors to request that the County be more pro-active in documenting actions related to the provisions of both agreements, as well as to demonstrate the sustainability of efforts. The Monitors are willing to engage in any dialogue that is needed to clarify what constitutes substantial compliance and sustainable compliance.

Tour #8[4] - Summary of Status of Compliance - Consent Agreement

Yellow = Collaboration - Medical (Med) and Mental Health (MH)
Purple = Colla
Orange = Mec
Green = Ment

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments: Implement recommendations by:
A. MEDICAL AND MENTAL HEALTH CARE				
1. Intake Screening				
III.A.1. a.		Med; MH		By February 1, 2018, report on the recommendations contained regarding this paragraph.
III. A. 1. b.		MH		
III. A. 1. c.		MH		
III.A.1. d.	Med; MH			
III.A.1. e.		Med; MH		By March 1, 2018 identify the clinical performance measures, and update quarterly.
III.A.1. f.	Med; MH			
III.A.1. g.	Med; MH			
2. Health Assessments				
III. A. 2. a.			Med	By May 1, 2018, assure all incoming and current patient care meets requirements. Provide documentation of such by this date.
III. A. 2. b.		MH		
III. A. 2. c.		MH		By May 1, 2018 provide documentation of compliance with this paragraph and recommendations.
III. A. 2. d.		MH		
III.A.2. e.			Med	By February 1, 2018, provide report on clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time.

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

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments: Implement recommendations by:
III.A.2.f. (See (IIIA1a) and C. (IIIA2e))		Med; MH		By February 1, 2018, provide report on clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time.
III.A.2. g.	Med	MH		By February 1, 2018, provide report on clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time.
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		By February 1, 2018, provide documentation of process and outcomes for delivery of care.
III.A.3. b.			Med; MH	
4. Medication Administration and Management				
III.A.4. a.		Med; MH		By April 1, 2018 provide process information and outcomes for recommendations.
III.A.4.b(1)	Med; MH			
III.A.4.b(2)		MH	Med	See III.A.2.a. and 3e. Due February 1, 2018.
III. A. 4. c.		MH		
III. A. 4. d.		MH		
IIIA.4. e.		MH	Med	By February 1, 2017 address the systems issues of this requirement; provide evidence/documentation of outcome of remedies, including action plans.
III.A.4.f. (See (III.A.4.a.)	Med; MH			
5. Record Keeping				
III.A.5. a.		Med; MH		By April 1, 2018, demonstrate compliance with recommendations.
III.A.5 b.		MH		By March 1, 2018, provide a written evaluation of the electronic scheduling system, and plan for expeditious achievement with the requirements of this paragraph.
III.A.5.c. (See III.A.5.a.)		Med; MH		See III.A.5. a.
III.A.5. d.		Med; MH		By April 1, 2018, provide a report on the

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments: Implement recommendations by:
				adoption of recommendations and compliance with the paragraph.
6. Discharge Planning				
III.A.6.a.(1)		MH	Med	By June 1, 2018 provide a report regarding compliance with this paragraph.
III.A.6.a.(2)		MH	Med	By June 1, 2018 provide a report regarding compliance with this paragraph.
III.A.6.a.(3)		Med; MH		By June 1, 2018 provide a report regarding compliance with this paragraph.
7. Mortality and Morbidity Reviews				
III.A.7. a.		Med; MH		By March 1, 2018, demonstrate compliance with these recommendations.
III.A.7. b.			Med; MH	See III.A.7. a.
III.A.7. c.			Med; MH	By February 1, 2018, provide data for July – December 2017.
B. MEDICAL CARE				
1. Acute Care and Detoxification				
III.B.1. a.			Med	By February 1, 2018, provide performance measures.
III.B.1.b. (Covered in (III.B.1.a.)		Med		See III.B.1 a. and III A.3.a.(4)
III.B.1. c.	Med			
2. Chronic Care				
III.B.2. a.		Med		By February 1, 2018, provide report regarding the recommendations.
III.B.2.b. (Covered in (III.B.2.a.)		Med		See III.B.2. a.
3. Use of Force Care				
III.B.3. a.		Med; MH		By April 1, 2018, provide a report regarding the CHS' and MDCR's compliance with this requirement.
III.B.3. b.		Med		By April 1, 2018 provide a report regarding the recommendations and documentation.
III.B.3.c. (1) (2) (3)		Med		By April 1, 2018 provide a report regarding assessment and implementation of recommendations.

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments: Implement recommendations by:
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		By June 1, 2018, document development of a dev process to self-monitor this provision and have it available for review for the next site visit. See recommendations.
III. C. 2. f.		MH		By June 1, 2018, provide report on CHS' validation of leveling.
III. C. 2. g.	MH			
III. C. 2. g. (1)		MH		
III. C. 2. g. (2)	MH			By June 1, 2018, provide evidence of the use of the quality improvement program and ability to self-monitor, including description of performance indicators.
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		

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments: Implement recommendations by
4. Review of Disciplinary Measures				
III. C. 4. a. (1) (2) and b.		MH		
5. Mental Health Care Housing				
III. C. 5. a.		MH		
III. C. 5. b.		MH		
III. C. 5. c.		MH		
III. C. 5. d.		MH		
III. C. 5. e.		MH		
6. Custodial Segregation				
III. C. 6. a. (1a)		MH		
III. C. 6. a. (1b)		MH		
III. C. 6. a. (2)		MH		By June 1, 2018, respond to the recommendations from this and Compliance Report #7.
III. C. 6. a. (3)		MH		See III.C.6.a.(2)
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	By June 1, 2018, provide documentation regarding compliance with this paragraph.
III. C. 6. a. (7)			MH	See III.C.6.a. (6)
III. C. 6. a. (8)			MH	See III.C.6.a. (6)
III. C. 6. a. (9)		MH		
III. C. 6. a. (10)		Med; MH		
III. C. 6. a. (11)			MH	By June 1, 2018, provide the data to track this provision and perform audits demonstrating adherence, and include analysis of any information specific to the timely referral of patients for SMI during custodial segregation (and assessment by a QMHP).
7. Staffing and Training				
III. C. 7. a.	MH			By March 1, 2018, provide clearer a clearer staffing matrix that addresses the concerns noted in the narrative.
III. C. 7. b.	MH			By June 1, 2018, demonstrate that new hires require corrections-specific training.
III. C. 7. c.	MH			

Subsection of Agreement	Compliance	Partial Compliance	Non-Compliance	Comments: Implement recommendations by
III. C. 7. d.		MH		By June 1, 2018, please provide updated staffing analyses per this provision in the future. Please provide all data requested prior to the tour (e.g., FTEs).
III. C. 7. e.	MH			
III. C. 7. f.	MH			
III. C. 7. g. (1)(2)(3)	MH			
III. C. 7. h.		MH		By June 1, 2018, 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.
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			Not reviewed this tour. By June 1, 2018, provide a self-audit of this provision.
9. Risk Management				
III. C. 9. a.		MH		By June 1, 2018, provide more in-depth analysis of risk management data.
III. C. 9. b. (1)(2)(3)(4)		MH		By June 1, 2018, provide risk management specific data analysis and associated interventions to prevent or minimize harm to inmates.
III. C. 9. c. (1)(2)(3)(4)(5)		MH		By June 1, 2018, provide evidence of written annual performance assessments and presentation its findings to the Interdisciplinary Team regarding the following: Quality of nursing services regarding inmate assessments and dispositions, and Access to mental health care by inmates, by assessing the process for screening and assessing inmates for mental health needs.
III. C. 9. d. (1)(2)(3)(4)(5)(6)		MH		

D. AUDITS AND CONTINUOUS IMPROVEMENT				
1. Self-Audits				
III. D. 1. b.			Med; MH	By April 1, 2018 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.
III. D. 1. c.		Med; MH		
2. Bi-annual Reports				
III. D. 2. a. (1)(2)		Med; MH		By June 1, 2018, develop a biannual report that describes findings from clinical performance measurement, M&M reviews, grievances, etc. with consolidated action plans and trended date. The second biannual review of each calendar year could serve as an evaluation of the quality management program. It can serve as a stepping off point for the next year's annual QI Plan.
III. D. 2. a. (3)		MH		See III.D.2. a.
III. D. 2. a. (4)		MH		See III.D.2. a.
III. D. 2. a. (5)		MH		See III.D.2. a.
III. D. 2. a. (6)		Med; MH		By May 1, 2018, provide a report responsive to all the requirements of this provision.
III. D. 2. b. (Covered in III. D. 1. c.)		Med; MH		See III.D.1. c.
IV. COMPLIANCE AND QUALITY IMPROVEMENT				
IV. A.		Med; MH		
IV. B.			Med; MH	See III. A. 7. a.
IV. C.	Med; MH			
IV. D.	Med; MH			

A. MEDICAL AND MENTAL HEALTH CARE

1. Intake Screening

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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) is ongoing. 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	Medical Care: The nursing education program has been revised. It is now acceptable. It currently includes: • 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.		

representations, and the factual basis for finding(s):	• 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 curriculum for alcohol/drug withdrawal in-service has improved. Records of 14 inmates who were admitted between July through September 2017 were reviewed. Records were selected from lists provided by CHS. Findings: • Intake screening is accomplished within 5 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. Ten of 12 were seen within the required timeframe. • Of the 4 inmates who reported taking medication at the time of intake, all had treatment continued and the first dose was given within 24 hours. However, one patient with HIV had two avoidable ER visits due to a lag in initiation of medication for HIV in September 2017. Requests for an ID consultation for this patient were mishandled by the scheduler. • Medical histories on intake are scanty. • Three laboratory orders and three referrals were not accomplished. According to recent data, 70% of intake assessments are occurring within eight hours, which is an improvement. The process improvements for the medical and MH screening have been notable, with a reduction in the medical care time from 5.43 hours to 3.33 hours. <u>Mental Health Care:</u> The tool being utilized for mental health and suicide screening now refers approximately 50-55% of the population for mental health evaluation which is down from 60-70% of the population at the time of the last report. While this percentage is still high compared to other similarly sized jail facilities, it represents an improvement. Per audit data provided by CHS, observation of the intake screening process, and as noted above, 70% of intake assessment are occurring within 8 hours with a reduction in overall medical care time.

Monitors' Recommendations:	By February 1, 2018, report on the recommendations contained regarding this paragraph. Medical Care: 1. Improve documentation of medical history and continuity of care. 2. Include the medical intake process in the clinical performance measurement component of the QI Plan, paying special attention to improving adequate medical and behavioral health histories and timely accomplishment of referrals to practitioners. 3. Evaluate and remedy the orders for laboratory tests and referrals to clinicians that "fall through the cracks." 4. Continue to work on decreasing the total intake time to five hours, or less. Mental Health Care: 1. The County should streamline its intake procedure. 2. Existing data should be analyzed for to identify areas for opportunity and bottle necks. 3. Screeners with mental health knowledge should be placed in areas where their skills may be optimized to alleviate bottlenecks and maximize throughput.

Paragraph Author: Johnson	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; 12/7/17	Non-Compliance:
Measures of Compliance:	<u>Mental Health:</u> 1. Results of internal audits demonstrating compliance with NCCHC indicator J-E-05 2. Results of internal audits demonstrating completion of intake screening upon admission 3. Result of internal audit demonstrating 90% or more of inmates who screen positively shall be referred to qualified mental health professionals for further evaluation 4. Record review 5. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	CHS has 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 were QMHPs (social workers) and nurse practitioners during the review period. Internal audits provided related to intake screening indicated that 100% of patients who screen positively are being referred to a QMHP. However, the time from referral to when the patient is seen (2 hours or 4 hours) has not been consistently met and decreased from 70% to 40% within the referral time frame. Analysis by CHS suggest this is due to Detox Screening now being completed by the QMHP which has increased the total time for evaluation. This has also led to a higher number of patients falsely screening positive per anecdotal reports from the QMHPs on the detox unit and patient interviews. For example, a patient who was arrested for drug possession but who denied use of alcohol or opiates was still referred for evaluation and sent to the detox unit despite not exhibiting any signs or symptoms consistent with needing detoxification. CHS has indicated through QI Audit corrective action planning that by February 2018 they will create and train staff on a 6-hour "routine" referral for patients who don't require emergent or urgent referrals. All referrals are either urgent or emergent at this time and though a 5-day routine referral currently exist, it is rarely if ever used. They believe this new category may help their referral fulfillment time frame to appropriately fall within the established parameters.		
Monitor's Recommendations:	1. As discussed above, further efforts to streamline intake should be explored. 2. All mental health clinicians should be trained to appropriately identify symptoms of withdrawal and who is appropriate for placement on the detox unit to avoid false positives (over referral). 3. Proceed with creating a routine 6-hour routine referral for patients that don't require emergent or urgent referrals.		

Paragraph Author: Johnson	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; 12/7/17	Non-Compliance: 3/14; 10/14; 1/16; 7/29/16
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 observation logs for patients placed on suicide precaution. 3. 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)	CHS identified inappropriate leveling by QMHPs which may have led to two preventable deaths by suicide. They were in the process of auditing data to ascertain the severity of the issue at the time of the site tour. Preliminary data was not available at that time. Verbal explanations of the preliminary data included the QMHPs who were inappropriately leveling stating that they used their "clinical judgment" instead of following the guidelines for leveling. 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. 3. Retrain QMHPs on the appropriate criteria and process for leveling. 4. Complete self-audits of accuracy of level and triage system for mental health care to avoid preventable morbidity and mortality.		

Paragraph Author: Greifinger and Johnson	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; 12/7/17	Partial Compliance: 3/3/17, 7/29/16,	Non-Compliance: 3/14 (NR); 10/14
Mental Health Care: Compliance Status:	Compliance: 12/7/17	Partial Compliance: 7/13; 5/15; 3/3/2017	Non-Compliance: 3/14 (NR); 10/14; 1/16; 7/29/16
Measures of Compliance:	Medical Care: • Medical record review Mental Health Care, as above and: 1. Record review of adherence to screening, assessment, and trigger events as described in Appendix A 2. Review of observation logs for patients placed on suicide precaution. 3. Interview of staff and inmates		
Steps taken by the County to Implement this paragraph:	Medical: Not applicable Mental Health Care: 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):	Medical Care: The intake process is currently timely for the identification of serious medical needs and risk of harm. Mental Health Care CHS has significantly improved on this requirement since the last tour. The QMHP can order "Constant Observation" via the "Relocation Form" which is reflected in Cerner. They do not call this "1:1" because an officer may watch more than one patient at a time. Now patients who are identified as Danger to Self/Other in Booking are placed in chairs in booking area where an officer is present to watch. This is documented on the "Physical Sight Check Sheet." If the patient is agitated the patient can be placed into one of the retrofitted holding cells. The Physical Sight Check Sheet is used to document observations through the door. There is also a camera in cell that allows MDCR to maintain visual observation of the patient. The Physical Sight Check Sheet also serves as the Holding Cell Log which documents when the patient entered/exited the holding cell. These forms are maintained by custody. They are not placed into Cerner but are accessible by CHS upon request. Bridging this information from the Physical Sight Check Sheet into Cerner will allow for analysis and, if appropriate, improvement on the process.		

Monitors' Recommendations:	Medical Care: Mental Health Care: 1. Make the Physical Sight Check Sheet data consistently available to CHS and/or bridge the data into Cerner for active analysis, if appropriate, improvement on the process.

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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		
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 rarely sought. Mental Health Care: The electronic health record (EHR) contained records from Jackson. However, fewer charts reviewed contained records that were scanned into the chart from outside providers.		
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: Few progress notes reflected review of prior records. JHS records were available for one patient who died during the past year. Failure to consult these records posed a substantial challenge to diagnosis and treatment of this patient. Mental Health Care: Many records are available from prior contacts within the Jackson Health System (JHS) but they were inconsistently referenced in the CHS progress notes, and fewer referred to the content of outside medical records (e.g., such as transfer from the ED of a Ft. Lauderdale hospital). However, CHS consistently referenced the outside hospital medical records of patients who had just returned from forensic hospitalizations (e.g., patients sent out for restoration of competency). QMHPs consistently verbalized that they review the JHS records of patients and one QMHP was observed doing so during the tour.		
Monitors' Recommendations:	By March 1, 2018 identify the clinical performance measures, and update quarterly. Medical Care: 1. Monitor clinical performance in this area and implement effective remedies. Mental Health Care: 1. Practitioners should document their review of available medical records by incorporating the relevant findings into their documentation. Incorporating this important in the QMHP's decision-making process can significantly impact diagnostic and treatment choices (i.e., suicidality, mental illness, etc.).		

Paragraph Author: Greifinger and Johnson	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: 12/7/17	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: 12/7/17	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: Behavioral health staff now operates the evaluation and treatment for withdrawal/detoxification. 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 and Mental Health Care: Diagnosis and treatment of withdrawal has improved substantially. Patients in active withdrawal are monitored with CIWA and COWS and are treated appropriately. CHS has no provision for methadone maintenance for pregnant inmates who have been enrolled in a methadone maintenance program in the community. Pregnant patients who have been on methadone are monitored and treated with medication assisted therapy, as medically appropriate.		
Monitors' Recommendations:	No additional recommendations at this time.		

Paragraph Author: Greifinger and Johnson	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: 12/7/17	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: 12/7/17	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:	Medical Care: • Review training materials Mental Health Care: • Review training materials		
Steps taken by the County to Implement this paragraph:	Revision of training materials so that they conform to the correctional environment.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: CHS developed new employee training curriculum that is specific to the provision of health care in correctional settings since the last site visit. The curriculum for nurses includes training in the intake policy with discussion about the purpose of screening, how to best elicit information during the encounter and ways to address challenges in getting intake screening done timely. The session concludes with a case scenario discussion to assist nurses in making decisions about referral and follow up care with an inmate in withdrawal. This training meets the requirements for this item. Mental Health Care: CHS has developed an intake screening training curriculum for nurses that includes: direction on the purpose of screening, effective information gathering, and case review/discussion about referral and follow-up for an inmate experiencing withdrawal. Discussion with Asst. Medical Monitor identified several improvements since the last tour that indicates CHS is now in compliance with this paragraph.		
Monitor's Recommendations:	No additional recommendations at this time.		

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; 12/7/17
Measures of Compliance:	*The measures of compliance from the Settlement Agreement and/or Consent Agreement and/or what you will use to measure compliance* • Medical record review		
Steps taken by the County to Implement this paragraph:	The County initiated a policy and procedure to perform initial health assessments.		
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):	In a review of 14 records of patients in custody for 14 or more days (intakes July – September 2017), none had documented health assessments. In further review of six records with the Chief Nursing Officer it was apparent that health assessments were scheduled but did not take place or were not scheduled timely.		
Monitor's Recommendations:	By May 1, 2018, assure all incoming and current patient care meets requirements. Provide documentation of such by this date. 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: Johnson	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; 12/7/17	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16; 3/3/2017
Measures of Compliance:	Mental Health: • 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. • Review of clinical performance measurements		
Steps taken by the County to Implement this paragraph:	Interagency Policy 003 "Inmate Suicide Prevention and Response Plan was last reviewed in 11/2017 prior to the onsite tour.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Per review of QI audits and chart review, 100% of appropriate patients are receiving a Behavioral Health screen on intake. Suicide screening is also occurring per policy and as of 11/2017 QI audits reflect 100% of patients who screen positive for suicide risk are being appropriately placed on suicide precaution (level 1A) with appropriate safety measures (e.g., suicide vest). However, according to 11/2017 QI audit data, only 78% of 5-day follow-ups are occurring (per policy when a patient is discharge from suicide precaution) due to missed orders by the QMHP. This was an improvement from 40% in 8/2017. This represents missed opportunities to further mitigate suicide risk by ensuring timely clinical follow-up with patients. The corrective action plan states the QMHPs will be retrained on the referral process. Of note, concern was raised during the tour regarding CHS' failure to follow recommended QI guidelines for obtaining, analyzing, and reporting data. For example, they were instruction to refrain from having physicians obtain and analyze the QI data for their own areas due to risk of bias. However, CHS did just that. While upon review the MH QI data appears to be valid, there are still questions as to the veracity of the analysis of the data that was provided.		
Monitor's Recommendations:	1. Provide data with timely analysis and explanation of findings. 2. Follow through with all identified steps in the corrective action plan to ensure provision of suitable access to follow-up care is obtained by patients discharged from suicide precautions.		

Paragraph Author: Johnson	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; 12/7/17	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16
Measures of Compliance:	<u>Mental Health:</u> 1. Review of policy regarding mental health evaluation and screening 2. Record review for adherence to trigger events, referral and assessment as described in Appendix A. 3. Interview of staff and inmates. 4. Review of all adverse events involving inmates with mental health and substance misuse issues.		
Steps taken by the County to Implement this paragraph:	CHS and MDCR have developed an Inmate Suicide Risk and Prevention Plan policy IP-003. Emergency Treatment Orders (ETOs) are now being tracked by both MDCR and CHS (via QI audit).		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Mental Health assessments are being performed after triggering events. However, per MH staff report, they do not always utilize the CHS suicide risk assessment and instead may document their own free text assessments. While what they described assessing was appropriate, not utilizing the suicide risk assessment will result in essential data being lost to follow-up audits and analysis. CHS and MDCR are tracking emergency treatment orders and a correlation between ETOs and use of force was noted. Upon analysis by CHS it became clear that MDCR is classifying all ETOs as use of force even when force was not used. Face-to-face evaluations by the Psychiatrist are now happening within 24-hours of notification of an ETO per chart review which is an improvement from the last report. Analysis of the ETO data suggests that ETOs are occurring more often in patients who are non-adherent to prescribed medication and in those who have refused to consent for medication.		
Monitor's Recommendations:	<u>By May 1, 2018 provide documentation of compliance with this paragraph and recommendations.</u> 1. Train MH staff on the appropriate use of the suicide risk assessment. 2. Please analyze the ETO data to ascertain the underlying factors associated with ETOs and possible ways to decrease their incidence. 3. Work with MDCR to declassify ETOs as use of force if the use of force was not required to administer the ETO.		

Paragraph Author: Johnson	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; 12/7/17	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR); 3/3/2017
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. Review of Mental Health Review Committee minutes from 9/2017.		
Steps taken by the County to Implement this paragraph:	3. 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. CHS has since began to audit its compliance to this requirement.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Again, the 'risk profile' that was submitted was a copy of the CHS Suicide Risk Assessment (SRA) that is utilized at intake. The SRA considers the assessment factors identified in Appendix A including the patients' strengths and weaknesses, including the patient's support systems to assess the patient's risk for self-harm. Audit data provided was solely included in the Mental Health Review Committee minutes from 9/2017. In the minutes, data from 8/2017 was analyzed and of 138 scheduled Interdisciplinary Treatment Team (IDTT) meetings, 134 (97%) occurred. Analysis of the data yielded the explanation that "miscommunication" led to the IDTTs happening late. No explanation of what "miscommunication" occurred in the analysis but the corrective action plan indicates there may have been a "coverage" lapse that led to the IDTTs not occurring. CHS indicated that IT will begin to track reports of IDTTs for future analysis. More recent data was not provided in response to my information request. The Director of Social Work performed the analysis. However, she has since left the organization presumably leaving a gap in who will address this requirement. A new Director of SW had yet to be hired at the time of this report.		
Monitor's Recommendations:	In order to achieve substantial compliance, deeper analysis of the data is required as well as ongoing demonstration that the County is performing regular self-audits and reviews of its IDTTs 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; 12/7/17
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. Policy does not require a practitioner visit.		
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):	• Nurses see patients who report a history of medication for chronic disease on intake. Nurses consult with prescribing practitioners for medication orders. By practice, they are not typically seen by the practitioner for up to 14 days. • 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 scheduled 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 • CHS clinical performance monitoring for chronic disease is currently unreliable.		
Monitor's Recommendations:	By February 1, 2018, provide report on clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time. Clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time.		

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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: See medical section above		
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 12 inmates identified as having emergent or urgent health care needs by the screening nurse all were seen by nurses within the required timeframe and received their first dose of medication within 24 hours. All but two of the 14 were seen by practitioners within four hours of referral. Of nine inmates identified with a chronic condition requiring continuity of care, three were seen by a provider within 48 hours of intake screening. Mental Health Care: Both the records reviewed, and the data provided demonstrate a significant improvement since the last tour. Patients are receiving their first dose of medication within 24 hours and that the majority are being seen within 24 hours by a provider. Labs were ordered when the patient was seen by a provider but not always drawn/executed resulting in missed data that impacts treatment decisions (e.g., psychotropic mood stabilizer blood levels ordered but not drawn). CHS is aware of the incomplete lab draws and is working on solutions to address this issue. Analysis of this issue suggests that QMHPs who were part-time were not present to receive the notification that the labs had not been drawn.		
Monitor's Recommendations:	Medical Care: 1. Clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time. Mental Health Care: 1. Follow through on the corrective actions plan to ensure that an on-duty QMHP is notified of missed Mental Health lab orders to ensure additional chances for execution of the orders.		

Paragraph Author: Greifinger and Johnson	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: 12/7/17	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: 12/7/17	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 has implemented the training required. 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: CHS developed a three training for nurses to conduct health assessments. The first day is classroom based physical assessment training and review of policy and procedure. The next two days' nurses perform assessments under the supervision of selected physician preceptors, which includes demonstration of competency. Health assessments that were reviewed are complete and well-documented. Mental Health Care: The information provided by CHS included power point and PDF presentations of training materials as it relates to mental health assessments and referrals that included: BH Standards and Guidelines. While pre-and post-test materials and a list of who "completed" the training were provided, scores were not. The data infers that everyone who completed the course passed the post-test. In the future (and to achieve full compliance), this information will be necessary. Based on preliminary audit data from 9/2017 to 11/2017 of MH leveling, significant concerns surrounding mistakes in leveling have been discovered by CHS. CHS has indicated that the training process has to be updated to correct errors in communication that may have led to the leveling mistakes (e.g., a patient's charges not being appropriately considered when deciding the MH level).		

Monitor's Recommendations:	By February 1, 2018, provide report on clinical performance measurement with data analysis, problem identification, remedy, and re-measurement over time. Medical Care: 1. Supervise through clinical performance measurement. 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 Johnson	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; 12/7/17	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; 12/7/17	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:	No additional recommendations at this time.		

Paragraph Author: Greifinger and Johnson	III. 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; 12/7/17	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; 12/7/17	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 prior to the tour that indicated the County has provided a way for detainees with impaired communication to access care. However, during site tours Correctional Officers and MH Staff verbally indicated that illiterate or disabled patients were receiving assistance with sick call.		
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: Language lines are available and used for patients who do not speak English or Spanish. The TGK medication nurse reported accepting verbal sick call requests for illiterate patients or disabled patients. Mental Health Care: See Medical Care above. However, the data is not being tracked in a way that allows CHS to assess if the processes in place are being followed. Sick call requests are currently tracked in log books at each facility. No other data was provided upon request, including audits. CHS is auditing Urgent Care sick call requests, they are not auditing BH sick calls.		
Monitors' Recommendations:	Medical Care: Mental Health Care: Audit BH sick call requests to ensure the BH sick call process is being followed.		

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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: • 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 scan receipt of the sick call request to initiate the request into a log that CHS has developed since the last site visit to ensure timeliness in responding to inmate requests for care. • Nurses also distribute sick call request forms to individual inmates upon request and leave a supply at the officer's desk as necessary. Mental Health Care: See previous report.		
Monitor's Recommendations:	No additional recommendations at this time.		

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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	This is a shared issue with the grievance process in both medical and mental health and the grievances were reviewed together with the Medical Monitor, Mental Health Monitor, and CHS During the site tour.		
Monitors' Recommendations:	By February 1, 2018, provide documentation of process and outcomes for delivery of care. 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. 4. The County should revisit the coding system for grievances. The categorization as substantiated or unsubstantiated serves no useful purpose. Further, it is belittling. <u>Mental Health Care:</u> 1. 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 Johnson	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; 12/7/17
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; 12/7/17
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: 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. At PTDC, we observed providers conducting clinic with the door open, and an officer immediately outside supervising a waiting room of approximately six inmates waiting to be seen. 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). On the detox unit, practitioners are not allowed to enter the patient's room; the patient is expected to come out of the room and sit in a chair. This brings the conversation into a public space, especially difficult for a patient who may be suffering from withdrawal. Mental Health Care: CHS has arranged for medical staff to come to the mental health housing units to provide chronic care services to mental health patients. This was not observed during the tour. However, direct questioning of medical staff, including hypotheticals involving mental health patients in need of chronic care, reflected knowledge of the referral process and active involvement (e.g., placing a phone call to the provider/clinic in question to ensure an appointment is scheduled).

	Privacy provided during clinical interactions varied by facility. Correctional staff remained in closer proximity to the QMHP in TGK and PTDC bringing into question privacy concerns. At MWDC staff sat outside the office, or at times in the doorway which also raises privacy concerns.
Monitors' Recommendations:	Medical Care: 1. Patients must be provided with auditory (and visual) privacy during clinical encounters. Such privacy should always be provided vis-à-vis other inmates. It is recognized that, at times in a jail setting, such privacy cannot be provided vis-a- vis custody staff. However, on those occasions, breaching of privacy should be based on a patient-specific need-to-know, or need-to-be-present. Mental Health Care: 3. Access to chronic care for mental health patients with SMI should be tracked and audited quarterly to ensure appropriate access to services is happening. 4. During clinical encounters patients should be afforded privacy as long as security concerns do not indicate.

4. Medication Administration and Management

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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: CHS has an extensive section in New Employee Orientation designed to teach nurses how to administer medication safely and correctly in the correctional setting. Furthermore, CHS and MDCDC developed a joint training for health care and medical staff about medication administration, the role of the nurse and correctional officer and ways to prevent hoarding, misuse and diversion. CHS and MDCDC supervisors monitor staff practices during medication administration directly and via video-tape to support best practices. These are significant improvements since the last site visit. However, a number of problems with the administration of medications and its documentation remain and include. • The new policy and procedure has yet to be fully implemented, for example, at TGK some officers did mouth checks and others did not. In these cases, there were no hand checks. • 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. • 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. • Officers were observed not to conduct hand checks for medications and at times were distracted when conducting mouth checks. In PTDC inmates were observed going into the restroom immediately after receiving medication and were not stopped or searched by correctional officers for possible contraband. • The number of inmates prescribed medication for difficulty sleeping seems inordinately large compared to other correctional settings.

	Mental Health Care: The policy requires CHS to notify the psychiatrist of medication after repeated refusals and counseling by a Nurse. However, CHS notifies the Associate Medical Director of Behavioral Health (AMD-BH) when a patient has refused clinically significant amounts of his or her medication and then the AMD-BH notifies the psychiatrist (e.g., if part-time) or a proxy to address the issue. This process was explained by the AMD-BH after asking a QMHP at PTDC how they were notified about med refusals. While the process as described allows for medication refusal to be addressed when staff are offsite, it will be limited by the time and availability of the AMD-BH to address this issue in addition to the other responsibilities of the role. The medication administration process was observed at PTDC for 2 patients. While the overall process has improved significantly since the last tour: all meds that were given were taken from blister cards and the officer and nurse stood side-by-side while administering the medication. Nursing performed mouth checks with the officer watching. A detailed mouth check by the correctional officer, per policy, was not performed during my observations. There is inconsistent sharing of data between MDCR and CHS on patients who were founds to have excessive medications (contraband) above the housing unit level. This was evidenced by CHS initially indicating that they had not received the data from MDCR. Upon further discussion during the tour it was discovered that the data was shared in a meeting format but not taken and shared with the CHS staff that would need to investigate and address the issue. The MAR is in a separate EMR and hinders fluid review of a patient's medication adherence. Cerner and Sapphire (MAR) do not communicate with each other.
Monitors' Recommendations:	By April 1, 2018 provide process information and outcomes for recommendations. Medical Care: 1. Pursue plans to implement patient specific packaging when converting to the Cerner EMAR. 2. Refer patients with serial missed medications to practitioner to determine reasons and implement remedies. 3. Continue auditing medication administration to ensure that actual practices are consistent with policy and procedure. 4. Implement a medication utilization project through the Pharmacy & Therapeutics sub-committee to minimize overuse of medications, e.g., medication for sleep. 5. Maintain a perpetual inventory of medications. Mental Health Care: 1. Streamline the notification process for QMHPs to address the issues of part-time QMHPs and the AMD-BH being the responsible for addressing or conveying med refusals. 2. Work with MDCR to actively participate in mouth checks as this may reduce the amount of contraband medications found on housing units. 3. Improve communication between CHS and MDCR on all levels regarding excessive medication that is founds to allow for both parties to investigate and address the issue 4. Explore ways to simplify access to the MAR. Ease of access will simplify QMHPs' ability to review the MAR and possibly to address medication non-adherence rather than waiting for the current process.

Paragraph Author: Greifinger and Johnson	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: 12/7/17	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: 12/7/17	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: This measure is audited by CHS every quarter and they have reported meeting this measure 100% for the last 2 quarters.		
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: Medication is currently given within 24 hours of the order, based on a review of 14 medical records. Mental Health Care: Medication is currently given within 24 hours of the order, based on a review of 11 medical records.		
Monitor's Recommendations:	Medical Care: 1. Measure performance in this area on a regular basis and implement remedies where appropriate. Mental Health Care: As above		

Paragraph Author: Greifinger and Johnson	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; 12/7/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 12/7/17	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: 1. Review policy 2. Review intake screening 3. Review audits 4. Review of medical records		
Steps taken by the County to Implement this paragraph:	Medical Care: See III. A. 2. a. Mental Health Care: CHS-033 addresses this section.		
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: Quarterly audits reviewed since the last tour indicated that CHS has improved from 20% at baseline measure in (March 2017) to 100% in April and August 2017. Of 16 charts reviewed, 9 were of patients who should have been seen by a psychiatrist within 48 hours of entry to the jail. However, only 4 (<50%) were seen by a psychiatrist within 48 hours. Three of the patients were seen by an ARNP for the CHS Initial Biopsychosocial evaluation on the day of intake.		
Monitor's Recommendations:	Medical Care: See III. A. 2. a. Mental Health Care: Recommend communication with medical providers for mental health patients who are also on the medical case load who have not been seen within the 48 hours of entry into the jail.		

Paragraph Author: Johnson	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; 12/7/17	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:	In October 2017 CHS began audits of the appropriateness of leveling.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS audits of the appropriateness of level 3 and 4 patients from September 2017 were found to 100% appropriate. However, no analysis of the data reviewed, or the factors considered in the outcome were included. These audits appear to have been performed for the upcoming site tour. A review of 10 patients' records resulted in 3 being discharged before they were able to obtain all the services at their initial level. Of the remaining 7 patients, the documentation through all the levels demonstrated that they had received the appropriate services required at each level. Patients were relevelled frequently. The notes documenting treatment/rounding in segregation were consistently inadequate and decisions were made on patients that were not supported. Decision making included review and adjustment of prescribed psychotropic medications. However, inconsistencies in leveling that were discovered by CHS prior to this tour bring into question the appropriateness of the treatment provided at each level.		
Monitor's Recommendations:	Complete audits of appropriateness of leveling and retrain MH staff to assess and assign the correct level of care.		

Paragraph Author: Johnson	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: 12/7/17, 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:	CHS implemented policy 026-Medication Administration Services		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The charts of 7 patients who were identified as refusing psychotropic mediations in September 2017 were reviewed. Only 2 out of the 7 charts reflected any indication that the patient had refused medication. In the first case the patient was counseled by a Nurse but the medication that was refused was not noted. The patient was seen by a psychiatrist within 24 hours, but no mention was made of the patient's refusal of medication suggesting that either the psychiatrist did not review the chart or that they overlooked the med refusal. In the second case the patient was seen by a psychiatrist the same day they refused medication and it was directly mentioned in the psychiatrist's progress note. The policy mentions a "*Nurse/Provider Communication*" but if this means of notification was used it was not noted in the Documentation section of Cerner.		
Monitor's Recommendations:	Recommend including the notification of medication refusals in the Documentation section of Cerner or indicate it by other means (e.g., perhaps a header that indicates medication non-adherence by linking it to a diagnosis).		

Paragraph Author: Greifinger and Johnson	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; 12/7/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/3/2017; 12/7/17	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. Interviews with staff		
Steps taken by the County to Implement this paragraph:	Medical Care: Major focused review of the accomplishment of laboratory orders to determine the barriers and opportunities. 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. Mental Health Care: See III. A. 2. f.		
Monitor's Recommendations:	By February 1, 2017 address the systems issues of this requirement; provide evidence/documentation of outcome of remedies, including action plans. Medical Care: 1. Repair the systems described in this paragraph of the CA. 2. Monitor performance and implement remedies, as appropriate. Mental Health Care: See recommendations for III. A. 2. f.		

Paragraph Author: Greifinger and Johnson	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: 12/7/17	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: 12/7/17	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: Continue audits of medication administration. Provide periodic coaching and targeted re-training based upon audit results and supervisor observations. Mental Health Care: See recommendations for III. A. 2. f.		

5. Record Keeping

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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 has integrated the medication module the EHR (Cerner). Mental Health Care: The EHR now indicates when a patient has been discharged from the jail. However, the MAR is still separate from Cerner on a system called Sapphire. Sapphire requires a separate login to access records and the two systems thus far do not interface.		

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: • 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 is now done on a CHS rapid response sheet which is scanned into the record timely after de-briefing. The use of paper forms to communicate to Corrections is phasing out with more information communicated electronically. Mental Health Care: 1) The MAR remains separate from the Cerner, the EHR system. This is a barrier to ease of access during BH evaluations.
Monitors' Recommendations:	By April 1, 2018, demonstrate compliance with recommendations. Medical Care: 1. Eliminate paper systems for ordering x-rays and other diagnostics. 2. Train and supervise staff to document encounters contemporaneously Mental Health Care: 1. Explore ways to simplify access to the MAR. Ease of access will simplify QMHPs' ability to review the MAR,

Paragraph Author: Johnson	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; 12/7/17	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 mental health records 3. Review of scheduling system		
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. However, they do not "order" groups in the electronic health record (EHR). They have a group schedule and operate this on a drop-in basis system. They chart on patients who participate but they do not track whether people who were assigned group as part of treatment plan are participating via the EHR. They do not track their attendance or reasons for refusals. The electronic scheduling system does not track wait times, and automatically reschedules patients who have missed their appointments per CHS. CHS was unable to provided data on missed appointments because of this. However, data review and audits reflect that mental health professionals are seeing mentally ill patients as clinically appropriate, in accordance with the Agreement's requirements.		
Monitor's Recommendations:	By March 1, 2018, provide a written evaluation of the electronic scheduling system, and plan for expeditious achievement with the requirements of this paragraph.		

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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.		

	III. A. 5. d. CHS shall submit medical and mental healtl health care. CHS shall obtain records of car timely implement specialist recommendati for non-implementation).		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 7/29/16, 3/3/17; 12/7/17	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; 12/7/17	Non-Compliance: 5/15 (NR); 1/16 (NR)
	Medical Care: • Medical record review Mental Health Care: 1. Review of policy relevant to collateral i 2. Review of medical records. 3. Interview of staff and 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: • 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 routinely notified. However, there is great variation in the documentation by nurses about the results and recommendations. • The recommendations of outside physicians were followed in seven of 10 charts reviewed of patients sent to the ED. In two of the charts there was no documentation by the provider of the rationale for not following the recommendations. • There was evidence that records from hospital EDs other than JHS were received and reviewed by providers to inform their clinical decisions. Mental Health Care: Many records are available from prior contacts within the Jackson Health System (JHS) but they were inconsistently referenced in the CHS progress notes, and fewer referred to the content of outside medical records (e.g., such as transfer from the ED of a Ft. Lauderdale hospital). However, CHS consistently referenced the outside hospital medical records of patients who had just returned from forensic hospitalizations (e.g., patients sent out for restoration of competency). QMHPs consistently verbalized that they review the JHS records of patients and one QMHP was observed doing so • during the tour.		

Monitors' Recommendations:	By April 1, 2018, provide a report on the adoption of recommendations and compliance with the paragraph. Medical Care: 1. Suggest development of a template or power form for nurses to use in documenting consistent information about patients upon return from off-site care and communication with providers about continuation of care. Mental Health Care: 1. Practitioners should document their review of available medical records by incorporating the relevant findings into their documentation. Incorporating this important in the QMHP's decision-making process can significantly impact diagnostic and treatment choices (i.e., suicidality, mental illness, choice of medication, etc.).

6. Discharge Planning

Paragraph Author: Greifinger and Johnson	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; 12/7/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 1/16; 7/29/16; 3/3/2017; 12/7/17	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. • 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. • There is no documentation of a functioning system for continuity of care on discharge. Mental Health Care: CHS provided a log of patients discharged from the jail in September 2017 who were given a bridge supply of medication(s). They also provided an audit of level 1A and 1B patients discharged from court, and a log of patients in September 2017. Review of 5 charts showed that 100% of charts reviewed said that a supply of bridge medication was being provided. Review of the above data provided by CHS indicated that almost all patients are receiving Discharge Planning Services soon after arriving at the jail that is clearly documented in the Discharge Planning Assessment. The ordering and plan of administration of a bridge supply of medication(s) was consistently included in CHS Discharge Summary.
	However, it should be noted that while all patients appear to receive a Discharge Planning Services visit, fewer patients received a CHS Discharge Summary. It was unclear from review of the data provided and chart review why this was occurring. Although there is no connectivity between the jail management system and Cerner to communicate about discharge dates, the "anticipated release date" was usually included in the Discharge Planning Assessment. However, there is no documentation of a functioning system for continuity of care on discharge. The AMD-BH said CHS is working on community partnerships that may assist with the latter if the patient does not follow-up at a Jackson Health System facility.
Monitor's Recommendations:	By June 1, 2018 provide a report regarding compliance with this paragraph. Medical Care 1. Implement effective discharge planning including medication and referral to community resources. Track data on results. Mental Health Care: 1. Work on community partnerships to improve continuity of care on discharge for patients that do not seek all of their medical services at a Jackson Health System facility.

Paragraph Author: Greifinger and Johnson	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; 12/7/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 1/16; 7/29/16; 3/3/2017; 12/7/17	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:	By June 1, 2018 provide a report regarding compliance with this paragraph. 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 using reliable performance audits.		

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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 few reports 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: Please see III. A. 6. A. 1.		
Monitor's Recommendations:	By June 1, 2018 provide a report regarding compliance with this paragraph. Medical Care: Please see III. A. 6. A. 1. Mental Health Care: 1. Please see III. A. 6. A. 1.		

7. Mortality and Morbidity Reviews

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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. Within 45 days of each death or serious suicide attempt, provide report for review to Monitor and United State 3. 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. 4. Interviews with staff. 5. Review of the Psychological Autopsy. 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:	With technical assistance from the monitors, CHS is working to improve their self-critical analysis		
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):	1. M&M reviews are much timelier. They are somewhat self-critical with corrective action plans. The findings and action plans are not integrated into the quality management program and are not evaluated for effectiveness over time. The M&M's are not reviewed and updated when new information is made available, e.g., autopsy reports and toxicology reports.		

Monitors' Recommendations:	By March 1, 2018, demonstrate compliance with these recommendations. 1. M&M reviews are much timelier. They are somewhat self-critical with corrective action plans. The findings and action plans are not integrated into the quality management program and are not evaluated for effectiveness over time. The M&M's are not reviewed and updated when new information is made available, e.g., autopsy reports and toxicology reports. 2. Analysis and corrective action should be done conjointly between CHS and MDCR.

Paragraph Author: Greifinger and Johnson	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; 12/7/17
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; 12/7/17
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:	See III.B.1 a. and III A.3.a.(4) Medical Care: See Comments in III.A.7.a. Mental Health Care: 1. See Comments in III.A.7. a.		

Paragraph Author: Greifinger and Johnson	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; 12/7/17
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; 12/7/17
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: The County did not produce a bi-annual report of M&M or Corrective Action Plan (CAP) implementation into policies. However, CHS did provide two master CAP lists that they use for tracking purposes.		
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: The biannual reports were not produced. Review of the CAP demonstrated that they neither updated the plans as new data became available nor identified who the responsible party for the CAP was (e.g., vs. CAP assignment solely to a committee).		
Monitors' Recommendations:	By February 1, 2018, provide data for July – December 2017. Medical Care: 1. Develop a policy and procedure on morbidity and mortality review and implement it. 2. Produce bi-annual reports that include categorization of critical incidents, findings, action plans, and follow-up to determine if action plans have been implemented and if they have been effective. Mental Health Care: 1. Provide a bi-annual report to the monitors per this requirement and include categorization of critical incidents, findings, analysis of data, corrective action plans, and follow-up to update and determine if action plans have been implemented and were effective.		

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; 12/7/17
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. • 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. • 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. A focused review of eight medical records of patients with potentially serious conditions, seen by nurses during November 2017, revealed substantial deficiencies in the documented history, physical examination, assessment consistent with history and exam findings, and timely referrals. • Of ten patients returning from the ED in September 2017, three had preventable deterioration had they been cared for appropriately in the three months prior to their visit. Two had recommendations from the ED that were neither followed nor did they have a documented rationale for deviating from the recommendations of the ED physicians. Intoxication & Withdrawal Vastly improved care, in comparison to the care documented during Compliance Tour #7.
Monitor's Recommendations:	By February 1, 2018, provide performance measures. With analysis and remedies for acute care and detox.

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; 12/7/17	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: 12/7/17	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):	Vastly improved monitoring, documentation, and treatment.		
Monitor's Recommendations:	No additional recommendations at this time.		

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; 12/7/17	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):	• Chronic care currently follows nationally-accepted guidelines. • Enrollment in chronic care occurs more often than it used to, however, patients are not seen in a timely manner by a practitioner. • 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 scheduled to coincide with the time medication needs to be renewed resulting in discontinuity of care. • Diabetes: only 2 of 5 patients were scheduled for chronic care visits within 14 days; 1 of 5 had a documented degree of control. 1 of 5 had documentation of pneumococcal vaccine and 0 of 5 had documentation of influenza vaccine. • The results were similar for seizure disorder and hypertension. A patient who was seen in the ED in August 2017 returned with medication orders, however no levels were ordered for this patient. The patient was returned to the ED two more times over the next four weeks with symptoms consistent with seizure medication toxicity. • Performance was good for patients on anticoagulant medication. • Note: As of 12/7/17, only 0.05% of MDCR inmates were vaccinated against influenza.		
Monitor's Recommendations:	By February 1, 2018, provide report regarding the recommendations. 1. Improve the reliability of clinical performance measurement in the area of chronic disease. 2. Measure clinical performance as part of the quality management program, identify deficiencies, implement remedies and re-measure over time. 3. Improve rates of vaccination against influenza for general health purposes, not the least of which is employee health and public health.		

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 them 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; 12/7/17	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 Johnson	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: 12/7/17	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; 12/7/17	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 The monitor did not review this aspect of care on this visit. Mental Health Care: CHS recently completed its revision of the policy on the use of clinical restraint. Emergency Treatment Orders are no longer included in the policy.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care Mental Health Care: There was once incident identified by CHS where a patient was placed into 2-point restraints and a helmet due to self-injurious behaviors. Review of documentation in the chart did not readily reflect the use of restraints on the patient, even for a short time period. No other data was provided.		

Monitor's Recommendations:	By April 1, 2018, provide a report regarding the CHS' and MDCR's compliance with this requirement. Mental Health Care: I was unable to verify that if the use of restraints occurred per this requirement and per the CHS policy for restraint and seclusion. I recommend that any order for the use of restraints be appropriately reflected in the EHR's and in documentation.

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; 12/7/17	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):	• In only seven out of 15 records reviewed was it possible to ascertain if inmates were seen immediately following use of force. • There is no documentation that the medical evaluation of the inmate is outside the hearing of officers or other inmates. • In none of the 15 incidents reviewed was any suspicion raised that the injury could have been a result of staff-on-inmate abuse. • There is no evidence that medical staff understands or know how to report a suspicion of staff-on-inmate abuse as required by the Settlement Agreement. • Medical evaluation and care provided was adequate in all but one case. • In 12 of 15 incidents a HS Incident Addendum was completed. It appears that completing the form is at the request of custody staff rather than as described in the Settlement Agreement, which is more limited in its requirement.		
Monitor's Recommendations:	By April 1, 2018 provide a report regarding the recommendations and documentation. 1. Develop a policy on care surrounding use of force. 2. Train staff on this policy. 3. Measure conformance to the policy on a regular, periodic basis.		

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; 12/7/17	Non-Compliance:7/13 (NR); 3/14 (NR); 5/15 (NR); 1/16 (NR); 7/29/16, 3/3/17; 12
7M17easures 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):	See III. B. 3. b.		
Monitor's Recommendations:	<u>By April 1, 2018 provide a report regarding assessment and implementation of recommendations.</u> 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.		

B. MENTAL HEALTH CARE AND SUICIDE PREVENTION

1. Referral Process and Access to Care

Paragraph Author: Johnson	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; 12/7/17	Non-Compliance: 3/14; 10/14 (NR); 5/15 (NR); 1/16 (NR);
Unresolved/partially resolved issues from previous tour	3/3/17: Perform intermittent internal reviews (audits) of intake screening for accuracy of leveling.		
Measures of Compliance:	Mental Health: 1. Review of medical records for implementation of policy. 2. Review of internal audits.		
Steps taken by the County to Implement this paragraph:	Referral to a QMHP is occurring at the time of initial screening. Self-referral can occur via the sick call process.		
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. Two QMPs at PTDC reported the ability to refer patients to a QMHP by placing them on the QMHPs schedule, or calling to have them seen the same if they assessed the patient to be in need of urgent MH evaluation (e.g., floridly psychotic).		

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. Provide audits with relevant patient jail numbers that reflect that a designated social worker or the Charge Nurse will be available to assist patients with cognitive disabilities with any health care requests, and that a specific designee was assigned for patient with severe cognitive impairment (e.g., from SMI).

Paragraph Author: Johnson	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; 12/7/17	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 is providing a continuum of care services, has been diligent in working to hire new staff to meet staffing needs, and collect data relevant to the provision of mental health care.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	While CHS's provision of care has improved since the last tour (e.g., improvements in intake and detox treatment, including the measurement of vital signs), their creation and maintenance of mechanisms sufficient to measure whether they are providing constitutionally adequate care are still be developed and at the current time are not wholly reliable. The fact that they are now consistently measuring some provision of care (e.g., use of force in MH patients) is a significant improvement.		
Monitor's Recommendations:	Continue to streamline data collection, analysis, and the development of corrective action plans that are regularly updated and followed through to completion.		

2. Mental Health Treatment

Paragraph Author: Johnson	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.		
Compliance Status this tour:	Compliance:	Partial Compliance: 7/13; 1/16; 7/29/16; 3/3/2017; 12/7/17	Non-Compliance: 3/14;10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: 1. Review of manual of mental health policies and procedures 2. Level of care and provision of mental health services including medication management, group therapy and discharge planning 3. Review of mental health staffing vs. mental health population 4. Review of internal audits 5. Review implementation of projected changes in mental health services including: Medical Appointment Scheduling System (MASS), Sapphire (Physician Order Entry System and Electronic Drug 6. Monitoring) and the Electronic Medical Record, Cerner, all projected in August 2014.		
Steps taken by the County to Implement this paragraph:	CHS is providing a continuum of care services, has been diligent in working to hire new staff to meet staffing needs, and collect data relevant to the provision of mental health care.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	While CHS's provision of care has improved since the last tour (e.g., improvements in intake and detox treatment, including the measurement of vital signs), their creation and maintenance of mechanisms sufficient to measure whether they are providing constitutionally adequate care are still be developed and at the current time are not wholly reliable. The fact that they are now consistently measuring some provision of care (e.g., use of force in MH patients) is a significant improvement.		
Monitor's Recommendations:	Continue to streamline data collection, analysis, and the development of corrective action plans that are regularly updated and followed through to completion.		

Paragraph Author: Johnson	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; 12/7/17	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)	Timely treatment for inmates remains an issue despite improvements in the timeliness of referrals and the adequacy of treatments provided (e.g., delay in lab draws or notifications of medication refusals). CHS can monitor the type and timeliness of their services from point of intake through the booking process. They can track the type and timeliness of referrals made to both mental health and medical providers. In the booking process, they rely on MDCR to provide observation and do not have access to the data collected by officers for their use in treatment decision-making. The mechanism to track adequate and timely treatment response in relation to referrals from medical and custody once a patient has entered the jail is unclear. Staff report indicates that many issues are resolved via verbal communication or in response to telephone calls/pagers. The time and nature of the referral received is not reliably entered the EHRS. Consequently, there is no reliable way to monitor and verify the adequacy and timeliness of the response.		
Monitor's Recommendations:	Continue to focus on improving identified factors that impact the timeliness of care of patients (i.e., missed lab draws, medication refusal notification, incorrect leveling, etc.).		

Paragraph Author: Johnson	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; 12/7/17	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)	This area has significantly improved. Clinical forms have been revised to include documentation of an initial treatment plan. This treatment plan "pulls forward" and is included in subsequent progress notes. Of 10 charts that were reviewed 100% demonstrated an initial treatment plan in the QMHPs note. The quality of the plans varied, and it was difficult to track some aspects of plans (e.g., group therapy attendance). Psychiatry notes also included initial treatment plans. Despite being patient centered, the treatment plans were not individualized beyond medication differences for psychiatry notes and many of the non-MD treatment plans were very general. Staff explained that once a patient received an interdisciplinary treatment plan component of the psychiatrist and non-MD provider notes are integrated into a comprehensive treatment plan. For patients that were at a specific level long enough to receive an interdisciplinary treatment plan this was true. However, most patient charts reviewed revealed that patients frequently change level before an interdisciplinary treatment plan is required and patients at the lower levels of care (III and IV) rarely obtain an interdisciplinary treatment plan.		
Monitor's Recommendations:	All treatment plans (those created by individual providers and those created by the IDTT) should include concrete, measurable, and observable goals that are individualized for each patient.		

Paragraph Author: Johnson	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: 12/7/17	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 provided rosters of patients who were Level 1A, 1B, and II during the review period. A random sampling of patients at each level revealed that CHS patients levelled 1A, 1B, and II received the treatment activities (i.e. daily evaluation by Psychiatrist & access to individual counseling) as required. Those patients who remained at level 1A or 1B for more than 7 days received an IDTT within 14 days as required. None of the patients reviewed remained at level 1A or 1B for more than 30 days' post IDTT. They were either re-leveled and obtained the specified treatment activities at their new level or they were released.		
Monitor's Recommendations:	No additional recommendations at this time.		

Paragraph Author: Johnson	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; 12/7/17	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 was stated above, a random sampling of the charts of patients who were Level 1A and 1B during the review period revealed that the patients received the treatment activities (i.e. daily evaluation by Psychiatrist & access to individual counseling) as required. Those patients who remained at level 1A or 1B for more than 7 days received an IDTT within 14 days as required. None of the patients reviewed remained at level 1A or 1B for more than 30 days post IDTT. They were either re-leveled and obtained the specified treatment activities at their new level or they were released. There was no documentation of contact and follow-up with the mental health coordinators to facilitate movement through the criminal justice competency determination process and placement in an appropriate forensic mental health facility. Nevertheless, staff reported, and records indicated that patients were referred and received from forensic mental health facilities and multiple booking staff explained how patients who return to the jail with restored competency from an outside forensic mental health facility are given priority in the booking process.		

Monitor's Recommendations:	By June 1, 2018, document development of a dev process to self-monitor this provision and have it available for review for the next site visit. 1. To achieve full compliance, please develop a process to self-monitor this provision and have it available for review for the next site visit. The process should be able to demonstrate how many patients are on the mental health caseload on each level and how many patients on each level receive a written interdisciplinary treatment plan within 7 days and 30 days thereafter in the form of an internal audit/quality improvement review / or performance plan. Additionally, the process needs to demonstrate how patients who may not have been required are assessed and evaluated to ensure that their needs are addressed.

Paragraph Author: Johnson	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; 12/7/17	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)	Mistakes in leveling were identified		
Monitor's Recommendations:	By June 1, 2018, provide report on CHS' validation of leveling. 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: Johnson	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; 12/7/17	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:	Since the last tour CHS has hired more mental health staff including social workers, psychologists, and psychiatrist. Individual and group psychotherapy continues to be provided at all facilities and attendance is tracked by sign-in sheets.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS remains compliant with this requirement.		
Monitor's Recommendations:	It is recommended that CHS utilize the electronic health record to track and document patient participation in services. A system for tracking the reasons for missed appointments is also recommended (i.e. court, released, conflicting medical appointment, refusal, etc.).		

Paragraph Author: Johnson	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: 12/7/17	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16; 7/29/16
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 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:	Please monitor access to care, inmate on inmate violence vis-à-vis mental health level and mental health grievances.		

Paragraph Author: Johnson	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: 12/7/17	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:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies consistent with appropriate treatment in Level III, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	CHS policy 058-B was recently updated and submitted. 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)	Ten patient charts were audited and followed sequentially through the various levels. Three discharged before they were able to obtain all the services at their initial level. The remaining seven charts documentation demonstrated that they received the requisite services required at the levels they were assigned, including level 3. Patients were relevelled frequently and the quality of the services varied across provider.		
Monitor's Recommendations:	<u>By June 1, 2018, provide evidence of the use of the quality improvement program and ability to self-monitor, including description of performance indicators.</u> 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: Johnson	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: 12/7/17	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 058-B was recently updated and submitted. Level II patients receive: a. Evaluation and stabilizing in the appropriate setting: b. Psychotropic medication, as clinically appropriate; c. 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; 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 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)	Ten patient charts were audited and followed sequentially through the various levels. Three discharged before they were able to obtain all the services at their initial level. The remaining seven charts documentation demonstrated that they received the requisite services required at the levels they were assigned, including level 2. Patients were relevelled frequently and the quality of the services varied across provider.		
Monitor's Recommendations:	1. Move quality improvement program audits to include whether care provided was appropriate to the level, and not just if they saw a psychiatrist. 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. 3. Another option to expand review of appropriateness of level of care is through a traditional quarterly peer-to-peer review by psychiatrists and QMHPs.		

Paragraph Author: Johnson	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; 12/7/17	Partial Compliance: 7/13; 1/16; 7/29/16;	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 1. Manual of mental health policies and procedures 2. Results of internal audits, if any 3. Review of medical records for implementation of policies consistent with appropriate treatment in Level I, including progress notes reflecting group therapy by the treating psychiatrist as clinically appropriate.		
Steps taken by the County to Implement this paragraph:	CHS policy 058B outlines the provisions of care of Levels 1A and 1B. Level 1A is differentiated from 1B by the safety garment.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS continues to provide satisfactory mental health care to patients classified as requiring Level I level of care. CHS has obtained safe and hygienically appropriate disposable underwear for women who are menstruating and on suicide precaution. It was not clearly explained in the chart when or why a patient was not allowed to participate in programming or recreation. Information obtained from staff interview revealed that clinical and custodial factors could be better integrated so that patients could have increased access to programming without jeopardizing the safety and security of the units.		
Monitor's Recommendations:	1. Document reasoning regarding decisions to restrict access to recreation and showers for patients on Level 1A and Level 1B. 2. Document reasoning regarding decisions to restrict Level 1A and Level 1B patients access to other forms of programming (e.g., yoga) to provide stimulation during the day.		

Paragraph Author: Johnson	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; 12/7/17	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. Site tour of the Mental Health Treatment Center (MHTC), which according to CHS/MDCR is the 2nd floor of TGK, to assess compliance with this requirement. 3. Review of audits of use of force in MH patients		
Steps taken by the County to Implement this paragraph:	The Mental Health Treatment Center (MHTC) was officially identified by CHS/MDCR as the 2nd floor of the TGK facility. The county is auditing medication treatment adherence in MH patients involved in use of force incidents.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Patients on Levels I and II remain at TGK which was visited during the site tour. The unit and services provided were reviewed while onsite. The services provided on the mental health unit are "enhanced" in comparison to the general population in accordance with the higher level of acuity of the patients housed there (e.g., suicidal patients or patients experiencing acute withdrawal dxs). Patients on Levels III and IV remain at Metro West. Outstanding issues include: 1. Use of force in the mental health population (may be in part related to classification of ETOs as use of force by MDCR). Preliminary data suggests that medication non-adherent mental health patients on Level 1A and 1B may be involved in more incidents of use of force. 2. Discussion with the AMD-BH indicates that collaborations with community organizations are being explored and that collaborations with other JHS associated facilities have been reduced due to concerns over violating Sunshine laws.		
Monitor's Recommendations:	1. Continue auditing data on use of force in MH patients. 2. Continue to work to establish community organization and governmental agency partnerships.		

Paragraph Author: Johnson	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: 12/7/17	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. 4. Review of mental health records		
Steps taken by the County to Implement this paragraph:	CHS policy 058B has been revised and implemented.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is now monitoring of 5-Day Follow-Up Services (for patients who are levelled down from Level 1). CHS created a mechanism in Cerner to order all 5-Day Follow-Up Services to reduce misses. An audit of 40 patients leveled down from Level 1B was completed in September 2017 and showed a 96% compliance rate with follow-up requirements. The missed follow-ups were noted to be due to "person specific rather than process specific." However, an explanation for how this was ascertained was not included in the audit data provided. Chart review reflected that 5-day follow-up visits are occurring though identifying them was difficult at times. However, CHS staff document patient "refusal" of a 5-Day Follow-Up Visit. While it was explained that in all instances if a patient refuses to meet with CHS staff out of cell the CHS staff member will go to the inmate's cell door to insure she or he is safe. As the purpose of the 5-Day Follow Up is to insure the safety of inmates who have been discharged from the highest level of clinical care and the inmates are receiving services whether they exit their cell doors it is recommended that CHS document completion of 5-Day Follow Up Services by indicating the patient was evaluated out of cell or at the cell door. This will more accurately capture the work they are performing.		
Monitor's Recommendations:	Prior to the next tour please provide the reasoning behind analysis provided with audits of this data, along with any CAPs as appropriate.		

Paragraph Author: Johnson	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; 12/7/17	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:	Since the last tour, TGK was established as the MHTC for acute Level I and Level II mental health care. A therapeutic environment has been established with access to counseling in a private setting and access to group therapy. Constant observation cells have been added to the medical housing units at TGK.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Non-pharmacologic treatment options for Level I patients housed on medical units are available but remain limited. The reasoning for decision making regarding restricting access to interventions are not always clearly indicated in the charts of patients on Level 1.		
Monitor's Recommendations:	Prior to the next tour, clearly indicate in the chart why a patient is not allowed to participate in a non-pharmacologic treatment option, in both MH and Medical housing.		

Paragraph Author: Johnson	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: 12/7/17	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:	The dashboard to manage Key Performance Indicators has been established.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The results from the dashboard have not been presented to the monitor. CHS has developed a robust CHS QI Tool kit that they have implemented and are now analyzing the data they have obtained. However, during the tour it became apparent that several of the QI tools were of questionable reliability based on CHS' failure to follow the appropriate sampling and analysis guidelines and procedures to help avoid provider bias when assessing the results.		
Monitor's Recommendations:	Continue to refine the CHS QI Tool Kit and adhere to sampling guidelines and procedures as recommended by the monitors during the site visit.		

3. Suicide Assessment and Prevention

Paragraph Author: Johnson	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; 12/7/17	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)	Policy IP-003 meets this requirement. However, in practice it appears that access to custodial activities (i.e., chapel visits, recreation time, etc.) are not happening on a consistent case-by-case basis per staff reports. Documentation of the rationale behind restriction of access (e.g., ongoing high levels of agitation posing a risk to staff) was not apparent.		
Monitor's Recommendations:	Prior to the next tour, document reasoning regarding decisions to restrict access to custodial activities.		

Paragraph Author: Johnson	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; 12/7/17	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 and suicide risk assessment.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Consistent with the last review, MH staff should be able to conduct a suicide risk assessment whenever it is clinically indicated (e.g. loss of a close family member after sentencing). Discussion with QMHS/P indicated that they are consistently evaluating patients who report triggering events. However, one staff person did not know to access the suicide risk assessment and instead indicated that they would document the suicide risk assessment in a free text section of the note. Of note, the follow through steps of placing the patient on level 1 and constant observation prior to transfer to appropriate housing was correct. CHS indicated the risk profiles is the suicide risk assessment. A separate risk profile was not provided. Evidence that the suicide screening tool and the suicide risk assessment were validated was not provided.		
Monitor s Recommendations:	1. Review if suicide risk assessments are being performed and documented on the appropriate form in response to triggering events and retrain as appropriate. 2. Provide evidence that the suicide screening tool and suicide risk assessment were validated, if sufficient time has elapsed. 3. Clarify that the suicide risk assessment as the risk profile for a patient is being appropriately considered during clinical decision making.		

Paragraph Author: Johnson	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; 12/7/17	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 constant observation 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)	This requirement was witnessed during the intake process. However, MDCR is documenting on visual check logs or into the MDCR Black Creek Watch System. This system does not interface with Cerner. MDCR indicated that results are available to CHS upon request. Therefore, there was no way to establish that constant observation had been initiated in Cerner.		
Monitor's Recommendations:	Establish communication between the MDCR Black Creek Watch System and Cerner for the purposes of tracking, auditing, and analyzing data on observation of suicidal patients.		

Paragraph Author: Johnson	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; 12/7/17	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:	CHS/MDCR have implemented IP-003 including appropriately compliant suicide prevention training.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Accuracy of leveling remains an issue as mentioned in prior sections of this report and may have resulted in preventable deaths.		
Monitor's Recommendations:	Continue audits of appropriateness of leveling and retrain MH staff to assess and assign the correct level of care to possibly avoid preventable morbidity and mortality events.		

Paragraph Author: Johnson	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; 12/7/17	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 and new format for treatment plans instituted by the Interim Chief Psychologist.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Medical records reviewed did include relevant to risk factors and preventive factors for suicide risk but did not specifically indicate how they would be addressed and mitigated. Instead many of the treatment plans focused on the presumed mental states (i.e. depression) underlying suicidal ideation or behavior instead of directly addressing the suicidal ideation or behavior.		
Monitor's Recommendations:	Treatment plans for suicide patients should include concrete and measurable individualized treatment goals for patients with the goal of: increasing protective factors, reducing and/or mitigating known and modifiable risk factors, and acting on and bolstering treatment interventions.		

Paragraph Author: Johnson	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; 12/7/17	Non-Compliance: 10/14 (NR); 5/15 (NR)
Measures of Compliance:	<u>Mental Health:</u> 4. On-site check for cut-down tool. 5. Manual of mental health policies and procedures 6. Results of internal audits or on-site inspections, if any 7. Incident reports documenting use of cut-down tool		
Steps taken by the County to Implement this paragraph:	Interviews with staff indicated that they knew where at least one of the rescue tools (the wonder knife) where to located and how to use them. However, during a recent suicide attempt the cut-down tool was found to be too dull to cut the noose made by a patient requiring staff to find the back-up rescue tool. Per verbal report from MDCR, they have started to test the rescue tools upon purchase and have developed a plan to test them periodically. Training on the location of the cut-down tools is happening as part of the Suicide Prevention Training process.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR will continue to ensure that all cut-down tools are in full working order.		
Monitor's Recommendations:	1. Interviews with staff indicated that they knew where at least one of the rescue tools (the wonder knife) where to located and how to use them. 2. However, during a recent suicide attempt the cut-down tool was found to be too dull to cut the noose made by a patient requiring staff to find the back-up rescue tool. Per verbal report from MDCR, they have started to test the rescue tools upon purchase and have developed a plan to test them periodically. 3. Training on the location of the cut-down tools is happening as part of the Suicide Prevention Training process.		

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	Non-Compliance: 7/13; 3/14 (NR); 10/14 (NR)
Measures of Compliance:	Medical Care: • Interviews • Observation Mental Health Care: 1. On-site review of first aid kit and resources. 2. Review of record of education / training to CHS and officers in emergency response 3. Review of adverse events		
Steps taken by the County to Implement this paragraph:	Medical Care: Mental Health Care: Emergency bags were available.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	Medical Care: "Crash carts" in the clinic were observed with contents labeled, cart locked and tagged with a number and evidence of every shift checks documented on the log. Remarkably, naloxone was not approved for use in the facility, for bureaucratic reasons. Mental Health Care: As above in medical care		
Monitors' Recommendations:	Medical Care: Make naloxone available on every housing unit and train staff in its use. Mental Health Care: All staff shall be trained in the use of emergency procedures that includes naloxone once the policy is approved as discussed during the tour.		

Paragraph Author: Johnson	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: 12/7/17	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:	CHS is monitoring the requirements of this section as part of the CQI process.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Review of QI Tools for this requirement showed a gradual improvement from February/March 2017 to November 2017 with 100% adherence to this requirement. Random chart review of over 60 patients reflects the same. However, failure to follow recommended QI guidelines for obtaining, analyzing, and reporting data. For example, they were instruction to refrain from having physicians obtain and analyze the QI data for their own areas due to risk of bias. However, CHS did just that. While upon review the MH QI data appears to be valid, there are still questions as to the veracity of the analysis of the data that was provided.		
Monitor's Recommendations:	Adhere to QI guidelines provided when obtaining, analyzing, and reporting data.		

4. Review of Disciplinary Measures

Paragraph Author: Johnson	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; 12/7/17	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)	Out of a total of 30 patients seen in September 2017, CHS cleared 80% of the mental health cases that needed to be seen for the disciplinary review (DR) process. Of the 6 cases that were not cleared, 5 were officially not cleared and with the last one MDCR did not move forward with the DR process. No analysis of the data was provided. A column of the audit was "Staff Available" appeared to indicate that staff was available to perform the evaluation. It was unclear if this also indicated that staff was available to assist them during the actual DR process.		
Monitor's Recommendations:	Continue to track data and conduct internal analyses for trends to improve the evaluation method proceeding the DR process.		

5. Mental Health Care Housing

Paragraph Author: Johnson	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; NR 12/7/17	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. Constant observation beds have been provided on the medical units and medical providers are now going to the MH housing units to see patients at TGK.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Two suicide resistant cells are in the TGK medical clinic for patients who have cleared booking but not yet been assigned to a unit, as well as for medically ill patients who may need Level 1A/1B care.		
Monitor's Recommendations:	Please track MH patient visits with chronic care to assess that this requirement is being met.		

Paragraph Author: Johnson	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; 3/3/17; 12/7/17
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)	One of the suicides since the last tour occurred due to a patient being able to tie a noose around a loose wall plate in a shower at MWDC. Since then MDCR has bolted the plates to the wall. In another suicide a patient broke away from officers and jumped off the stairs of a general population housing unit.		
Monitor's Recommendations:	Continue to retrofit housing units to be suicide resistant and utilize constant observation until a patient can be appropriately placed on a housing unit on suicide precaution. Consider adding mesh or another means to block inmates from jumping from the upper tiers of non-mental health housing units.		

Paragraph Author: Johnson	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; 3/3/17; 12/7/17	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:	MHTC was established.		
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 reveal why patients were restricted from recreation or other custodial activities. It should be documented in Cerner why patients are restricted from activities.		
Monitor's Recommendations:	Prior to next tour, clearly indicate reasoning for restrictions to patient activities in the chart and what if any activities are allowed in the treatment plan.		

Paragraph Author: Johnson	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; 3/3/17; 12/7/17	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 are now at TGK and patients on Levels III and IV are at Metro West. Space for face-to-face QMHP visits has been established and group therapy is occurring.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Outstanding issues from last report include: 1. "Dorm-style setting of Metro West": this appears unlikely to change in the near future based on discussion with CHS. 2. Though there is some confusion how the scheduled groups are being covered when compared to the staffing matrix. 3. No quarterly reviews of the capacity of the Mental Health Treatment Center as compared to the need for beds have been received or provided by CHS to this monitor.		
Monitor's Recommendations:	1. Prior to next tour, clearly indicate appropriate coverage by staff of scheduled groups (e.g., MWDC). 2. Please ensure that quarterly reviews of the capacity of the Mental Health Treatment Center as compared to the need for beds are being conducted and shared with the monitors.		

Paragraph Author: Johnson	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; 12/7/17	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. Frequent releveling complicated chart review. 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: Johnson	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:	Partial Compliance: 7/13; 1/16; 7/29/16; 3/3/2017; 12/7/17	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: 1. Manual of mental health policies and procedures 2. Results of internal audits, if an 3. Review of medical records for implementation of policies, including results of disciplinary proceedings of persons on the mental health caseload and evidence of consultation with Qualified Mental Health Staff. 4. Review of logs of compliance with initial evaluation of inmate by Medical and QMHS.		
Steps taken by the County to Implement this paragraph:	CHS Policy 044		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR uses the Black Creek Watch Tour System to monitor the inmates and document behavioral observations. This information does not go into the EHRS and is not readily available to mental health staff. Having this available, particularly the behavioral observations, would help CHS determine whether or not a person is decompensating and/or is symptomatic. Two evaluations for custodial segregation were observed and were deemed clinically appropriate. Both patients were cleared for custodial segregation. The process involved both documentation in Cerner and completion of paper forms for MDCR. All aspects of this process are not trackable via Cerner and are therefore difficult to review fully. PTDC is still being utilized to house overflow of custodial segregation patients should the need arise.		
Monitor's Recommendations:	1. Data and information should be analyzed in real-time to mitigate harm to patients. 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, particularly those with SMI. 2. Explore creating electronic copies of MDCR forms associated with the custodial segregation process for Cerner to improve ease of use and tracking for both CHS and MDCR. Ideally, the electronic versions of the forms would not disclose any HIPAA inappropriate information when shared with MDCR.		

Paragraph Author: Johnson	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; 12/7/17	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.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Initial Segregation Note contents did not clearly address all of the provisions in this section. The notes were not clearly labelled and did not reflect the purpose of the service being provided. It was not clearly identified in the (disposition section or otherwise) of the note that checks were occurring. The 15-minute checks are documented by MDCR in their Black Creek Watch System which does not interface with Cerner.		
Monitor's Recommendations:	1. Streamline identifiers on CHS Pre-segregation notes for ease of identification and auditing. 2. Review and analyze data and trends from the Black Creek Watch System and I recommend creating a bridge between Cerner and the watch system to allow exchange of relevant data for this patient population and for purpose of auditing adherence to this requirement.		

Paragraph Author: Johnson	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; 12/7/17	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.		
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 relevant to this particular requirement. See III.C.6.a(1) regarding analysis of charts reviewed as there was significant variance in quality of the documentation. No indication that the above monitor's prior recommendations were met was provided this tour.		
Monitor's Recommendations:	<u>By June 1, 2018, respond to the recommendations from this and Compliance Report #7</u>. 1. Address unresolved monitor recommendations from the prior tour for this section (3/3/2017). 2. Streamline identifiers on CHS Pre-segregation notes for ease of identification and auditing. 3. Review and analyze data and trends from the Black Creek Watch System and I recommend creating a bridge between Cerner and the watch system to allow exchange of relevant data for this patient population and for purpose of auditing adherence to this requirement,		

Paragraph Author: Johnson	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; 12/7/17	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 specific to this requirement, in regard to custodial segregation, were provided for review.		
Monitor's Recommendations:	Please see III.C.6.A.(2)		

Paragraph Author: Johnson	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 12/7/17	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 Policy 044		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Evidence that this requirement was met was provided in the form of an audit of 23 patients with SMI in segregated housing between 8/1/17 and 10/1/17. Over half (52%) of the patients in the audit were not seen 3 times a week per this requirement. Verbal explanation from CHS staff suggest that patient refusals are not being documented in the chart despite staff saying that they conduct a face-to-face interaction to ensure the patient is actually refusing.		
Monitor's Recommendations:	1. Continue to track these visits and perform audits demonstrating adherence, meaningful analysis of the data, as well as corrective action plans to correct missed appointments. 2. Document face-to-face refusals in Cerner to indicate that visual and verbal contact was actually made with the patient and that they refused to accurately reflect fulfillment of this requirement.		

Paragraph Author: Johnson	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;12/7/17
Measures of Compliance:	<u>Mental Health Care:</u> 1. Manual of mental health policies and procedures 2. Review of logs documenting that MDCR has permitted recreation and showers at least three times per week 3. Review of log of patient in custodial segregation with SMI		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The monitors were informed that patients were receiving appropriate out of cell time based on their segregation status. Otherwise, information to this section was not provided submitted to demonstrate adherence to the national and state recommended guideline of at least one hour or more of out of cell recreation time per day for each patient. Due to no data actually being provided this section remains in non-compliance.		
Monitor's Recommendations:	1. Review and analyze data and trends from the Black Creek Watch System and I recommend creating a bridge between Cerner and the watch system to allow exchange of relevant data for this patient population and for purpose of auditing adherence to this requirement. 2. Please work with MDCR to obtain the data to track this requirement and perform audits demonstrating adherence, and include analysis of the data.		

Paragraph Author: Johnson	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; 12/7/17	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)	Evidence that this requirement was met was provided in the form of an audit of 23 patients with SMI in segregated housing between 8/1/17 and 10/1/17. A column in the audit indicated that the written approval of the Facility "Supervisor," but not the Director of Mental Health Services for placement of patients with SMI in custodial segregation.		
Monitor's Recommendations:	1. Please track requirement and perform audits demonstrating adherence, and include analysis of the data. 2. Prior to the next tour, please provide a clear key for the terms and data included (e.g., clarification of what "Supervisor" means in the audit.		

Paragraph Author: Johnson	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; 12/7/17
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 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)	Evidence that this requirement was met was provided in the form of an audit of 23 patients with SMI in segregated housing between 8/1/17 and 10/1/17. The review of the audit data indicated that despite 2 patients self-harming or decompensating while in custodial segregation due to their mental disorder they were not removed from confinement. All of the patients remained in custodial segregation despite having SMI. Finally, one patient remained in custodial segregation from 11/25/14 to 9/11/17 with "Written Approval by Supervisor." This clearly meets criteria for "long-term custodial segregation," that was sanctioned by (CHS?) leadership, despite no working definition from MDCR or CHS. Although, this is only one patient, it is significant given the extended time frame.		
monitor's Recommendations:	By June 1, 2018, provide documentation regarding compliance with this paragraph. 1. Recommend the development of clear criteria for decision making for mental health staff to follow when evaluating patients with SMI in custodial segregation. Especially when they are expected to make a decision regarding to continue allow the patient to be housing in custodial segregation or not. 2. Provide data and analysis for assessment and treatment after symptoms develop during confinement including analysis of the rationale to continue to house decompensated or self-harming patients in custodial segregation. 3. Please work with MDCR to develop a clear working definition of what "long-term custodial segregation" means so that this requirement can be appropriately tracked and monitored for compliance.		

Paragraph Author: Johnson	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; 12/7/17
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 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)	See Monitor's analysis for III. C. 6. a. (6) indicating that despite patients self-harming or decompensating they were not removed from custodial segregation.		
	1. Patients that develop signs or symptoms of SMI while in custodial segregation shall be immediately removed and referred to treatment. 2. Recommend the development of clear criteria for decision making for mental health staff to follow when evaluating patients with SMI in custodial segregation. Especially when they are expected to make a decision regarding to continue allow the patient to be housing in custodial segregation or not. 3. Provide data and analysis for assessment and treatment after symptoms develop during confinement including analysis of the rationale to continue to house decompensated or self-harming patients in custodial segregation.		

Paragraph Author: Johnson	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; 12/7/17
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 policy 044		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See Monitor's analysis for III. C. 6. a. (6) indicating that despite patients self-harming or decompensating they were not removed from custodial segregation. Chart review of the 2 patients who decompensated from the audit list indicate that they were evaluated by a QMHP after they decompensated. Per chart review, patient A was psychotic and suffering from command auditory hallucinations at the time she was cleared for segregated housing. Patient A should have been leveled up from 4 to 1B at that time. She was evaluated by a QMHP 2 days later due to further decompensation, was leveled to 1B, and then transferred from MWDC to TGK. Two days later she was transferred back to MWDC were she was cleared again to continue segregation by mental health staff. No indication was made in the chart regarding whether custodial segregation played a role in the further deterioration of the patient. It was neither clear when custodial segregation was initiated on Patient B nor when the patient decompensated. There also was no indication in the chart whether the patient's decompensation was related to being in custodial segregation.		
Monitor's Recommendations:	1. Prior to the next tour, please include whether a patient was immediately referred and evaluated after they suffer deterioration in his or her mental health, decompensate, engages in self-harm, or develop a heightened risk of suicide. Also include whether the evaluating QMHP documented the role if any of custodial segregation in the patient's deterioration.		

Paragraph Author: Johnson	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; 12/7/17	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)	This documentation is entered into the MDCR Black Creek Watch System which does not interface with Cerner. Data from the watch system was not provided for a comprehensive review of this provision.		
Monitor's Recommendations:	1. Review and analyze data and trends from the Black Creek Watch System and I recommend creating a bridge between Cerner and the watch system to allow exchange of relevant data for this patient population and for purpose of auditing adherence to this requirement. 2. Please work with MDCR to obtain the data to track this requirement and perform audits demonstrating adherence, and include analysis of the data.		

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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: MDCR has implemented a scan system to document custody rounds on inmates in segregation. 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. 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. 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. MDCR plans to build a medical exam room in unit 8.1 or 8.2 at PTDC. This will provide segregation patients access to medical/mental health staff without having to escort them to the clinic. 5. The relevant policies and training curricula have yet to be developed. Mental Health Care:		

	The referral, sick call process, 30-minute checks from custody, nursing, and social worker rounding (3 days) all allow for this parameter to be met. Each of these processes in regard to CHS has its own challenges whether it be with the consistency with which they happen (e.g., SW rounds 3 days a week) or with challenges with tracking their occurrence due to the data not being sent to Cerner from the MDCR watch system. Custody staff are now aware of the basic mental health schedule and know most of the providers who work in their facilities (e.g., PTDC) which is an improvement from the last tour. MDCR plans to build a medical exam room in unit 8.1 or 8.2 at PTDC. This will provide segregation patients access to medical/mental health staff without having to escort them to the clinic.
Monitors' Recommendations:	1. Review and analyze data and trends from the Black Creek Watch System and I recommend creating a bridge between Cerner and the watch system to allow exchange of relevant data for this patient population and for purpose of auditing adherence to this requirement. 2. Please work with MDCR to obtain the data to track this requirement and perform audits demonstrating adherence, and include analysis of the data.

Paragraph Author: Johnson	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; 12/7/17
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 policy 044		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The monitors were told this provision was being met but it was not verifiable in the medical record and we were not provided with adequate data was provided in the audits of emergent/urgent referrals and other audits that reviewed patients in segregated housing to completely assess whether patients were referred for assessment due to developing symptoms of mental illness while in custodial segregation.		
Monitor's Recommendations:	By June 1, 2018, provide the data to track this provision and perform audits demonstrating adherence, and include analysis of any information specific to the timely referral of patients for SMI during custodial segregation (and assessment by a QMHP).		

7. Staff and Training

Paragraph Author: Johnson	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; 12/7/17	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:	As of 9/2017 staffing consists of the following: • 16 Psychiatrists • 2 Clinical Psychologists (includes the Acting Chief of Psychology) • 4 Licensed Mental Health Counselors • 1 Associate Nurse Manager of BH • 12 Nurse Practitioners • 6 Medical Assistants • 32 Nurses (RNs and LPNs) • 1 Director of Social Workers • 32 Social Workers (LCSWs and MSWs) As of 9/2017 vacancies in staffing were the following: • 2 Psychiatrists • 1 Chief of Psychology • 2 Psychologists • 1 Licensed Clinical Social Worker *** It was unclear if the other positions listed as vacant were specific to MH or to CHS in general because some positions appeared unrelated to BH (e.g., Patient Finance Specialist). This information was obtained from a staffing matrix and vacancy audits. The staffing matrix did not provided FTEs. However, staffing data provided verbally on-site during the tour differed slightly to what was provided in September 2017 (e.g., the prior Director of SW was no longer with the agency).		
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 almost fully staffed. Additional staff that we were informed were hired since the audit include a Lead Psychiatrist and 2 more psychologists. BH is adequately staffed per this provision.		

Monitor's Recommendations:	As of 9/2017 staffing consists of the following: • 16 Psychiatrists • 2 Clinical Psychologists (includes the Acting Chief of Psychology) • 4 Licensed Mental Health Counselors • 1 Associate Nurse Manager of BH • 12 Nurse Practitioners • 6 Medical Assistants • 32 Nurses (RNs and LPNs) • 1 Director of Social Workers • 32 Social Workers (LCSWs and MSWs) As of 9/2017 vacancies in staffing were the following: • 2 Psychiatrists • 1 Chief of Psychology • 2 Psychologists • 1 Licensed Clinical Social Worker *** It was unclear if the other positions listed as vacant were specific to MH or to CHS in general because some positions appeared unrelated to BH (e.g., Patient Finance Specialist). By March 1, 2018, provide clearer a clearer staffing matrix that addresses the concerns noted above. This information was obtained from a staffing matrix and vacancy audits. The staffing matrix did not provided FTEs. However, staffing data provided verbally on-site during the tour differed slightly to what was provided in September 2017 (e.g., the prior Director of SW was no longer with the agency).

Paragraph Author: Johnson	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; 12/7/17	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:	By June 1, 2018, demonstrate that new hires require corrections-specific training.		

Paragraph Author: Johnson	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; 12/7/17	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:			

Paragraph Author: Johnson	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; 12/7/17	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:	No FTE allotments were provided with the September 2017 Staffing Matrix that was provided prior to the onsite tour.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Despite specifically requesting it prior to the tour, the staffing matrix provided neither reflected the allotted FTEs for CHS, including BH, nor the employment status (i.e., FT, PT, etc.) of staff listed. No staffing analyses have been provided other than the one prior to the tour. I look forward to receiving them in the future per this policy.		
Monitor's Recommendations:	By June 1, 2018, please provide updated staffing analyses per this provision in the future. Please provide all data requested prior to the tour (e.g., FTEs).		

Paragraph Author: Johnson	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; 12/7/17	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 AMD-BH/Chief Psychiatrist, Dr. Patricia Junquera, has hired a Chief Psychologist who reports directly to her and who per this provision supervises the social workers and daily operations of the MH services. She has also hired a Lead Psychiatrist to assist with direct clinical supervision of staff and other administrative duties.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Consistent with the prior tour, "Dr. Junquera performs primarily administrative functions. She answers administratively to Dr. Concepcion as her supervisor." Through comprehensive review of data, meeting minutes, interviews of staff, discussions of all aspects of clinical care and QI, and direct observation it was ascertained that the parameters of this provision are being met.		
Monitor's Recommendations:	No additional recommendations at this time.		

Paragraph Author: Johnson	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; 12/7/17	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, and PDF, format. Training materials submitted prior to the tour included pre- and post-training test materials as well as attendance and course completion logs.		
Monitor's Recommendations:	No additional recommendations at this time.		

Paragraph Author: Johnson	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; 12/7/17	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)	CHS continues to remain compliant with this provision based on review of training materials provided.		
Monitor's Recommendations:			

Paragraph Author: Johnson	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; 12/7/17	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:	A memorandum from the Chief Nursing Officer dated April 6, 2017 was submitted with the subject of "Staff Huddles in the Inpatient Units (Behavioral Units, Medical Housing and the Infirmary" outlines clear lines of communication between CHS, MDCR, and the providers on the unit at the beginning of every shift to communicate key patient information (i.e., patients on 1:1, change in condition, refusing medication, etc).		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This provision remains unchanged since the last tour, "No written policy entitled interagency communication has been developed between MDCR and CHS." However, CHS and custody have started to conduct huddles at each facility since the last tour which is an improvement as per the above-mentioned memorandum from the Chief Nursing Officer. Complications with interagency communication remains an active issue that was repeatedly identified by the monitors during the site visit (i.e., M&Ms, CAPs, etc.) since the last tour.		
Monitor's Recommendations:	By June 1, 2018, 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.		

8. Suicide Prevention Training

Paragraph Author: Johnson	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: 12/7/17	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 both CHS and Correctional staff 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):	Review of the materials provided and follow-up discussions with the AMD-BH and Acting Chief Psychologist demonstrated that enough persons and percentage of the material required of this provision was completed to render it in full compliance. For example, the suicide prevention training now contains the required mock drill element and pre- and-post-tests which were provided.		
Monitors' Recommendations:	No additional recommendations at this time.		

Paragraph Author: Johnson	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: 12/7/17	Partial Compliance: 10/14; 3/3/2017	Non-Compliance: 7/13; 3/14; 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	III. C. 8. a.		
Steps taken by the County to Implement this paragraph:	III. C. 8. 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):	III. C. 8. a.		
Monitors' Recommendations:	By June 1, 2018, demonstrate that new hires require corrections-specific training.		

Paragraph Author: Johnson	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; 12/7/17	Partial Compliance: 10/14	Non-Compliance: 7/13; 3/14; 5/15 (NR); 1/16; 7/29/16
Measures of Compliance:	III. C. 8. a.		
Steps taken by the County to Implement this paragraph:	III. C. 8. 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):	III. C. 8. a.		
Monitors' Recommendations:	No additional recommendations at this time.		

Paragraph Author: Johnson	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; 12/7/17	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):	There is no updated information for this section. Therefore, the rating will remain unchanged based on the information available at the prior tour.		
Monitors' Recommendations:	By June 1, 2018, provide a self-audit of this provision.		

9. Risk Management

Paragraph Author: Johnson	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; 12/7/17	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:	CHS hired a Director of Risk Management who has since been promoted to QI Director, and another Director of Risk Management was appointed. CHS is using the risk measure utilized by the Jackson Health System in the community. It provides a risk score for risk management that is used a one of the means to assess the impact of suicide or self-harm patient incidents and to design interventions at both the individual and system levels.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	There has been a significant improvement in the collection and basic analysis of data since the Director of Risk Management was hired. Explanation of how the risk score is used by the Director of Risk Management during the site tour provided a cleared understanding of how the risk score is used for individual interventions (e.g., provision of the names of providers who are consistently involved with high risk incidents for further review by their direct supervisor or division director). There have been significant improvements since the last tour. However, the data obtained requires deeper analysis and more specific corrective action plans, and updates.		
Monitor's Recommendations:	By June 1, 2018, provide more in-depth analysis of risk management data.		

Paragraph Author: Johnson	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; 12/7/17	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. Mental Health Review Committee minutes of monthly meetings 3. Suicide, adverse event, attempted suicide, and, review of associated audits, and reports.		
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)	This process has started to occur per verbal report of the previous Risk Management Director. However, no data was provided to demonstrate its occurrence. Support of this provision is documented in the Mental Health Review Committee minutes from 8/2017 and 9/2017.		
Monitor's Recommendations:	By June 1, 2018, provide risk management specific data analysis and associated interventions to prevent or minimize harm to inmates.		

Paragraph Author: Johnson	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; 12/7/17	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 met all elements of the provision which are necessary for compliance as per the Consent Agreement, except evidence of written annual performance assessments and presentation 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:	By June 1, 2018, provide evidence of written annual performance assessments and presentation its findings to the Interdisciplinary Team regarding the following: Quality of nursing services regarding inmate assessments and dispositions, and Access to mental health care by inmates, by assessing the process for screening and assessing inmates for mental health needs.		

Paragraph Author: Johnson	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; 12/7/17	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR)
Measures of Compliance:	Mental Health: • Review of screenings by psychiatry • Review of monthly Quality Meeting minutes • Review of suicides and adverse events • Review of Quantros reports. • Review of internal quality / risk audits		
Steps taken by the County to Implement this paragraph:	See III. C. 9. a. 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)	The Quality Improvement Committee is meeting regularly, and has developed a number of QI Tools to monitor provision of care per the CA. During the tour, all CAPs were reviewed with CHS and the Medical Monitor. Analysis of data was not deep enough nor were CAPs as specific or inclusive as they should be (e.g., issues that were identified as problematic but not related to the core incident were not listed as items to be addressed in CAPs). There is no documentation in the QI minutes that findings were presented and discussed.		
Monitor's Recommendations:	Please ensure more meaningful analysis of data, specificity of CAPs, and clear assignment of persons responsible for CAPs are needed. Updates to CAPs were not happening on a consistent basis. Document presentation of data and analysis in QI committee meetings.		

C. Audits and Continuous Improvement

1. Self Audit Steps

Paragraph Author: Greifinger and Johnson	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; 12/7/17
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; 12/7/17
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 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 and MH 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 or a subcommittee meets monthly, data are not analyzed and opportunities for improvement are not discussed. Data and analyses are not reported in the committee minutes. Though performance measurement has improved in all areas, except chronic care, there is no effective analysis and follow-through on action plans. 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. Chronic care performance measurements were unreliable.
Monitor's Recommendations:	Medical and MH Care: By April 1, 2018 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.

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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: 12/7/17	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: Please see comments in III.A.7.a., III.A.7.c., and III.D.1. b.		
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: Please see comments in III.A.7.a., III.A.7.c., and III.D.1. b.		
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: Please see recommendations in III.A.7.a., III.A.7.c. and III.D.1. b.		

2. Bi-annual Reports

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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:		
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 is insufficiently analytical for constructive use. Mental Health Care: Point in time data for this provision was provided for September 2017 which is inadequate for significant compliance to be met due to insufficient provision of data for analysis.		
Monitor's Recommendations:	Medical and MH Care: By June 1, 2018, develop a biannual report that describes findings from clinical performance measurement, M&M reviews, grievances, etc. with consolidated action plans and trended date. The second biannual review of each calendar year could serve as an evaluation of the quality management program. It can serve as a stepping off point for the next year's annual QI Plan.		

Paragraph Author: Johnson	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; 12/7/17	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 was produced.		
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 from III.D.2. a.		
Monitor's Recommendations:	See recommendations from III.D.2. a.		

Paragraph Author: Johnson	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; 12/7/17	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 produced.		
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 from III.D.2. a.		
Monitor's Recommendations:	See recommendations from III.D.2. a.		

Paragraph Author: Johnson	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; 12/7/17	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):	See comments from III.D.2. a.		
Monitor's Recommendations:	See recommendations from III.D.2. a.		

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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>		
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> See comments from III.D.2. a		
Monitors' Recommendations:	<u>Medical and MH Care:</u> <u>By May 1, 2018, provide a report responsive to all the requirements of this provision.</u> 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.		

Paragraph Author: Greifinger and Johnson	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; 12/7/17	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; 12/7/17	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 Johnson	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; 12/7/17	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; 12/7/17	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR);1/16
Measures of Compliance:	Medical and MH Care: To be determined		
Steps taken by the County to Implement this paragraph:	Medical and MH 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.		
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 and MH Care: See above.		
Monitor's Recommendations:	Medical and MH Care: See various recommendations throughout this report.		

Paragraph Author: Greifinger and Johnson	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; 12/7/17
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; 12/7/17
Measures of Compliance:	Medical Care: Inspection of policies and procedures. Mental Health Care: 1. Review of policies and procedures.		
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. The peer review process, as it is currently constituted, is self-defeating. Mental Health Care: • CHS has schedule QI and MHRC meetings with minutes that reflect some of the requirements of this provision, and, As above in Medical Care comments		
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 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: As above. Review of this provision and the associated elements was completed in conjunction with the Medical Monitor.		
Monitors' Recommendations:	Medical Care and Mental Health Care: 1. Please see the comments in provision III. A. 7. a. 2. Develop a peer review process that is constructive, not destructive, as described in NCCHC standards.		

Paragraph Author: Greifinger and Johnson	IV. C. and D. 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; 12/7/17	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; 12/7/17	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 polici 3. Review of committee meeting mi 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 policy updates with the monitors is an ongoing process.		
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 review is an ongoing process (see above Medical Care commentary).		
Monitor's Recommendations:	No additional recommendations at this time.		

Appendix A Settlement Agreement

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

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Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17
Use of Force by Staff								
III.A. 5 a.(1) (2) (3)	pc	pc	pc	pc	pc	pc	c	pc
III.A.5. b.(1), i., ii, iii, iv, v, vi (2)	pc	pc	pc	pc	nr	c	c	pc
III.A. 5. c. (1)	nc	c	pc	nr	nr	c	c	c
III.A. 5. c. (2)	nc	pc	pc	nr	pc	pc	c	pc
III.A. 5. c. (3)	pc	pc	pc	c	nr	c	c	c
III.A. 5. c. (4)	pc	not audited	c	nr	nr	c	c	c
III.A. 5. c. (5)	pc	c	c	nr	nr	c	c	c
III.A. 5. c. (6)	nc	not audited	pc	c	nr	c	c	pc
III.A. 5. c. (7)	pc	c	c	nr	nr	c	c	c
III.A. 5. c. (8)	nc	nc	c	nr	c	c	c	c
III.A. 5. c. (9)	nc	nc	pc	pc	c	c	c	c
III.A. 5. c. (10)	pc	c	c	c	nr	c	c	nc
III.A. 5. c. (11)	nc	nc	nc	pc	nr	pc	pc	pc
III.A. 5. c. (12)	nc	nc	nc	pc	nr	pc	c	pc
III.A. 5. c. (13)	nc	c	c	nr	nr	c	c	c
III.A. 5. c. (14)	nc	nc	nc	pc	nr	pc	c	pc
III.A.5. d. (1) (2) (3) (4)	pc	pc	pc	nr	nr	pc	c	pc
III.A.5. e. (1) (2)	nc	pc	pc	nr	nr	pc	c	pc
Early Warning System								
III.A.6. a. (1) (2) (3) (4) (5)	nc	nc	pc	nr	c	pc	c	c
III.A.6.b.	nc	nc	not due	pc	c	pc	c	c
III.A.6.c.	nc	nc	no	pc	c	pc	c	pc

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Section	Jul-17	May-17	Oct-17	May-17	Jan-17	Jul-17	Mar-17	Dec-17
Fire and Life Safety								
III.B.1.	pc	pc	pc	nr	nr	pc	c	c
III.B.2.	c	c	c	nr	nr	pc	c	c
III.B.3.	pc	pc	pc	nr	nr	pc	c	c
III.B.4.	pc	pc	pc	pc	pc	pc	c	c
III.B. 5.	nc	pc	pc	nr	nr	pc	c	c
III.B.6	nc	nc	nc	pc	nr	pc	c	c
Inmate Grievances								
III.C. 1.,2.,3.,4.,5.,6.	pc	pc	pc	c	nr	c	c	pc
Audits and Continuous Improvements								
PFH III.D.1. a. b.	nc	nc	pc	nr	nr	pc	c	pc
FLS III.D.1. a. b.	nc	nc	pc	nr	nr	pc	c	c
PFH III.D. 2.a. b.	not due	nc	pc	pc	pc	pc	c	pc
Compliance and Quality Improvement								
PFH IV. A.	not due	nc	pc	nr	nr	pc	c	c
FLS IV. A.	not due	not audited	pc	nr	pc	pc	c	c
PFH IV. B.	nc	nc	pc	nr	nr	pc	c	pc
FLS IV.B.	nc	nc	pc	nr	nr	pc	c	c
PFH IV.C.	not due	nc	pc	nr	c	c	c	c
FLS IV. C.	not due	nc	pc	nr	pc	c	c	c
PFH IV. D.	pc	pc	c	nr	nr	c	c	c
FLS IV. D.	pc	pc	pc	nr	pc	c	c	c

Legend:	PFH - Protection from
nc = noncompliance	FLS - Fire Life Safety
pc = partial compliance	
c = compliance	
nr = not reviewed	

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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**	**Dec-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	Med-PC MH -PC
III. A. 1. b.	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. A. 1. c.	MH - NC	MH - NC	MH - NC	MH - PC	MH - NC	MH - NC	MH - PC	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	Med - C MH - C
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	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	Med - C MH - C
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	Med - C MH - C
2. Health Assessments								
III. A. 2. a.	Med- NR	Med- NR	Med- NR	Med- NR	Med- NR	Med- NR	Med - NC	Med - NC
III. A. 2. b.	MH - NR	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - PC
III. A. 2. c.	Not Yet Due	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC
III. A. 2. d.	Not Yet Due	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC	MH - PC
III.A.2.e.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NR	MH - C	MH - NC	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	Med-PC 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	Med-C MH -PC
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	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	Med - C MH - PC

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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	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	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	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	Med - PC 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	Med - C MH - C
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	Med- NC MH -PC
III. A. 4. c.	MH - PC	MH- NR	MH- NR	MH- NR	MH- NR	MH - NC	MH- PC	MH- PC
III. A. 4. d.	MH - PC	MH- NR	MH- NR	MH- NR	MH- NR	MH - NC	MH- NC	MH- PC
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	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	Med - C MH - C
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	Med - PC MH - PC
III.A.5 b.	MH - NC	MH - PC	MH - PC	MH - NR	MH - NR	MH- PC	MH - NC	MH - PC
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	Med - PC MH - PC

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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	Med - PC MH - PC
Section	**Jul-13**	**May-14**	**Oct-14**	**May-15**	**Jan-16**	**Jul-16**	**Mar-17**	**Dec-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 - PC MH - PC	Med - PC 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	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	Med - PC 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	Med - PC MH - PC
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	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	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	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	Med - PC
III.B.1.c.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - C
2. Chronic Care								
III.B.2.a.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC
III.B.2.b. (See (III.B.2.a.)	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC
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	Med - PC MH -PC
III.B.3.b.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC
III.B.3.c. (1) (2) (3)	Med - NR	Med - NR	Med - PC	Med - NR	Med - NR	Med - NC	Med - NC	Med - PC

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Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-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	MH - PC
III. C. 1. b.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NR	MH - PC	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	MH - PC
III. C. 2. b.	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 2. c.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC
III. C. 2. d.	MH - PC	MH - PC	MH - PC	MH - NR	MH - NC	MH - PC	MH - PC	MH - C
III. C. 2. e. (1) (2)	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC
III. C. 2. f.	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 2. g.	MH - NC	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - C	MH - C
III. C. 2. g. (1)	MH - NC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - C	MH - PC
III. C. 2. g. (2)	MH - NC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - C
III. C. 2. g. (3)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - C
III. C. 2. g. (4)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. h.	MH - PC		MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC
III. C. 2. i.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - C
III. C. 2. j.	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 2. k.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC
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	MH - PC
III. C. 3. b.	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC	MH - PC
III. C. 3. c.	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC
III. C. 3. d.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 3. e.	MH - PC	MH - NC	MH - NR	MH - NR	MH - NC	MH - PC	MH - NC	MH - PC
III. C. 3. f.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	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	Med - PC MH - PC
III. C. 3. h.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC

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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	MH - PC
5. Mental Health Care Housing								
III. C. 5. a.	MH - NC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 5. b.	MH - NC	MH - NC	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - NC
III. C. 5. c.	MH - NC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC
III. C. 5. d.	MH - NR	MH - PC	MH - PC	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 5. e.	MH - PC	MH - NC	MH - NR	MH - NR	MH - NC	MH - PC	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	MH - PC
III. C. 6. a. (1b)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	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	MH - PC
III. C. 6. a. (3)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	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	MH - PC
III. C. 6. a. (4) ii	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC	MH - NC
III. C. 6. a. (5)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC
III. C. 6. a. (6)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC
III. C. 6. a. (7)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC
III. C. 6. a. (8)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC
III. C. 6. a. (9)	MH - C	MH - PC	MH - NR	MH - NR	MH - PC	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	Med - PC MH - PC
III. C. 6. a. (11)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC
7. Staffing and Training								
III. C. 7. a.	MH - PC	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C	MH - C
III. C. 7. b.	MH - NR	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C	MH - C
III. C. 7. c.	MH - NC	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C	MH - C
III. C. 7. d.	MH - NR	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 7. e.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C
III. C. 7. f.	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C
III. C. 7. g. (1)(2)(3)	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C

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III. C. 7. h.	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - NC	MH - PC
Section	**Jul-13**	**May-14**	**Oct-14**	**May-15**	**Jan-16**	**Jul-16**	**Mar-17**	**Dec-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	MH - C
III. C. 8. b.	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - PC	MH - C
III. C. 8. c.	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - C	MH - C
III. C. 8. d.	MH - NC	MH - NC	MH - PC	MH - NR	MH - PC	MH - PC	MH - C	MH - C
9. Risk Management								
III. C. 9. a.	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	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	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	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	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	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	Med - PC MH - PC
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	Med - PC MH - PC
III. D. 2. a. (3)			MH - NR	MH - NR	MH - PC	MH - NC	MH - PC	MH - PC
III. D. 2. a. (4)			MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - PC
III. D. 2. a. (5)			MH - NR	MH - NR	MH - PC	MH - NC	MH - PC	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	Med - PC MH - PC

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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	Med - PC MH - PC
Section	**Jul-13**	**May-14**	**Oct-14**	**May-15**	**Jan-16**	**Jul-16**	**Mar-17**	**Dec-17**
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	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	Med - NC MH - NC
IV. C	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	Med - C MH - C
IV. D	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	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