THIRD COMPLIANCE REPORT
LAKE COUNTY JAIL
MAY 2012

A. MEDICAL CARE: Settlement Agreement Section III Part A.

1. LCJ shall provide adequate services to address the serious medical and mental health needs of all inmates.

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

Leadership for the medical program at Lake County Jail has changed. Lake County has given a 1 year contract to Correctional Health Indiana (CHI). Dr. Forge is the Medical Director, Thomas Todd is the CHI Administrator and Deb Back is the Director of Nursing. This team was in place at the beginning of the contract in January of 2012. The contract is for personnel only. Supplies and equipment are provided by the Sheriff. CHI organizes and advises on specialty costs but the cost is paid by the Sheriff. Lake County also pays for pharmacy costs through a contract with In Touch Pharmaceuticals. CHI is asked to verify cost of pharmaceutical invoices.

This reconfigured program is engaged and performing well. Dr. Ron Shansky has been added to the consultant group of Ken Ray. Dr. Shansky will be extremely useful in assisting Dr. Forge and CHI to complete policies, protocols and initiate steps to improve processes of clinical care at the Jail.

I discussed metrics which should be in place and monitored by a Quality Improvement Committee. These include:

- The length of time from intake screening to provider assessment by acuity status.
- Percent of incarcerated detainees who receive intake screening.
- Percent of incarcerated detainees who receive tuberculosis screening.
- Number of health care slips picked up daily.
- Number and percent of health care slips picked up which are triaged with 24 hours.
- Number and percent of symptomatic complaints on health care slips which have a face-to-face evaluation within 72 hours.
- Average time from physician order to administration of medication for prescription medication.
- A no show report indicating the number of specialty, sick call, and provider appointments who showed up and were seen as well as those who don't show and the reason for no show. This should include percentages.

In addition to these metrics, the program should establish several quality metrics for clinical care as delivered by nurses and providers which should include chronic care visits and evaluation of health care slips.

RECOMMENDATIONS FOR NEXT 6 MONTHS:

1. Develop metrics outlined above as part of a Continuous Quality Improvement Program.

2. LCJ shall develop and implement medical care policies, procedures, and practices to address and guide all medical care and services at LCJ, including, but not limited to the following:

(1) access to medical care;
(2) continuity of medication;
(3) infection control;
(4) medication administration;
(5) intoxication and detoxification;
(6) documentation and record-keeping;
(7) disease prevention;
(8) medical triage and physician review;
(9) intake screening;
(10) infection control;
(11) comprehensive health assessments;
(12) mental health;
(13) women's health;
(14) quality management; and
(15) emergent response.

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

All policies are still in progress. CHI has had 3 months to hire staff, get the program up and running and in that time has begun to settle in and develop their strategy for operating the program. Dr. Shansky has been engaged by Ken Ray to assist the medical program in policy development, protocol development, and process improvement.

The team needs to focus on the 15 policies required in the Agreement. Writing policies needs to be followed by staff training and implementation. In addition, there are several areas including medication administration, intake and infirmary or special needs housing which should result in combined custody/medical policies which describe responsibilities of medical and custody staff. Coordinating these processes between custody and medical and committing them to writing will establish rules for operations which will expedite attaining substantial compliance.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. Develop key policies relevant to this agreement and listed in Part A, item 2 of the Agreement.
2. Ensure leadership involvement in policy development.

3. Follow up policy development with training and implementation.
4. In key areas, have interagency policies which coordinate custody and medical responsibility for certain processes: e.g., medication administration, intake procedures, and special housing care or infirmary care.

3. Intake Screening and Health Assessments.

a. LCJ shall develop and implement policies and procedures to ensure that adequate medical and mental health intake screenings and health assessments are provided to all inmates within 14 days.

b. LCJ shall ensure that, upon admission to LCJ, Qualified Medical Staff utilize an appropriate medical intake screening instrument to identify and record observable and non-observable medical needs, and seek the inmate's cooperation to provide information, regarding:

(1) medical, surgical, and mental health history, including current or recent medications;
(2) current injuries, illnesses, evidence of trauma, and vital signs, including recent alcohol and substance use;
(3) history of substance abuse and treatment;
(4) pregnancy;
(5) history and symptoms of communicable disease;
(6) suicide risk history; and
(7) history of mental illness and treatment, including medication and hospitalization. Inmates who screen positively for any of these items shall be referred for timely medical evaluation, as appropriate.

c. LCJ shall ensure that the comprehensive assessment performed for each inmate within 14 days of his or her arrival at LCJ shall include a complete medical history, physical examination, mental health history, and current mental status examination. The physical examination shall be conducted by Qualified Medical Staff. Records documenting the assessment and results shall become part of each inmate's medical record. A re-admitted inmate or an inmate transferred from another facility who has received a documented full health assessment within the previous three months and whose receiving screening shows no change in the inmate's health status need not receive a new full physical health assessment. For such inmates, Qualified Medical Staff shall review prior records and update tests and examinations as needed.

d. LCJ shall ensure that Qualified Medical Staff attempt to elicit the amount, frequency and time of the last dosage of medication from every inmate reporting that he or she is currently or recently on medication, including psychotropic medication.

e. LCJ shall implement a medication continuity system so that incoming inmates' medication for serious medical needs can be obtained in a timely manner, as

medically appropriate when medically necessary. Within 24 hours of an inmate's arrival at LCJ, or sooner if medically necessary, Qualified Medical Staff shall decide whether to continue the same or comparable medication for serious medical needs. If the inmate's reported medication is discontinued or changed, a Qualified Medical Professional shall evaluate the inmate face-to-face as soon as medically appropriate and document the reason for the change.

f. LCJ shall ensure that incoming inmates who present with current risk of suicide or other acute mental health needs will be immediately referred for a mental health evaluation by a Qualified Mental Health Professional. Staff will constantly observe such inmates until they are seen by a Qualified Mental Health Professional. Incoming inmates reporting these conditions will be housed in safe conditions unless and until a Mental Health Professional clears them for housing in a medical unit, segregation, or with the general population.

g. LCJ shall ensure that all inmates at risk for, or demonstrating signs and symptoms of drug and alcohol withdrawal are timely identified. LCJ shall provide appropriate treatment, housing, and medical supervision for inmates suffering from drug and alcohol withdrawal.

h. LCJ shall incorporate the intake health screening information into the inmate's medical record in a timely manner.

i. LCJ shall ensure that correctional officers supervising newly arrived inmates physically observe the conduct and appearance of these inmates to determine whether they have a more immediate need for medical or mental health attention prior to or following the intake health screening by Qualified Medical Staff.

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

3.a.

The policy on reception screening is still incomplete. I was shown a draft policy but a finalized product is pending. I discussed with medical leadership the acuity ranking system, how TB screening might be performed, and generally how the process of intake might function. I advised that if the organization utilizes the National Commission on Correctional Health Care (NCCHC) alternate standard for intake screening, they may be able to eliminate the 14 day assessment for healthy individuals. I recommend this alternative as it is a more efficient process which saves labor.

Currently, CHI has provided for nurse intake screening 24/7; this is working well and staff are performing well. However, the intake screening is still not performed under conditions of privacy as screenings are done in the lobby of the intake area. I was shown a floor plan of the proposed rehabilitation of an existing inmate waiting area which will provide 3 screening booths

and an examination room which will provide privacy for screening questionnaires and examination if required. An additional examination room will be created out of an existing nursing office in the intake area. Currently there are no examination tables in the intake medical office. When inmates need an EKG, the inmate has to lie on the floor. This is unacceptable. These problems can be remedied easily and staff discussed solutions with me during the visit.

3 b. (1-7)

The existing medical intake form in electronic format is adequate for purposes of screening. One comment is that the electronic form is a little confusing at there are two questions involving medical history. The form asks what are the inmate's current medical conditions and a second question asks what is the inmate's medical history. These are both similar questions and are probably confusing to staff. If possible, I propose that this be consolidated to one question.

3 c.

As described above in 3 a., it is my opinion that utilizing the alternative NCCHC assessment standard, is optimal for this program. Though there is no policy yet for health assessments, there is a practice of assigning an acuity ranking to patients (1-5) with 1 being the highest acuity. This acuity is suppose to be documented in the intake screening document but there is no standardized location where it is to be documented and the EMR does not have a data field for this item. Acuity 1 means that the inmate is to be seen for a medical assessment the same day. Acuity 2 means that the inmate is to be seen for a medical assessment within 24 hours. Acuity 3 means that an inmate is to be seen for a medical assessment in 72 hours. Acuity 4 means that the inmate is to be seen by medical staff within 2 weeks and Acuity 5 was not defined for me. Acuity levels 1-3 are to contain all patients with chronic illness. I could not verify that this is occurring based on record review. This idea is fundamentally sound. Acuity rankings should be defined and placed into the standardized procedure for intake. When this is done training should occur for staff. After training, audits should focus on appropriate assignment by intake nurses, timeliness of provider assessments, and the quality of the assessments.

3 d.

There is a field in the EMR intake screening document which elicits medication history. Intake notes which I examined did have the medication history filled out. It is best if the intake procedures standardize the information that the intake nurse is required to obtain.

3 e.

When the nurse takes a medication history and discovers that a patient is on medication, the intake nurse is to call a provider who may give a verbal order for medication. I could not verify that the verbal orders were co-signed by providers and I could not verify that nurse orders for medication were all documented as verbal orders. I verified that orders for medication from intake were administered within 48 hours and some within 24 hours. The facility should have a goal of administering the first dose of medication within 24 hours. All verbal medication orders must be electronically signed by a provider. This procedure should be standardized into a written procedure as part of the intake policy and procedure.

3 f.

Refer to Dr. Metzner's report.

3 g.

There are insufficient questions to identify alcohol or other drug withdrawal on the screening EMR questionnaire. There is currently no actively used standardized procedure for drug or alcohol withdrawal. Furthermore, there is no identified location to house suspected persons with drug or alcohol withdrawal during a treatment phase. I recommended 3 items:

- A screening mechanism for intake nurses to use to uncover those at risk for withdrawal from alcohol or other drugs and to incorporate that risk assessment into the intake screening form.
- Identification of a place to house patients during a detoxification process.
- A nursing and provider procedure for detoxification incorporating the CIWA and COWS scales.

3 h.

The intake screening information is electronically incorporated into the medical record and all records were accessible to me upon inspection. There were a few problems with an inmate having two separate electronic records. This was confusing and a root cause analysis should be initiated to search for the problem and eliminate it.

3 i.

The intake process is not described in a standardized procedure. Due to the chaotic nature of this process, I could not verify the role of the correctional officer in this process. Officers from other jurisdictions can pressure health care staff to hasten the intake evaluation so that they can leave the facility. This may result in health care staff accepting inmates who should not be accepted into the jail. The responsibilities of the officers, including the roles of observation of inmates by officers prior to medical screening, should be codified in a standardized procedure.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The system should perform an acuity ranking sy stem so that those with serious medical problems are tim ely seen after intake screening. Providers should prioritize those detainees with serious m edical conditions. Th is should be codified in a standardized policy and procedure
2. I suggest performing the Mantoux skin test at intake to improve screening rates.
3. A standardized system of review of the intake evaluations should be put in place.
4. Privacy should be established for intake screening evaluations.
5. Standardized alcohol and opi ate withdrawal procedures should be developed and synchronized with orders in the electronic r ecord. These procedures should be approved by the Medical Director and should be cons istent with standard ized treatment of withdrawal syndromes.

6. CHI should work with the Sheriff to have an Interagency Intake policy and procedure which states the responsibilities of officers and medical staff in intake.
7. Verbal orders must be signed by providers and signature must be clear in the record.

4. Acute care.

a. LCJ shall provide adequate and timely acute care for inmates with serious and life-threatening conditions, and ensure that such care adequately addresses the serious medical needs of inmates. Adequate care will include timely medical appointments and follow-up medical treatment.

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

4 a.

The policy on emergency medical response and admission to hospitals is not completed. The policy should specify who is making clinical decisions. It should stipulate the response depending whether a physician, mid-level provider, nurse, or correctional officer is the person responding to the emergency. There should be a log of urgent or emergent responses. The policy should indicate what hospitals the Jail has arrangements with for care.

The hospital log is now in place; I made a few minor recommendations to staff. This log is generally satisfactory. It would be better if the log were maintained on an electronic spreadsheet.

There are still some problems with clinical care of people with acute problems. A woman with a threatened abortion and another male inmate with heart failure both had problems getting their acute problem addressed timely. These cases were discussed with staff. These cases demonstrate that identification of patients by acuity and subsequent appropriate clinical follow up is still lacking. Another inmate who presented through the inmate card system wrote that he had an injured hand. Through a series of errors the inmate didn't get a definitive evaluation for a few weeks.

RECOMMENDATIONS FOR NEXT 6 MONTHS:

1. The policy and procedure on acute and emergency care must be completed.
2. Patients requiring hospitalization should have their clinical care at the facility evaluated in order to identify any process or clinical quality issues which are correctable. This can be part of the Quality Improvement program.

5. Chronic care.

a. LCJ shall develop and implement a written chronic care disease management plan, which provides inmates with chronic diseases with timely and appropriate diagnosis, treatment, medication, monitoring, and continuity of care.

b. LCJ shall adopt and implement appropriate written clinical practice guidelines for chronic and communicable diseases, such as HIV, hypertension, diabetes, asthma, and elevated blood lipids, consistent with nationally accepted guidelines.

c. LCJ shall maintain an updated log to track all inmates with chronic illnesses to ensure that these inmates receive necessary diagnosis, monitoring, and treatment.

d. LCJ shall keep records of all care provided to inmates diagnosed with chronic illnesses in the inmates' individual medical records.

e. LCJ shall ensure that inmates with chronic conditions are routinely seen by a physician to evaluate the status of their health and the effectiveness of the medication administered for their chronic conditions.

f. LCJ shall ensure that inmates with disabilities or who need skilled nursing services or assistance with activities of daily living shall receive medically appropriate care.

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

5.a.

Chronic illness policies and procedures are not completed and must be completed with training and implementation to follow.

5.b.

Clinical practice guidelines for chronic illness are not yet completed. Rather than re-inventing these, I recommend that the Jail utilize existing chronic illness guidelines used by other correctional systems and modify these to accommodate unique issues at the Lake County Jail. Dr. Shansky will be able to assist in this effort.

5.c.

The status information sent to me from LCJ included a chronic illness roster. The roster is sorted by location and duplicates names of people who have more than one disease. The disease is not related to a diagnosis but to categories such as "general medical" or "gastrointestinal" which do not assist clinical staff in prioritizing appointments. There is not yet a consistent roster which lists patients with their associated disease. The chronic illness roster is manually derived from CorrectTek information. Data is dumped into a spreadsheet and manipulated. But this data is defective because it is incompletely or inaccurately entered.

Staff, including management staff, remain confused as to how to use CorrectTek to enter problems. It remains to be seen whether this software is capable of doing what staff expect it to do. CorrectTek must satisfy the needs of clinical staff and the Jail to obtain necessary data. If the software works, then additional training is indicated. If the software does not work, then the Jail should consider other software. The requirement should be that all patients with a chronic illness have a data element in the medical record identifying their illness and this data must be able to be placed into a list. Inactive patients must be excluded from the list. The acuity ranking of disease should be a data element.

In sum, the current chronic care roster is deficient for several reasons.

1. The roster is manually derived from CorrectTek and a variety of sources and it appears that many errors exist. It is not clear if this is because CorrectTek is deficient or because staff is not using the software properly.
2. The providers are inconsistently entering the problem into the EMR in a manner which allows for data capture. Without this happening, the search of the EMR is not able to produce an accurate list of persons with chronic illness and patients will be missed.
3. The system has not considered chronic illness for uncommon illnesses such as collagen vascular disease, valvular heart disease, or cancer. As a result, persons with a serious but uncommon illness will not be found on the chronic illness roster and are at risk for being lost to follow up.
4. The disease of the patient is not listed. This is important because staff who are using the list to identify high risk patients will be unable to do so. If a person with Chron's disease is listed as "Gastrointestinal" then one cannot differentiate someone with Chron's disease which is serious, from someone with reflux disease which is not serious.
5. The acuity of the patient is unavailable.

5.d.

Though CorrectTek is difficult to use, it does keep a record of care provided, including medication administration and provider visits. Chronic illness visits are not identified as such in the electronic record but I could acceptably navigate through the chart nevertheless.

5.e.

CHI has hired a chronic illness nurse who is tasked with tracking persons with chronic illness and ensuring that necessary diagnostic testing, monitoring, and treatment is accomplished. She has developed a tracking spreadsheet but has had difficulty in identifying the entire panel of inmates with chronic illness for the reasons specified in the previous paragraph. Nevertheless, her work is valuable and will become more effective when the policy, procedure, protocols and chronic illness roster are completed.

Patients with chronic illness are identified at intake and scheduled for provider appointments based on an acuity ranking. Afterwards, the provider re-schedules the patient at intervals determined by protocol. The scheduling interval is determined solely by the schedule as ordered

by the provider. The new protocols should stipul ate minimum intervals. Medication renewal of persons with chronic illness is not yet standardized in a procedure.

Labs are perform ed by a vendor, CareEvolve, but lab data is not in terfaced to CorrectTek. Results are scanned into CorrectTek. This is not good because the laborato ry data is not easily accessible or able to be used in monitoring disease prog ress. The protoco ls should indicate intervals for routine blood testing or other testing.

Review of medical records of persons with ch ronic illness still dem onstrate missing diagnoses, dropped appointments, follow up errors, an d lack of continu ity. As part of the Quality Improvement program, medical leadership should review samples of at-risk ch ronic illness patients to test the performance of the system and chronic illness program.

5.f.

There is no infirmary in the jail. The 4 th floor of the old jail is considered medical housing. However there is no program of identification or management of inmates with spec ial medical needs, including disabilities, or those requiring skilled nursing. The Jail will need to identify a location where such inmates can be housed and then establish policy and procedure for managing such a unit.

In review of the 4th floor housing unit, it was not possible to identify which patients were m ental health or medical. Numbers used to identify m edical patients on a ro ster were not all accurate and signs to identify mental health patients were not all accurate. It wasn't clear what illnesses patients had and what their plan of care was. This is a major problem area of concern and m ust be corrected.

RECOMMENDATIONS FOR NEXT 6 MONTHS:

1. Policy and procedure and clinic al guidelines for chronic i llness management and special needs management must be developed.
2. Management of chronic illn ess should begin in intake with identification, acuity rank ing and appropriate referral to a provider.
3. Transportation issues involving getting patients to clinics must be resolved.
4. The providers m ust use a standardized m ethod of recording problem s in the electronic record which permits maintaining a roster of persons with chronic illness.
5. Physicians must m anage chronic illness by seeing patients at appropriate intervals, renewing medication, and perfor ming thorough evaluations pertinent to the chronic disease being managed.
6. Lab and other testing (EKGs) should be performed as indicated by appropriate guidelines at indicated intervals. This information should be interfaced with the EMR.
7. A system of m anagement of patients with disabilities and serious m edical problems equivalent to infirmary care must be established. Such a system would include:
    a. Admission by a physician
    b. Tracking of these 4th floor patients by name and diagnosis
    c. Acuity ranking of patients

d. Defined interval evaluations by nursing and medical staff
e. Rules for management of types of patients
f. Rules for who can be admitted to the unit
g. Discharge criteria
h. Discharge only by a physician
i. Complete access to physicians
j. Adequate nursing coverage
k. Physical space that accommodates ADA type patients
l. A manual of care for nurses on the unit

6. Treatment and Management of Communicable Disease.

a. LCJ shall develop and implement adequat e testing, monitoring, and treatment programs for management of communicabl e diseases, including tu berculosis ("TB"), skin infections, and sexually transmitted infections ("STIs").

b. LCJ shall develop and implement infection control policies and procedures that address contact, blood borne and airborne hazards, to prevent the spread of infections or communicable diseases, in cluding TB, skin i nfections, and STIs. Such policies should provide guidelines for identification, treatment and containment to prevent transmission of infectious diseases to staff or inmates.

c. LCJ shall continue to test all inma tes for TB upon booking at LCJ and follow up on tes t results as medically indicated, pursuant to Centers for Disease Control ("CDC") Guidelines. LC J shall follow current CDC guidelines for management of inmates with TB infec tion, including pr oviding prophylactic medication when medically appropriate. If directed by a physician, inmates who exhibit signs or symptoms consistent with TB shall be isolated from other inmates, evaluated for contagious TB, and hospitalized or housed in an appropriate, specialized respiratory isolation ("negative pressure") room on-site or off-site. LCJ shall provide for infection control and for the safe housing and transportation of such inmates.

d. LCJ shall ensure that any negative pr essure and ventilation sys tems function properly. Following CDC guidelines, LCJ shall test daily for rooms in-use and monthly for rooms not currently in-use. LCJ shall docu ment results of such testing.

e. LCJ shall d evelop and implement adequat e guidelines to ensure tha t inmates receive appropriate wo und care. Such guidelines will include precautions to limit the possible spread of M ethicillin-resistant Staphylococcus aureus ("MRSA") and other communicable diseases.

f. LCJ shall adequately maintain statis tical information regarding communicable disease screening programs and other re levant statistical data necessary to adequately identify, treat, and control infectious diseases.

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

6.a.

CHI has hired an infection control nurse. This nurse is actively engaged in starting an infection control program, but the leadership is investigating the specific requirements of a correctional infection control program. There is significant energy and excellent morale in this effort. I suggest that rather than reinvention of the a de novo program, CHI work with Dr. Shansky to obtain material from other jail programs and Centers for Disease Control documents to modify for their use.

6.b.

The infection control policy and procedure and the infection control manual are still being developed. Again, I recommend utilizing existing policy, procedures, manuals and other standardized procedures from other systems and modify rather than produce these de novo.

6.c.

Written policy and procedure in conformance with the Centers for Disease Control (CDC) TB guideline has not yet been written. The CDC reference can be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509a1.htm. The main purpose of tuberculosis screening is to prevent an infectious person from gaining admission to the general population of the Jail. There is a temptation to establish a procedure to reduce the number of people screened by waiting for the latest date possible to screen. This would not be in keeping with the intent of the established CDC standard. In this regard, CHI should draft guidelines and then meet with the State Health Department to review and obtain approval for these guidelines.

The current practice at LCJ is to perform TB symptom screening at intake. All inmates who remain incarcerated 24-72 hours are given a Mantoux skin test. But the medical assistant who does this only plants tests Monday through Thursday because she is off weekends. Thus, there may be a delay of 3 days every week when people are not screened. As well, the burden of tests to be done on Mondays makes it difficult to perform. These barriers result in reduced screening numbers.

The infection control nurse is starting to keep data on TB screening. For the recent 3 month period, 3415 inmates were incarcerated in the jail but only 924 (27%) were screened for TB. The medical team implied to me that most people leave the jail before they could be screened but I could not verify that 73% of those incarcerated leave the jail within a week. These data may mean that inmates remain unscreened for weeks.

My suggestion is to place a Mantoux skin test upon intake admission and read it within 72 hours. This would permit intake nurses to test every incoming inmate and for the medical assistant to

focus entirely on reading tests. This will increase the number of persons screened and will result in earlier screening.

6.d.

There is no negative pressure ventilation system at the jail. The jail has a stated practice of placing an N-95 respirator on any individual identified as suspicious for having tuberculosis. The stated practice is transfer to a local hospital for evaluation. This stated practice needs to be developed into a written standardized policy and procedure.

6.e.

Wound care and MRSA guidelines do not now exist. As with other policies, I recommend utilizing documents from other jails and modifying to accommodate conditions at the Lake County Jail. Dr. Shansky can be helpful in this process.

I did identify on chart review of inmate health requests that inmates with skin lesions consistent with MRSA infection were not timely evaluated. So, improvements can be made when an appropriate procedure is implemented.

I reviewed the 2008 report from the State Board of Health regarding the MRSA outbreak at the jail. Their recommendations should taken into consideration in development of the infection control policy and procedure and infection control manual.

6.f.

A nurse is now assigned to infection control. Surveillance data is modified from data taken from correctTek but getting standardized data has been difficult. Manual derivation of data is still done and this is subject to error.

For MRSA surveillance data, the infection control nurse is basing reports on positive culture results and contact isolation lists. Many false positive reports occur because intake nurses in intake are reporting any skin rash as a presumptive MRSA infection. On the other hand, the infection control nurse never hears about the multitude of patients presumptively treated for MRSA who do not undergo culture. Surveillance needs to be based on actual and presumptive MRSA cases and should include provider referral of presumptive cases. The purpose of surveillance is so that the jail will know when clusters of presumptive MRSA cases exist so that the Sheriff can appropriately sanitize the jail and can effectively control MRSA transmission. The surveillance data should include type of lesion, whether discharge was present, whether the patient was treated and culture result. Results should be sent to Quality Improvement.

For influenza, there is no surveillance data now captured.

For tuberculosis, surveillance consists of skin testing and is done. As mentioned above, only 27% of inmates are screened. Surveillance data should be consistent with CDC requirements. This requires annual employee testing and conversion rates for employees. Suspicious and

active tuberculosis cases should also be tracked.

Finally, it would help is the infection control nurse was working from a standardized procedure for collection of infectious disease data. This is best established by developing a surveillance dataset which was reviewed with the State and Local Department of Health.

RECOMMENDATIONS FOR NEXT 6 MONTHS:

1. Develop an infection control plan that includes tuberculosis screening, MRSA management and influenza management. This plan should also include Occupational Health and Safety required blood borne pathogen practices and isolation procedures in the event of an airborne contagious disease event.
2. Develop treatment guidelines for MRSA, tuberculosis.
3. Develop vaccination procedures for influenza.
4. Develop airborne isolation procedures consistent with Centers for Disease guidelines.
5. Establish surveillance tracking of tuberculosis, skin test rates, conversion rates, employee conversion rates, and MRSA rates,
6. Establish physician oversight over infection control issues.
7. Involve the State Department of Health and Local Department of Health in review and acceptance of the Infection Control policy, procedure, and manual.

7. <u>Access to Health Care</u>.

a. LCJ shall ensure inmates have timely and adequate access to appropriate health care.

b. LCJ shall ensure that the medical request ("sick call") process for inmates is adequate and provides inmates with adequate access to medical care. The sick call process shall include:

(1) written medical and mental health care slips available in English, Spanish, and other languages, as needed;
(2) a confidential collection method in which the request slips are collected by Qualified Medical Staff seven days per week;
(3) opportunity for illiterate inmates and inmates who have physical or cognitive disabilities to access medical and mental health care; and
(4) opportunity for all inmates, irrespective of primary language, to access medical and mental health care.

c. LCJ shall ensure that the sick call process includes logging, tracking, and timely responses by Qualified Medical Staff. The logging procedure shall include documentation of the date and summary of each request for care, the date the inmate was seen, the name of the person who saw him or her, the disposition of the medical or mental health visit (e.g., referral; whether inmate scheduled for acute care visit), and, if follow-up care is necessary, the date and time of the inmate's next appointment. LCJ shall document the reason for and

disposition of the medical or mental health care request in the inmate's medical record.

d. ***LCJ shall develop and implement an effective system for screening medical requests within 24 hours of submission. LCJ shall ensure sick call requests are appropriately prioritized based upon the seriousness of the medical issue.***

e. ***LCJ shall ensure that evaluation and treatment of inmates in response to a sick call request occurs in a clinical setting.***

f. ***LCJ shall ensure that there is an adequate number of correctional officers to escort inmates to and from medical units to ensure that inmates requiring treatment have timely access to appropriate medical care.***

g. ***LCJ shall ensure that Qualified Medical Staff make daily rounds in the isolation areas to give inmates in isolation adequate opportunities to contact and discuss medical and mental health concerns with Qualified Medical Staff in a setting that affords as much privacy as reasonable security precautions will allow. During rounds, Qualified Medical Staff will assess inmates for new clinical findings, such as deterioration of the inmate's condition.***

h. ***LCJ shall revise its co-pay system in terms of amount and waivers and such policy will clearly articulate that medical care will be provided regardless of the inmate's ability to pay. No fee-for-service shall be required for certain conditions, including health screenings, emergency care, and/or the treatment and care of conditions affecting public health, e.g., Tuberculosis, MRSA, pregnancy, etc., particularly for indigent inmates who are not covered by a health insurance plan or policy.***

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

7.a.

Significant progress has been initiated toward obtaining compliance with this item. However, for all the reasons listed below, a considerable amount of work remains to be done. In accordance with the Agreement, the Jail must develop a standardized policy and procedure for this process. My suggestion is that in conjunction with development of a medical procedure, the medical program work with custody on an interagency procedure for handling and managing the health call request process.

Based on requirements of the Agreement, the policy, procedure and interagency arrangements must include the following:

- Confidentiality of collection 7 days a week
- Slips with Spanish and English language
- Method of access for cognitively impaired and illiterate
- A methodology for tracking timeliness of triage and follow up.
- Description of where the patient would be triaged, have face-to-face evaluations and where follow up would occur.
- A methodology for prioritization of slips based on medical seriousness
- A method to track patients not brought for evaluation by custody so that transportation processes can be monitored.

7.b.

The current system of inmates making medical requests utilizes an "inmate medical card". These pieces of paper have room for the detainee to write their complaint but no space for clinical staff to write their evaluation. The health care staff section is very small and only has room to write the date received, triaged and a small line to indicate a response. This response line is inadequate as a clinical response. However, the "card" is adequate provided that nurses write their response in the medical record. If this is done, there must be a way to correlate the request with the nurse note. In chart review it was extremely difficult to correlate a nurse progress note with a specific inmate medical card.

The current system of access is still deficient in that it is not available to all inmates. "Medical Cards" are not available in Spanish or other languages and I could not verify any mechanism for the cognitively impaired or illiterate to access health care. I would suggest using a service by AT &T for telephonic language interpretive services which is priced on a use basis.

7.c-d

A log is maintained which has the date submitted, the date collected and triaged, the name, the complaint, the disposition, the acuity level, the people who had the 72 hour evaluation and appointment date. The nurse collects all slips daily M-F. When she is off or when someone calls in, sick slips are not collected that day. For March there were five days when no slips were collected. There is no face to face on Saturday and Sunday. So there is a large volume on Monday AM. The sick call nurse estimated that there might be 30 medical requests a day. Because officers are available to transport patients only on a limited basis and only between 7:30 AM to 10:30 AM and again from 12:30 PM to 2:30 PM, the single nurse only has 5 hours a day to perform face-to-face evaluations. As a result there are more patients to be seen than can be seen in a day and the excess is merely referred to a provider clinic without a nurse evaluation. The result is that most inmates in the provider clinic leave the facility before anyone sees them for their complaint. Eventually, this will result in mistakes. Staff related to me that a parallel sick call process has developed in which inmates with urgent complaints contact officers who bring them to the clinic as urgent visits. This has probably developed because the routine sick call process is not able to process requests timely.

The actual process of evaluating slips consists of the nurse verifying in CorrectTek that there are no duplicate requests for that inmate. The fact that there are many duplicate requests is

testament that the sick call process is still broken requiring multiple requests before being seen. For non-symptomatic cases, the nurse just addresses the concern by discussing the issue with the detainee; for non-symptomatic request this is adequate. For symptomatic requests the nurse addresses only the most critical requests and refers the others to the clinic.

Face-to-face encounter notes are written as "sick call documentation" or "sick call" notes. Triaging notes are only written on the sick call slip and there may be no documentation in the record. The face-to-face encounter dates are not documented or tracked. The number referred to provider is not tracked. The number reviewed entirely by a nurse is not tracked. Nurse oversight and review is not now being done. When staffing is short, sick call requests are not done.

7.e.

Nurses still perform some face-to-face evaluations cell side. Given that there are 3-4 clinic exam rooms dispersed throughout the jail for the purpose of sick call evaluation, there is probably adequate space for this process. However, because there are in sufficient officers to bring inmates to these rooms, nurses still go to tiers to see inmates.

7.f.

There is general agreement that there are insufficient officers to transport inmates for scheduled appointments for nurse evaluation as well as for medical clinic. As a result inadequate numbers of inmates are seen for requests. I spoke with the transportation officers. Officers who transport inmates get a list daily from the medical staff for all inmates who need to be transported to clinics for sick call or provider visits. These lists have the medical reason for visit and may include diagnostic information. This should be discontinued as it is a HIPPA violation. The transportation officers, based on the number of available officers, prioritize the inmates they will bring to clinic based on the information on the sheet. The officer I spoke to indicated that only about 20-40% of inmate could be brought to their appointment on a daily basis. Those inmates not brought are rescheduled. However rescheduling into an overcrowded schedule results in a steady state of inmates not being able to access care because they will be discharged from the jail before they can be seen.

7. g.

Medical staff do circulate in segregation areas. They document their presence on the tier in a tier log maintained by custody staff. I checked the log for one week in March. On five days there was a notation that medical staff were present on the unit; two days there was no documentation of segregation rounds. When I toured the unit, I asked several inmates if nurses came by to ask if they had problems and all three inmates I asked indicated that nurses do come by to ask if they have problems.

7. h.

Lake County Jail has a co-pay policy which requires a $10 payment for evaluation of sick call requests as well as doctor visits. Effectively, this policy is not enforced. Under the current

circumstances, I agree with not enforcing this policy. Since the process is broken and the system can not effectively process requests or schedule inmates for timely visits, adding a financial component to this dysfunction would only exacerbate the problem.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. Sick call policy and procedure must be developed.
2. Sufficient staff should be available to evaluate all slips.
3. Transportation issues involving getting patient to the clinic must be resolved.
4. Nurses should triage all slips within 24 hours.
5. Emergent issues must be addressed immediately.
6. Slips that include symptoms must include a nurse face to face evaluation in a clinical setting. This should occur no later than 72 hours based on the clinical issue.
7. A system of tracking requests should be maintained.
8. A way to document a face to face evaluation by nursing should be established in the medical record that associates with the medical card in question.
9. The "Inmate Medical Card" should be revised to include:
    a. Mental health requests
    b. Dental requests
    c. A space to date the day the card was received by medical and the date triaged by a nurse
    d. A space for a nurse to write a brief triaging note.
    e. Typical complaint types
10. Metrics should be instituted in the Quality Improvement program to include:
    a. The number of requests picked up daily
    b. The number of slips triaged within 24 hours
    c. The number of slips with symptoms that had a nurse evaluation within 72 hours.
    d. The number of slips referred for provider evaluation.
11. A monthly nurse quality evaluation should include supervisory review of a select number of nurse evaluations to ensure adequate quality.
12. All nurse evaluations should include vital signs.
13. Nurse protocols for evaluations should be developed. These must be approved by the Medical Director.
14. Officers must not be involved in prioritizing patients to bring to clinic off a schedule list. Any prioritization must be performed by medical staff.
15. Officers must not be in possession of scheduling lists which include protected health information.

8. <u>Follow-Up Care</u>.

a. LCJ shall provide adequate care and maintain appropriate records for inmates who return to LCJ following hospitalization.

b. LCJ shall ensure that inmates who receive specialty or hospital care are evaluated upon their return to LCJ and that, at a minimum, discharge instructions are obtained, appropriate Qualified Medical Staff reviews the

information and documentation available from the visit, this review and the outside provider's documentation are recorded in the inmate's medical record, and appropriate follow-up is provided.

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

8. a-b.

The policy or standardized procedure is not yet in place. There is a practice that is in place but it is not standardized and different staff I spoke with gave different interpretations of what is occurring. All inmates returning from off site medical visits (specialty visits or hospitalization) are supposed to go to the intake area for evaluation. This is a sound concept. However, the documentation which is to occur is not consistent. Nurses in intake I spoke with completely re-do another intake screening. Management staff did not understand that this was occurring. If the intake form is re-done, ostensibly any new medications would be picked up and the patient would be assigned another acuity assignment, but I could not verify that this occurs. I could also not verify that upon return from the hospital, patients were timely evaluated.

It is a good idea to have all inmates returning from off-site appointment (specialty visit, ER visits and hospitalizations) return to the jail through intake. However, the intake nurse must work off a standardized procedure for these individuals. I would not perform another intake evaluation for people returning from off-site appointments or hospitalization. Instead, the nurse should evaluate the patient, and consult a provider for any change in condition or change in therapy in order to obtain a new provider order for treatment. A provider must be consulted to renew medication including ordering any new therapy which was prescribed by the hospital or specialty doctors. A follow up appointment must be scheduled at an interval consistent with the condition of the inmate.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. Upon return from the hospital or off-site consultation, all patients should go to a standard central location and be evaluated by a nurse and physician. If a physician is not present, the nurse should evaluate the patient and consult with a physician regarding any change in therapy. This discussion should be documented in the medical record.
2. The patient should be scheduled for a follow up physician visit to discuss and evaluate disease status.
3. For quality purposes, the log should be evaluated monthly to assess whether follow up is occurring as indicated.
4. The inmate must be evaluated for renewal of medication or change in therapy based on the outside visit. The nurse must consult with a physician for these orders.

9. Emergency Care.

a. LCJ shall ensure that Qualified Medical and Mental Health Staff are trained to recognize and respond appropriately to medical and mental health emergencies. LCJ shall train correctional officers to recognize and respond appropriately to medical and mental health emergencies. LCJ shall ensure that all inmates with emergency medical or mental health needs receive timely and appropriate care, including prompt referrals and transports for outside care when medically necessary.

b. ***LCJ shall train all correctional officers to provide first responder assistance (including cardiopulmonary resuscitation ("CPR") and addressing serious bleeding) in emergency situations. LCJ shall provide all correctional officers with the necessary protective gear, including masks and gloves, to provide first line emergency response.***

OVERALL COMPLIANCE STATUS: Partial Compliance

ASSESSMENT:

9.a.

87 of 158 officers (55%) have been trained in health emergencies and CPR. I would ask that Ken Ray send me a set of training material used for this course.

9.b.

I randomly checked the control stations on the 3rd floor of the new jail and 3rd floor south of the old jail. Both areas had a first aid kit including masks and gloves.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The Medical Director should develop a training module for custody staff to include serious medical conditions and blood borne pathogen issues. I ask that Mr. Ray send the latest electronic version of this training material.
2. Officers should be trained and their training should be verified in a tracking log.

10. Record Keeping.

a. LCJ shall ensure that medical and mental health records are adequate to assist in providing and managing the medical and mental health needs of inmates at LCJ.

b. LCJ shall develop and implement policies, procedures, and practices to ensure timely responses to orders for medications and laboratory tests. Such policies,

procedures, and practices shall be periodically evaluated to ensure timely implementation of clinician orders.

c. LCJ shall ensure that medical and mental health records are centralized, complete, accurate, readily accessible, and systematically organized. All clinical encounters and reviews of inmates should be documented in the inmates' records.

d. To ensure continuity of care, LCJ shall submit appropriate medical information to outside medical providers when inmates are sent out of LCJ for medical care. LCJ shall obtain records of care, reports, and diagnostic tests received during outside appointments in a timely fashion and include such records in the inmate's medical record or document the inmate's refusal to cooperate and release medical records.

e. LCJ shall maintain unified medical and mental health records, including documentation of all clinical information regarding evaluation and treatment.

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

10.a.

There is an electronic record in place but staff find it difficult to use. It is not clear to me whether this is a training issue or a problem with the record itself; it isn't clear whether management staff are clear on this issue either. The interface with pharmacy has improved and is considered resolved. However, several areas of concern remain which will be discussed in the pharmacy section. On a few records I reviewed, the provider orders did match with orders in the Medication Administration Record. However, nurses are still capable of ordering medication and I could not verify that physician co-signature is occurring. The organization has performed 8 hours of training of all CHI staff when the contract started in January of 2012. New employees get on the job training but they should receive the same 8 hours of training. This also should be done for all mental health staff. CHI does have a data analyst to assist clinical staff in obtaining data from the electronic record. This is a positive development. This person should work to obtain metrics used to measure performance in the Agreement. There is a support line that is available for staff to call in the event of a problem. We called the number and did get a prompt response from an operator. This call number should be evident on a sign at stations where there is a computer. There is a down-time practice, but it is not standardized into a procedure and this should be done.

10.b.

Policies and procedures on timely responses to orders for medication and laboratory tests need to be developed. These should include physician co-signature for verbal orders.

10.c.

An electronic record is in use. Medical providers do have access to the record and the record is accessible to nurses as they administer medication. Laboratory results are not electronically interfaced with the record which is a problem. Encounters appear to be able to be entered into the record.

10.d.

I did not evaluate whether patients going to outside providers include appropriate information to that provider. However, for inmates going to outside providers the facility does make an attempt to obtain records of the outside visit. Many records do have a summary of the outside visit, but this is not consistently obtained. Records of outside specialty visits are particularly absent. For example, when pregnant females go to the obstetrician a record of that visit is not in the electronic record. The Hollister or some similar summary of treatment and evaluation should be present in the jail record so that the jail providers know what happened at the specialty visit.

10.e.

The electronic record is unified but is not completely electronic. Some elements are scanned into the record.

RECOMENDATIONS FOR THE NEXT 6 MONTHS:

1. An interface with the laboratory vendor should be put in place.
2. Software training should occur when new employees start work.
3. A system of tracking software issues should be instituted to ensure that software problems are solved.
4. A manual back up system should be in place in the event the software goes down. Instructions in the event of software crashes should be documented in a "down time procedure".

11. <u>Medication Administration</u>.

a. LCJ shall ensure that inmates receive necessary medications in a timely manner.

b. LCJ shall develop policies and procedures to ensure the accurate administration of medication and maintenance of medication records. LCJ shall provide a systematic physician review of the use of medication to ensure that each inmate's prescribed regimen continues to be appropriate and effective for his or her condition.

c. LCJ shall ensure that medicine administration is hygienic, appropriate for the needs of inmates, and is recorded concurrently with distributionn.

d. ***LCJ shall ensure that medication administration is performed by Qualified Nursing Staff who shall administer prescription medications on a directly-observed basis for each dose, (unless the physician's order notes that the inmate can self-administer the medication), shall not discontinue medications without a physician's order, and shall accurately document medication orders as being ordered via telephone. Qualified Nursing Staff shall practice within the scope of their licensures.***

e. ***When LCJ has advance notice of the discharge of inmates with serious medical or mental health needs, LCJ shall provide such inmates with at least a seven-day supply of appropriate prescription medication, unless a different amount is deemed medically appropriate, to serve as a bridge until inmates can arrange for continuity of care in the community. LCJ shall supply sufficient medication for the period of transit for inmates who are being transferred to another correctional facility or other institution. LCJ shall prepare and send with transferring inmates a transfer summary detailing major health problems and listing current medications and dosages, as well as medication history while at LCJ. LCJ shall ensure that information about potential release or transfer of inmates is communicated to Qualified Medical and Mental Health Staff as soon as it is available.***

f. ***LCJ shall create a formal mechanism, such as a Pharmacy and Therapeutics Committee, to assist in creating guidelines for the prescription of certain types of medications.***

g. ***LCJ shall ensure that Qualified Medical Staff counsels all patients who refuse medication.***

h. ***LCJ shall secure the medication room and discontinue allowing food to be stored in the medication refrigerator.***

COMPLIANCE ASSESSMENT: Partial Compliance

ASSESSMENT:

11.a.

On chart review, medications appear to be administered within 48 hours; some within 24 hours. The goal should be 24 hours from order. For some orders, no medication arrives from the pharmacy resulting in a couple hours a day per nurse of reconciliation work. Nurses maintain a large stock of medication to use in the event the medication does not arrive from the pharmacy. The pharmacy vendor, management and I had a discussion on this issue. One solution may be a daily delivery of medication which has the potential to reduce reconciliation issues. This will however, stress the ability of the pharmacy to produce non-formulary medication. There will need to be a process for the facility to expeditiously approve non-formulary medication so that pharmacy can quickly dispense it.

There isn't a standardized medication renewal process. This should be coordinated with chronic clinic activity.

11.b.

There are no policies or procedures available on this item yet. There is an existing medication renewal practice but it is not established in a written procedure. Based on conversations with various staff, there appear to be a variety of ways that medication gets renewed. This should be standardized.

11.c.

I observed medication administration. Overall, this item is properly performed. However, I have a couple of comments. One is that there should be an interagency policy and procedure on medication administration that specifies the responsibilities of officers as well as nursing staff. The nursing responsibilities should include the 5 rights of medication administration in the procedure. A second comment is that the nurses are verifying the correct medication compared to the MAR entry prior to medication delivery. Then the medication is placed in an envelope. When the nurse goes to the unit, the identification of the inmate is confirmed but the nurse then takes the pre-verified envelope of medication and administers to the inmate. This is a version of pre-pouring. I would say that this is an accepted but not recommended procedure. It is recommended that verification of the right medication should be made at the time it is administered. This can easily be done because the nurse has the medication administration record available.

11.d.

Medication administration is mostly performed by medical assistants. These individuals all have a certificate on file. I have not yet verified that medical assistants can administer medication and it would be helpful if the Director of Nursing could provide that documentation. Nursing staff do take verbal orders from physicians. When this occurs, documentation of that verbal order has to be in a progress note which I did not consistently find. As well, I could not find evidence of physician co-signing of verbal orders.

11.e.

LCJ does not now provide 7 days of medication to inmates who have serious problems who are discharged. An acceptable policy, procedure and practice needs to be established.

11.f.

There were meeting notes from a Pharmacy and Therapeutics Committee and that group has established a preferred pharmacy list. Sustaining this Committee needs to be evidenced.

11.g.

Currently, nursing staff do not have a written standardized process of addressing medication refusal.

11.h.

There are two rooms where medications are stored. In one of these rooms, there is a tiny narcotics box which does have a lock on it. That box is jammed full of medication. It needs to be larger and the utilization log readily available in the box. There is a significant quantity of stock on hand because provider orders do not always arrive timely from the pharmacy. Nurses therefore need a supply of drugs so that they have medication to complete the order. It is promising that the pharmacy vendor is working closely with CHI to remedy this problem.

There is not a good location to store medication carts, so they are still kept in a central area which is a major walkway in the health care unit. This leaves medications on the cart in view and access to individuals walking through that area. A better arrangement is recommended.

RECOMMENDATION FOR NEXT 6 MONTHS:

1. The quality committee should develop a mechanism to establish the average time from prescription to delivery of medication to the patient.
2. Policies and procedures must be developed for medication administration and storage of medication. Staff must receive regular training on these policies and procedures. In addition to the medical medication administration policy, there should be an interagency procedure which specifies the responsibilities of custody and medical staff in medication administration.
3. Medication administration must be standardized.
4. The procedure for handling refusals of medication must be standardized and developed into policy and procedure.
5. Storage of medication carts should be in a secured area, away from civilians and inmates.
6. Medication renewal should include evaluation of the patient.

12. <u>Medical Facilities</u>.

a. LCJ shall ensure that sufficient clinical space is available to provide inmates with adequate medical care services including:

(1) intake screening;
(2) sick call;
(3) physical assessment; and
(4) acute, chronic, emergency, and speciality medical care (such as geriatric and pregnant inmates).

b. LCJ shall ensure that medical areas are adequately cleaned and maintained, including installation of adequate lighting in medical exam rooms. LCJ shall

ensure that hand washing stations in medical areas are fully equipped, operational and accessible.

c. LCJ shall ensure that appropriate containers are readily available to secure and dispose of medical waste (including syringes and sharp medical tools) and hazardous waste.

d. LCJ shall provide for inmates' reasonable privacy in medical care, and maintain confidentiality of inmates' medical status, subject to legitimate security concerns and emergency situations.

OVERALL COMPLIANCE RATING: Non Compliance

ASSESSMENT:

12.a.

Sufficient space still does not exist to perform intake screening, physical assessments, and acute, chronic or specialty care. There is sufficient space for nurse sick call on the various tiers but there are insufficient officers to present inmates to the nurses. The jail has a plan to renovate a room in the intake area to create an adequate space and I looked at the space and drawing. These appear sufficient. The existing clinic space on the 4th floor is unacceptable as is. I discussed some options with the health administrator. Also, American with Disabilities Act (ADA) accommodations for disabled do not appear to be available on the 4th floor housing units.

The dental unit is unacceptable. There is no water for dental instrumentation and the dentist has his assistant utilize a syringe to squirt water in the patient's mouth during procedures. This is primitive. The compressor is located immediately next to the dental chair creating an extremely loud work environment which is unacceptable. An electric junction box is located immediately next to the dental chair and that junction box is located over a sewer drain. Periodically, when inmates plug up toilets on the floor above, raw sewage spills out from this drain into the clinc and onto the electric junction box. This is unsafe. There are no instruments for restorative procedures. This unit needs to be reconfigured as a minimally contemporary dental unit.

12.b.

The medical areas that are used were clean and equipped with the exception of the dental unit.

12.c.

This item was not reviewed.

12.d.

Privacy of care still does not exist in intake or in the clinic arrangement on the 4th floor. Remedial measures were discussed.

RECOMMEDNATIONS FOR THE NEXT 6 MONTHS:

1. An evaluation room for medical and mental health intake evaluations must be established which permits for both security and privacy concerns.
2. Adequate clinical examination rooms need to be built for sick call request evaluations by nurses and for routine clinic examinations by providers.
3. Develop a plan for medical and mental health infirmary care housing.
4. Remedy the dental clinic situation.

13. <u>Specialty Care</u>.

a. LCJ shall ensure that inmates who se serious medical or me ntal health needs extend beyond the serv ices available at LCJ s hall receive timely r eferral for specialty care to appropriate medical or mental health care professionals qualified to meet their needs.

b. LCJ shall ensure that inmates who have been referred for outside specialty care by the medical staff or another specialt y care provider are scheduled for timely outside care appointments and transported to their appointmen ts. Inmates awaiting outside care s hall be se en by Qualif ied Medical Staff as medically necessary, at intervals of no more than 30 days, to evaluate the current urgency of the problem and respond as medically appropriate.

c. LCJ shall mainta in a current log of all inmates who have been referred for outside specialty care, including th e date of the referral, the date the appointment was scheduled, the date th e appointment occurred, the reason for any missed or delayed appointments, an d information on follow-up care, including the dates of any future appointments.

d. *LCJ shall ensure that pregnant inmate s are provided adequate pre-n atal care. LCJ shall develop and implement appropriate written policies and protocols for the treatment of pregn ant inmates, including appropriate scr eening, treatment, and management of high risk pregnancies.*

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

13.a-b.

There were billing issues involvi ng many specialty providers who se rviced inmates at the jail. As a result, many providers refused to continue to see jail patients. It is easy to get appointments for Infectious Disease, Obstetri cs, Orthopedics, and Oral Surger y. H owever, it is difficult to obtain other consultations. One example was a patient needing a nephrology appointment which was ordered on March 12th. As of May 1st the patient still did not have an identified appointment

and a provider willing to see him can not be located. Dr. Forge is working on improving these relationships and I was told that the billing issues have been resolved. Because of the manner of tracking specialty appointments, the system can not verify the length of time it takes to obtain specialty appointments. If an appointment is canceled it is rescheduled. When rescheduled, it appears as if the appointment is ordered at the time of the reschedule. This needs to be corrected so that the medical staff can identify the length of time an appointment is pending.

The procedure for specialty appointments is not completed. It will need to include a method of managing patients whose appointment extends beyond 30 days. These individuals should be monitored by on-site providers at specified intervals until their specialty appointment occurs.

A no show report should be maintained which lists all appointments which occurred on every day and which did not. The reason for not going to a specialty appointment should be specified and provided to the QI Committee.

13.c.

The log of specialty and other off-site appointments exists. Entries into this log should be started for every patient with an order for a specialty visit. This log should contain the date of the provider order for specialty care and this order should continue for rescheduled appointments.

13.d.

An Obstetrician is now accepting Jail patients. However, records from those appointments are not available to provider staff at the Jail so they do not know the condition of the patient including lab values and items that should be monitored. There is no standard policy or procedure for the care of pregnant women. I recommend that this policy contain timeline requirements of visits for prenatal care as well as the timeliness of the first visit upon incarceration. All pregnant females should receive a provider visit the first opportunity after incarceration unless a complication exists which should be specified in policy. The timeliness of visits must adhere to ACOG standards.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The program should increase the capacity for specialty visits.
2. Specialty appointments which are cancelled because of lack of transport officers should be tracked and reviewed by the Quality Improvement Program. The time from provider order to the appointment should be tracked and reviewed for appropriateness by the Medical Director.
3. Sufficient officer staffing should be assigned to transport patients for scheduled appointments.
4. Persons who fail to go to a scheduled appointment should be tracked and the reason for the missed appointment should be provided. This information should be provided to the Sheriff on a regular basis.

5. Pregnant females should be evaluated by an obstetrician within a week of incarceration. Prenatal lab tests can be performed routinely upon incarceration so that they will be available to the obstetrician and primary care providers at the facility.
6. Information from the obstetrician should be exchanged with the medical staff at the jail and scanned into the medical record.
7. Someone on site should be capable of performing a routine pregnancy visit for pregnant females so that care can be managed along with the obstetrician.

14. <u>Staffing, Training and Supervision</u>.

a. LCJ shall ensure that its health care structure is organized with clear lines of authority for its operations to ensure adequate supervision of the system's health care providers.

b. LCJ shall maintain sufficient staffing levels of Qualified Medical Staff and Qualified Mental Health Staff to provide care for inmates' serious medical and mental health needs

c. LCJ shall ensure that all Qualified Medical Staff and Qualified Mental Health Staff are adequately trained to meet the serious medical and mental health needs of inmates. All such staff shall receive documented orientation and in-service training on relevant topics, including identification of inmates in need of immediate or chronic care, suicide prevention, and identification and care of inmates with mental illness. LCJ shall ensure that all other medical and mental health staff receive adequate training to properly implement the provisions of this Agreement.

d. LCJ shall ensure that Qualified Medical Staff receive adequate physician oversight and supervision.

e. LCJ shall ensure that all persons providing medical or mental health treatment meet applicable state licensure and/or certification requirements, and practice only within the scope of their training and licensure. Upon hiring and annually, LCJ shall verify that all medical or mental health staff have current, valid, and unrestricted professional licenses.

f. LCJ shall ensure that correctional officers are adequately trained in identification, timely referral, and proper supervision of inmates with serious medical needs. LCJ shall ensure that correctional officers are trained to understand and identify the signs and symptoms of drug and alcohol withdrawal and to recognize and respond to other medical urgencies.

g. LCJ shall ensure that correctional officers receive initial and periodic training on basic mental health information (e.g., recognizing mental illness, specific problematic behaviors, additional areas of concern); recognition of signs and symptoms evidencing a response to trauma; appropriately responding to mental

illness; proper supervision of inmates suffering from mental illness; and the appropriate use of force for inmates who suffer from mental illness. Such training shall be conducted by a Qualified Mental Health Professional, registered psychiatric nurse, or other appropriately trained and qualified individual.

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

14.a.

The Sheriff has established a contract with Correctional Health Indiana (CHI). This is a major improvement. There are clear lines of authority internally within the organization which appear adequate. Supervision is evident by staff interviews. However, there will need to be some documented review of provider and nurse performance by respective supervisors.

14.b.

A staffing plan was reviewed. It appears adequate with a couple of exceptions. There appears to be insufficient dental hours. As well, the dentist brings his own assistant which is OK but this arrangement should be formalized in his agreement. Additionally, the withdrawal procedures have not yet been started and there are days when there is no nurse to evaluate sick call requests. Either the system needs to get more efficient or 1-2 more nurses may be needed to address these deficiencies.

14.c.

Documentation of training is in place for medical record training received and all personnel files also include CPR training. However, other training on established procedures and policies is not maintained. This should be done.

14.d.

This program is just getting started. The supervising physician is available full time at the site. With time, there should be documented provider performance evaluations that evaluate the clinical performance of clinicians in a meaningful way against established standards.

14.e.

I reviewed personnel files. All provider, nursing and medical assistant staff have evidence of a license. Physicians should have evidence of a credential file which includes their training verification, Board status if applicable, and any sanctions by licensing boards.

14.f.

87 of 158 officers received training. I will need to verify the content of the training.

14.g.

Refer to Dr. Metzner's report.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. A proper orientation program should be put into place for all employees. This should include orientation to policies and procedures, security rules, and training necessary for functional competency (electronic record training, OSHA training, etc.). A record of training on policies and procedures should be in place.
2. Once adequate movement officers are in place, CHI should monitor the ability to perform required sick call request evaluations and performance under the withdrawal protocol and assess whether staffing is adequate. Also, care of the infirm on the 4th floor needs to be evaluated relative to staffing. This can't be done until policies and procedures are finished.
3. Provider credentialing must be put into place.
4. Officer training must be tracked including name of officer, dates training occurred, and type of training given.

15. <u>Dental Care</u>.

a. LCJ shall ensure that inmates receive adequate dental care, and follow up. Such care should be provided in a timely manner. Dental care shall not be limited to extractions.

b. LCJ shall ensure that adequate dentist staffing and hours shall be provided to avoid unreasonable delays in dental care.

OVERALL COMPLIANCE RATING: Non Compliance

ASSESSMENT:

15.a-b

The dentist only comes on Fridays for about 4 hours. Nurses collecting health care slips indicate that there are about 20-25 dental slips a week. The dentist is available once a week at about 9 AM to 1 PM but transport officers are only available between 7:30 AM until 10:30. So, in effect, the dentist has only about an hour and a half of dental time a week to see patients. He sees about 6-9 patients a session which is less than the number of slips placed. The dental backlog is 6 weeks or longer but it appears that patients with problems leave before the dentist sees them.

As described earlier, the dental unit is unacceptable for contemporary dental care and needs to be rehabilitated.

RECOMMENDATIONS:

1. Dental requests must be tracked in a manner similar to health service requests.
2. Patients with dental pain should not exceed a week in waiting.
3. Dental complaints with pain or infection must be evaluated by medical staff pending an appointment with the dentist.
4. Transportation officer issues must be corrected.
5. The dental unit must be rehabilitated to contemporary standards.

16. Mortality Reviews.

a. LCJ shall request an autopsy, and related medical data, for every inmate who dies while in the custody of LCJ or under medical supervision directly from the custody of LCJ.

b. LCJ shall conduct a mortality review for each inmate death while in custody and a morbidity review for all serious suicide attempts or other incidents in which an inmate was at high risk for death. Mortality and morbidity reviews shall involve physicians, nurses, and other relevant LCJ personnel and shall seek to determine whether there was a patter n of symptoms that might have resulted in earlier diagnosis and intervention. Mortality and morbidity reviews shall occur within 30 days of the incident or death, and shall be revisited when the final autopsy results are available. At a minimum, the mortality and morbidity reviews shall include:

(1) critical review and analysis of the circumstances surrounding the incident;
(2) critical review of the procedures relevant to the incident;
(3) synopsis of all relevant training received by involved staff;
(4) pertinent medical and mental health services/reports involving the victim;
(5) possible precipitating factors leading to the incident; and
(6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.

c. LCJ shall address any problems identified during mortality reviews through timely training, policy revision, and any other appropriate measures.

OVERALL COMPLIANCE RATING: Non Compliance

ASSESSMENT:

16.a-c.

The policies and procedures were not provided to me during the audit; instead they were sent to me by email after the audit. However, the Mortality Review Policy 16.01.11, revised 9/15/11, signed by an unknown party on 9/15/11, and sent to me after the audit, is different from the policy attached to and apparently used in the mortality review conducted on 11/4/11. This indicates that internally, staff are not using an agreed upon policy and procedure. Additionally, I have several problems with the policy signed on 9/15/11. These are:

- Internal audits of a clinical policy should not be performed by the Sheriff.
- When there is a conflict with the Medical Director completing the mortality review, the review should be completed by a different physician, not the Legal Department.
- The physician ultimately responsible for the mortality review should be specified.
- The mortality review should include review of the complete medical record and incident reports involving the detainee.
- The Administrative Review involves an assessment of emergency response actions and can be performed by the Sheriff or other custody staff. Review of an emergency response should be performed by a clinical person under supervision of the Medical Director not by the Sheriff or other custody staff.
- The initial summary or relevant circumstances of death should be by the Medical Director not the Compliance Inspector. This does not mean that the Compliance Inspector cannot give an administrative report of the death to custody staff. But relative to mortality review, the Medical Director should give the initial report.
- The policy does not require presentation and discussion of the separate components of the mortality review. Instead, my reading is that individuals (Compliance Inspector, Legal Department, Medical Director and psychologist or mental health professional) complete components of the report and submit to the Medical Director who either submits a report or notifies health care staff of the findings. Findings should be discussed as part of CQI.

In addition to these problems with the policy and procedure, there were significant problems with the mortality review which was sent to me. Besides the lack of using the signed procedure for the review, there were multiple clinical problems with care of the inmate which were not identified in the review. The clinical problems were serious. It was not also not clear who performed the review and because of the clinical care problems the person conducting the review should have been identified.

RECOMMENDATIONS FOR NEXT 6 MONTHS:

1. A mortality review committee should be established as part of the Quality Improvement Committee.

2. Mortality Review should be conducted by the Medical Director. In the event that there is a conflict with the Medical Director reviewing the case, an independent objective physician can perform the review.
3. Custody, mental health and medical should participate in these reviews.
4. The review should result in a document that gives recommendations for improving aspects of care that were deficient as identified in the mortality review.

B. MENTAL HEALTH CARE: Settlement Agreement Part III Section B

1. ***LCJ shall provide adequate services to address the serious mental health needs of all inmates, consistent with generally accepted correctional standards of care, including sufficient staffing to meet the demands for timely access to an appropriate mental health professional, to ensure qualified mental health staff perform intake mental health screenings and evaluations, and to perform comprehensive assessments and comprehensive multidisciplinary treatment planning. <u>See</u> Section III. A.***

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

As of July 31, 2011 all but one of the QMHP positions were filled (and were county employees except for the Clinical Director) as follows:

1 – QMHP Clinical Director, Ph.D.
1 - QMHP Clinical Supervisor, LCSW
4 - QMHPs, LMHC, LCSW
1 – QMHP-C (Candidate), MSW
9 – QMHS, Crisis Stabilization/Suicide Counselors, B.S. or higher

As of April 2012, the QMHP FTE allocated positions were allocated and filled as follows:

1.0 FTE QMHP Clinical Director, Ph.D.
1.0 FTE QMHP Clinical Supervisor, LCSW
2.0 FTE QMHPs
3.0 FTE QMHP-C (Candidate)
12.5 FTE QMHS, Crisis Stabilization/Suicide Counselors, B.S. or higher

The psychiatrists' allocation, which is not adequate for the needs of the inmate population at the LCJ, will be further discussed in a later SA provision of this report (see section B.3. e.).

The mental health clinical director, Dr. Harman, stated that the current mental health staff allocations were not adequate to perform the basic requirements as mandated by the Settlement Agreement. The basis for his assessment was a current list of 131 inmates who reportedly had not yet received a mental health evaluation. It apparently was not uncommon for many of such inmates to have been incarcerated in incarcerated in the jail for 2-3 weeks.

Other basic statistics such as the percentage of inmates booked who had positive mental healthcare screening from the initial healthcare screening was not known reportedly due to issues with the electronic medical record, CorrecTek (CT).

Recommendations for next 6 months: Resolve issues relevant to the management information system in order to be able to gather basic statistics needed for both management and quality improvement purposes. Many of these MIS issues appear to be related to staff learning more about the capabilities of the CorrecTek system in contrast to CT deficiencies.

2. Timely and Appropriate Evaluation of Inmates.

a. LCJ shall develop and implement policies and procedures to provide adequate screening to properly identify and assess inmates with mental illness, and evaluate inmates' mental health needs. See also Section III.A.2.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment: Policies and procedures relevant to restraint/seclusion, special needs and services, inmate care and treatment, suicide prevention program, governance and administration and inmate care and treatment were reviewed with relevant staff and consultants.

Other policies and procedures, as previously summarized in the September 2011 report, still need to be developed and implemented, which include the following topic areas:

1. Mission and goal
2. Administrative structure
3. Staffing (i.e., job descriptions, credentials, and privileging)
4. Involuntary treatment including the use of forced medications, and involuntary hospitalization
5. Other medicolegal issues including informed consent and the right to refuse treatment
6. Limits of confidentiality during diagnostic and/or treatment sessions with pertinent exceptions described
7. Mental health record requirements
8. Quality assurance and/or improvement plan
9. Research protocols

Recommendations for next 6 months: Complete the recommended draft policies and procedures.

b. LCJ shall ensure that the intake health screening process referred to in Section III.A.2 includes a mental health screening, which shall be incorporated into the inmate's medical records. LCJ shall ensure timely access to a Qualified Mental Health Professional when presenting symptoms of mental illness require such care.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

The major improvement relevant to this Settlement Agreement provision since the September 2011 site visit was that as of January 2012 all intake screening (including mental health/suicide risk intake form) were now completed by a Registered Nurse. In addition, it was reported that all newly booked inmates were receiving such screening although a QI has not been done relevant to this assertion.

As previously referenced, basic statistics such as the percentage of inmates booked who had a positive mental healthcare screening from the initial healthcare screening was not known reportedly due to CorrectTek (CT) problems. In addition, there was a current list of 131 inmates who reportedly had not yet received a mental health evaluation. It apparently was not uncommon for many of such inmates to have been in the jail for 2-3 weeks.

The following statistics were available:

Descriptive measure		January	February	March	April	Total
Total bookings		1043	1087	1360	1259	4749
Completed health screens		1085	1071	1339	1198	4693
Percent booked having health screens		104%	99%	98%	95%	99%

Recommendations for next 6 months: Resolve issues relevant to the management information system in order to be able to gather basic statistics needed for both management and quality improvement purposes.

Additional instructions/documents for next tour: A QI should be performed relevant to both the initial healthcare screening and subsequent mental health evaluations resulting from positive initial healthcare screening.

c. LCJ shall ensure that the mental health intake screening process includes inquiry regarding:

(1) past suicidal ideation and/or attempts;
(2) current ideation, threat, or plan;
(3) prior mental illness treatment or hospitalization;
(4) recent significant loss, such as the death of a family member or close friend;
(5) history of suicidal behavior by family members and close friends;
(6) suicide risk during any prior confinement;
(7) any observations of the transporting officer, court, transferring agency, or similar individuals regarding the inmate's potential suicide risk;
(8) medication history; and
(9) drug and alcohol withdrawal history.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

April 2012 Assessmen t: The m ental health intake s creening process continues to include inquiry regarding the above refe rence elements, which is unchanged from the previous site assessment. Successful implementation of this policy needs to be demonstrated via a QI process.

Recommendations for next 6 months: As above.

3. Assessment and Treatment.

a. LCJ shall ensure that any inmate wh o screens positively for mental illness or suicidal ideation during the intake screening process, or who is otherwise referred for mental health services, receives a comprehensive mental status evaluation in a timely manner from a Qualified Mental Health Professional (immediate for emergent issues, within 24 hours of referral for an expedited comprehensive evaluation, or 72 hours of referral for a routine comprehensive evaluation). The comprehensive mental health evaluation shall include a recorded diagnosis section, includ ing a standard five-Axis diagnosis from DSM-IV-TR, or subsequent Diagnostic and Statistical Manual of the American Psychiatric Association. If Qualified Mental Health Staff find a ser ious mental illness, they shall re fer the inma te for appropriate treatment. LCJ shall revi ew available information regardin g any diagnosis mad e by the inma te's community or hos pital treatment provider, and shall account for the inmate's psychiatric history as a par t of the assessment. LCJ sh all adequately document the comprehensive mental status evaluation in the inmate's medical record.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

Little has changed since the Septem ber 2011 site assessm ent. A February 2012 audit demonstrated significant compliance issues releva nt to tim ely mental health ass essments and frequent lack of com pleted mental health eval uation forms. The timeline ss issues were als o demonstrated by a 131 inm ate "waitlist" of in mates who had not yet been seen in a tim ely manner.

Staff reportedly was frequently not using the m ental health evaluation form due to it being very unwieldy and related to past staff vacancies that created workload issues.

Recommendations for next 6 mon ths: Revise the m ental health evaluation (MHE) form s in order to make them more useful user-friendly. A form designed for inform ation to be presented in a narrative style is recommended. Perform a QI relevant to the timeframe requirements of this SA provision and quality issues pertinent to the completion of the MHE.

b. LCJ shall ensure adequate and timely treatment for inmates whose assessments reveal serious mental illness, including timely and appropriate referrals for specialty care and regularly scheduled visits with Qualified Mental Health Professionals.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment: Inmates with mental illness on the fourth floor currently do not have access to group therapy treatments reportedly due to custody escort officers' issues. Inmates in the locked down units reportedly do not have access to out of cell mental health assessments, which are being done at the cell front.

Inmates on the fourth floor with mental illness in single cells are locked in their cells 23 hours per day except for those housed in G & B section on the fourth floor. These inmates generally have access to the dayroom areas about four hours per day. The lack of out of cell time for inmates in single cells was reportedly primarily due to the lack of programming space within the fourth floor.

As will be described elsewhere in this report, line staff indicated that they had poor access to inmates related to custody staff issues that included lack of adequate numbers of correctional officers for escort purposes.

The underlying factors contributing to lack of compliance with this SA provision are little changed from those identified in the September 2011 site visit assessment, which included the following:

1. mental health staffing allocation and vacancy issues,
2. correctional officer allocation issues,
3. many policies and procedures were still in draft form,
4. an underdeveloped management information system (at present),
5. significant physical plant limitations,
6. lack of an active functioning QI system,
7. current mental health treatment essentially limited to medication management and limited individual mental health counseling. Group therapy programs have not yet been initiated.

Recommendations for next 6 months: Inmates with the most serious symptoms of a mental illness are essentially locked in their cells 23 hours a day reportedly due to primarily physical plant issues. Such restrictions are not only non-therapeutic but are likely to make many of these inmates clinically worse. The current physical plant is not appropriate for many of these inmates with serious mental illnesses and alternative housing options should be explored.

Despite space being available for group treatment, such groups are no longer occurring due to apparent custody issues/practices. These issues need to be resolved in order to allow for out of cell structured activities to occur.

c. ***LCJ shall ensure that treatment plans adequately address inmates' serious mental health needs and that the plans contain interventions specifically tailored to the inmates' diagnoses.***

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment: A stand-alone treatment plan form has not yet been included in CorrecTek. Dr. Harman reported that significant problems continue re: the quality of the treatment plans being produced by the mental health staff. The treatment plan is currently part of the mental health evaluation form. The lack of adequate programming space and correctional officer escort allocations have contributed to the staff exerting less efforts in the development of treatment plans.

The QA audit in February 2012 determined that treatment planning for inmates on suicide precautions was not occurring.

The above assessments were consistent with my review of a sample of healthcare records.

Recommendations for next 6 months: Training, supervision, and a QI relevant to treatment planning needs to occur.

d. **LCJ *shall provide for an inmate's reasonable privacy in mental health care, and maintain confidentiality of inmates' mental health status, subject to legitimate security concerns and emergency situations.***

OVERALL COMPLIANCE RATING: NON-COMPLIANCE

April 2012 Assessment:

LCJ staff reported that little, if any, progress has been made in this area. Intake screening is not occurring inside the satellite medical office in booking. Rather it occurs in the corridor outside the medical office, but away from the high traffic bench area.

In addition, a QA audit in February 2012 determined that mental health staff continues to utilize the bench area to assess inmates upon referral.

Construction on a new intake screening area is scheduled to begin in June 2012.

On the 4th floor, although the psychiatrist sees most patients in his office, the QA audit in February 2012 determined that almost all inmates on suicide precautions are still assessed cell-side, including completion of SRAs. Visiting booths (available should the clinician feel a security issues exists) are not being utilized.

Cell front interviews routinely are done for suicide risk assessments and initial segregation mental health assessments related to both physical plan issues and correctional officer allocation shortages.

Recommendations for next 6 months: Privacy/confidentiality in the mental health setting is similar to sterility in the surgical setting. Resolve the privacy issue.

e. LCJ shall provide adequate on-site psychiatric coverage for inmates' serious mental health needs and ensure that psychiatrists see such inmates in a timely manner.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

The Lake County Council approved 16-hours of psychiatric coverage in October 2011. Marcus Wigutow, M.D. was hired October 8, 2011 for 16 hours per week. He is at the jail four days a week for 4 hours each day. He averages seeing 12 patients per day.

161 inmates were currently being prescribed psychotropic medications. Audits have not been performed re: timelines of appointments with the psychiatrists.

As reported in my September 2011 report, based on national guidelines for psychiatric services in jails and prisons and on my experience in such settings, it is clear that 16 hours per week of psychiatric coverage at the LCJ will be inadequate coverage. Adequate coverage is likely to require at least 1.5 FTE psychiatrists (which could be partially filled by a psychiatric nurse practioner).

Recommendations for next 6 months: Increase the psychiatric allocation to 1.0-1.5 FTE psychiatrists.

f. LCJ shall ensure timely and appropriate therapy, counseling, and other mental health programs for all inmates with serious mental illness. This includes adequate space for treatment, adequate number of Qualified Mental Health Staff to provide treatment, and an adequate array of structured therapeutic programming.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

Significant improvement has occurred relevant to improved access for inpatient psychiatric care (see B. 3. J.).

Except for the improved access to psychiatric hospitalization, little progress has been made relevant to this provision of the SA. Treatment for mental health caseload inmates on the fourth floor consists of medication management and individual counseling in an office setting with some exceptions related to concerns re: potential violence. Structured out-of-cell group therapeutic activities are currently not being offered related to reported custody escort issues.

Segregation inmates generally are not receiving counseling in a setting that allows for adequate sound privacy related to both physical plant issues and correctional officer staffing allocation issues.

Treatment provided to mental health caseload inmates is often negatively impacted by the lack of adequate correctional officer allocations and custody practices.

Recommendations for next 6 months: As stated in B.3.b., inmates with the most serious symptoms of a mental illness are essentially locked in their cells 23 hours a day reportedly related to primarily physical plant issues. Such restrictions are not only non-therapeutic but are likely to make many of these inmates clinically worse. The current physical plant is not appropriate for many of these inmates with serious mental illnesses and alternative housing options should be explored.

g. LCJ shall ensure mentally ill inmates in segregation receive timely and appropriate treatment, including completion and documentation of regular rounds in the segregation units at least once per week by adequately trained Qualified Mental Health Professionals in order to assess the serious mental health needs of inmates in segregation. Inmates with serious mental illness who are placed in segregation shall be immediately and regularly evaluated by a Qualified Mental Health Professional to determine the inmate's mental health status, which shall include an assessment of the potential effect of segregation on the inmate's mental health. During these regular evaluations, LCJ shall evaluate whether continued segregation is appropriate for that inmate, considering the assessment of the Qualified Mental Health Professional, or whether the inmate would be appropriate for graduated alternatives.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

Mental health "rounds" are now being conducted on a weekly basis in the segregation units by the same clinician, who is a QMHP-C. However, the rounds did not involve the QMHP-C walking cell to cell. A process is not yet in place relevant to the mental health assessment of the potential effects of segregation on inmates newly admitted to the segregation unit. A process is not in place relevant to assessing whether an inmate's disciplinary sanction might in any way be mitigated by their mental illness.

Mental health staff is no longer participating in the disciplinary hearing process as a finder of fact.

Recommendations for next 6 months: The mental health rounds process should involve the QMHP walking the segregation tiers cell by cell in order to "check-in" with each inmate. A mental health screening process should be implemented relevant to inmates newly transferred to segregation housing units, which should be performed in a confidential manner in order to assess

relevant mental health issues. A process should eventually be put in place relevant to assessing whether the inmate's disciplinary sanction might be mitigated by their mental illness.

h. LCJ shall maintain an updated log of inmates receiving mental health services, which shall include both those inmates who receive counseling and those who receive medication. The log shall include each inmate's name, diagnosis or complaint, and next scheduled appointment. Each clinician shall have ready access to a current log listing any prescribed medication and dosages for inmates on psychotropic medications. In addition, inmate's files shall contain current and accurate information regarding any medication changes ordered in at least the past year.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

As reported during September 2011, there continued to be significant management information system (MIS) issues relevant to tracking the mental health caseload at LCJ, which makes it difficult to ensure that such inmates are seen in a timely manner. However, during a CorrecTek site visit in February 2012, a new version of the system was installed to track this area. It was my understanding that reports will be generated consistent with the requirements of this SA provision.

Recommendations for next 6 months : Remedy the above management information system problems.

i. LCJ shall ensure that a Qualified Mental Health Professional conducts an in-person evaluation of an inmate prior to a medically-ordered seclusion or restraint, or as soon thereafter as possible. Patients placed in medically-ordered seclusion or restraints shall be evaluated on an on-going basis for physical and mental deterioration. Seclusion or restraint orders should include sufficient criteria for release.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment: The restraint/seclusion policy and procedure remains in draft form. Suggested revisions were discussed with pertinent staff. No inmates have been restrained or secluded for mental health purposes since the September 2011 site assessment.

Recommendations for next 6 months: Finalize the restraint/seclusion policy and procedure.

j. LCJ shall ensure an adequate array of crisis services to appropriately manage the psychiatric emergencies that occur among inmates. Crisis services shall not be limited to administrative segregation or observation status. Inmates shall have access to appropriate licensed in- patient psychiatric care, when clinically appropriate.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment: Arrangements have been made with Logansport State Hospital and the pertinent mental health center to provide access to inmates at the LCJ who are within the appropriate catchment area to be hospitalized at the Logansport State Hospital when clinically appropriate and judicially approved. Nine such inmates have been transferred to this hospital since the last site assessment.

Attempts to make similar arrangement with the Edgewater Community Mental Health Center for inmates at the LCJ within their catchment area have been unsuccessful. There were 4 inmates at the LCJ in this catchment area in need of inpatient psychiatric hospitalization.

Crisis services are were reported to include medications, individual treatment and observation status.

Policies and procedures regarding psychiatric emergencies still need to be developed with particular reference to use of psychotropic medications on an involuntary basis, crisis team treatment and access to inpatient psychiatric hospitalization.

Recommendations for next 6 months: Continue to remedy the above described problem with lack of access to an inpatient psychiatric hospitalization or inmates in the Edgewater Community Mental Health Center catchment area.

*4. **Psychotherapeutic Medication Administration***

a. LCJ shall ensure that psychotherapeutic medication administration is provided when appropriate.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

Policies and procedures relevant to this issue need to be developed.

Staffing allocations for psychiatrists' time are not adequate as previously discussed.

The Medical director and the PT committee have developed and implemented a new formulary in collaboration with the jail psychiatrist.

QI studies relevant to medication management issues were currently lacking. Based on interviews with staff and review of healthcare records, there were clearly problems with untimely medication appointments, untimely renewal of medications and untimely notice to inmates in the context of relevant formulary changes.

Recommendations for next 6 months: QI studies need to be performed re: medication management issues.

b. LCJ shall ensure that psychotropic medication orders are reviewed by a psychiatrist or physician on a regular, timely basis for appropriateness or adjustment. LCJ shall ensure that changes to inmates' psychotropic medications are clinically justified and documented.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

Review of selected healthcare records and information obtained from staff indicated that psychotropic medication orders are often not reviewed by a psychiatrist or physician on a regular, timely basis for appropriateness or adjustment. It was not uncommon to find inadequate physician documentation re: the rationale for inmates' psychotropic medications.

The previously recommended policies and procedures relevant to medication administration should include a policy addressing medication noncompliance, required laboratory testing and continuity of medication issues.

As referenced in other sections of this report, review of inmates' psychotropic medications by a psychiatrist or physician on a regular, timely basis for appropriateness or adjustment was problematic.

Recommendations for next 6 months: The above difficulties are most likely due to the inadequate psychiatrists' staffing allocations and MIS issues. Increase the psychiatrists' staffing allocation and remedy the MIS issues.

c. LCJ shall ensure timely implementation of physician orders for medication and laboratory tests. LCJ shall ensure inmates who are being treated with psychotropic medications are seen regularly by a physician to monitor responses and potential reactions to those medications, including movement disorders, and provide treatment where appropriate.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE
April 2012 Assessment:

See 4. a., b., & c. Also see report by Michael Puisis, D.O.

As previously referenced, policies and procedures need to be developed relevant to this provision of the SA. Audits have not been done re: medication administration.

Recommendations for next 6 months: Develop the relevant policies and procedures and audit implementation.

C. SUICIDE PREVENTION: Settlement Agreement Part III Section C.

1. Suicide Prevention Policy.

a. LCJ shall develop policies and procedures to ensure the appropriate management of suicidal inmates, and establish a suicide prevention program in accordance with generally accepted correctional standards of care.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment: Significant problems remain in implementation of the suicide prevention program policy as evidenced by the February 2012 audit by Lindsay Hayes which demonstrated that all provisions of the suicide prevention policy are not consistently followed. My findings were consistent with the results of that audit.

Recommendations for next 6 months: Train, supervise and monitor staff in the relevant provisions of the SA.

b. The suicide prevention policy shall include, at a minimum, the following provisions:

(1) an operational description of the requirements for both pre-service and annual in-service training;
(2) intake screening/assessment;
(3) communication;
(4) housing;
(5) observation;
(6) intervention; and
(7) mortality and morbidity review.

OVERALL COMPLIANCE RATING: SUBSTANIAL COMPLIANCE

April 2012 Assessment:

The suicide prevention policy includes all of the above provisions. Substantial compliance remains.

Recommendations for next 6 months: Monitor implementation of this policy and procedure.

c. LCJ shall ensure suicide prevention policies include procedures to ensure the safe housing and supervision of inmates based on the acuity of their mental health needs.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

The suicide prevention policy contains the necessary language.

Based upon a QA Audit in February 2012, all inmates on suicide precautions are assigned to suicide-resistant cells.

In almost all instances, inmates were being observed according to the level of required observation. The audit found a few instances in which inmates on Close Observation status were not being observed up to 1 or 2 hours on an overnight shift because of a shortage of available CST staff.

Recommendations for next 6 months: Continue to monitor implementation of the relevant policies and procedures.

d. LCJ shall ensure security staff posts in all housing units are equipped with readily available, safely secured, suicide cut-down tools.

OVERALL COMPLIANCE RATING: SUSTAINED COMPLIANCE

April 2012 Assessment:

See report by Manuel Romero.

As described in the September 2011 report, the following has occurred:

1) Each control booth of the Lake County Jail housing units contain a first aid kit, Ambu bag, and rescue tool (to quickly cut through fibrous material).

2) AEDs are strategically located throughout the facility. Additional AEDs have been purchased and will be located in key areas of the facility as determined by the director of nursing.

3) The director of nursing or designee ensures that all equipment utilized in the response to medical emergencies (e.g., emergency response bag, code cart, oxygen tank, AED, etc.) is inspected and in proper working order on a regular basis.

Sustained compliance in effect.

e. LCJ shall ensure that cells for suicidal inmates shall be retrofitted to render them suicide-resistant (e.g., elimination of protrusive shower heads, exposed bars, unshielded lighting or electrical sockets).

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

April 2012 Assessment:

Non-suicide resistant stools were removed from all cells utilized for inmates that were placed on suicide precautions.

f. LCJ shall document inmate suicide attempts at LCJ in an inmate's correctional record in the classification system, in order to ensure that intake staff will be aware of past suicide attempts if an inmate with a history of suicide attempts is readmitted to LCJ.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

A process has been established via the suicide prevention policy and procedure that includes the following:

> Whenever an inmate is discharged from suicide precautions, the designated QMHP shall enter the information into the "Past Medical History Screen" (i.e. "Suicide Precautions, Date") of the electronic medical record. This information shall not be deleted when the inmate is removed from suicide precautions or released from the Lake County Jail.
>
> The EMT or other designated staff in their absence shall determine from the review of the electronic medical record (i.e., "Past Medical History Screen") whether the inmate was a medical, mental health the suicide risk during any prior confinement within the Lake County Jail. Such information shall be documented on the mental *Health/Suicide Risk Intake Screening Form*.

However, the above has not yet been implemented. It is my understanding that the latest version of CorrecTek has the capability of tracking suicide history but due to users' errors implementation has been problematic.

Recommendations for next 6 months: Training, supervision and monitoring is required.

2. *Suicide Precautions.*

a. LCJ shall ensure that suicide prevention procedures include provisions for constant direct supervision of actively suicidal inmates and close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks). LCJ shall ensure that correctional officers document their checks.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

The February 2012 audit found a few isolated instances in which inmates on Close Observation status were not being observed up to 1 or 2 hours on an overnight shift because of a shortage of available CST staff.

Recommendations for next 6 months: Perform quality improvement audit relevant to this Settlement Agreement provision.

b. LCJ shall ensure that when staff initially place an inmate on Suicide Precautions, the inmate shall be searched and monitored with constant direct supervision until a Qualified Mental Health Professional conducts a suicide risk assessment, determines the degree of risk, and writes appropriate orders. Until such an assessment, inmates shall be placed in gowns recommended and approved for use with suicidal patients.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

The QA Audit of February 2012 found that all inmates initially placed on suicide precautions are provided only a safety smock, safety blanket, and mattress. Consideration is rarely given for clothing after a 24-hour reassessment. Contrary to suicide prevention policy requirements, QMHPs are not clinically justifying removal of clothing during each assessment.

Recommendations for next 6 months: Provide training, supervision and monitoring of this SA provision.

c. LCJ shall ensure that, at the time of placement on Suicide Precautions, Qualified Medical or Mental Health Staff shall write orders setting forth the conditions of the watch, including but not limited to allowable clothing, property, and utensils. These conditions shall be altered only on the written instruction of a Qualified Mental Health Professional, except under emergency circumstances.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

See C.2.b above.

The QA Audit of February 2012 found that all inmates initially placed on suicide precautions are routinely denied showers, visits, or telephone calls. All inmates receive only finger foods. Consideration is rarely given for changing these conditions after a 24-hour reassessment. Contrary to suicide prevention policy requirements, QMHPs are not clinically justifying removal of privileges.

Recommendations for next 6 months: Provide training, supervision and monitoring of this SA provision.

d. LCJ shall ensure inmates on Suicide Precautions receive regular, adequate mental status examinations by Qualified Mental Health Staff. Qualified Mental Health Staff shall assess and interact with (not just observe) inmates on Suicide Precautions on a daily basis.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

The policy was approved 7/15/11. Increased interaction utilizing MHT/CIS (QMHS) staff began 6/22/11 with daily and weekly notations in CT. QMHPs began utilizing "MH Rounds" template in CT on 7/29/11. SOAP-formatted requirements were issued by MH Director on 7/15/11, with expectation that new formatting will commence by 8/31/11. Auditing will then begin and be on-going.

A review of randomly selected medical records of inmates recently placed on suicide precautions indicated a lack of compliance with the requirement of daily progress notes written by a QMHP.

The QA Audit of February 2012 found that most, but not all, inmates placed on suicide precautions are assessed by QMHP staff on a daily basis. There were concerns, however, regarding the quality of documentation in the progress notes to justify continued management on suicide precautions.

Recommendations for next 6 months: Provide training, supervision and monitoring of this SA provision with particular reference to the quality of the progress note documentation.

e. LCJ shall ensure that inmates will only be removed from Suicide Precautions after approval by a Qualified Mental Health Professional, in consultation with a psychiatrist, after a suicide risk assessment indicates it is safe to do so. A Qualified Mental Health Professional shall write appropriate discharge orders, including treatment recommendations and required mental health follow-up.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

The February 2012 QA audit indicated a lack of consistent documentation relevant to consultation with the psychiatrist and inconsistent implementation of the follow-up assessments following discontinuation of suicide precautions. There were also concerns regarding treatment planning not being developed for each inmate in compliance with criteria for treatment planning in the suicide prevention policy.

Recommendations for next 6 months: Provide training, supervision and monitoring of this SA provision.

3. *Suicide Risk Assessments.*

a. LCJ shall ensure that any inmate showing signs and symptoms of suicide is assessed by a Qualified Mental Health Professional using an appropriate, formalized suicide risk assessment instrument within an appropriate time not to exceed 24 hours of the initiation of Suicide Precautions.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

A February 2012 audit result that found that most, but not all, inmates placed on suicide precautions are assessed by QMHP staff within 24 hours utilizing the Suicide Risk Assessment form. Most were assessed within an hour after referral.

Recommendations for next 6 months: Provide training, supervision and monitoring of this SA provision.

b. LCJ shall ensure that the risk assessment shall include the following and findings from the risk assessment shall be documented on both the assessment form and in the inmate's medical record:

i. description of the antecedent events and precipitating factors;
ii. suicidal indicators;
iii. mental status examination;
iv. previous psychiatric and suicide risk history;
v. level of lethality;
vi. current medication and diagnosis; and
vii. recommendations or treatment plan.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

The QA Audit of February 2012 found concerns regarding the comprehensiveness found within the completed the Suicide Risk Assessment forms, i.e., inconsistent quality of documentation to justify continued management on, or discharge from, suicide precautions.

In all cases, QMHP staff was ignoring the diagnosis field on the form. The treatment planning field was also rarely completed in compliance with criteria for treatment planning in the policy.

On February 22, 2012, the findings of the QA Audit were discussed at the weekly Mental Health Staff Meeting.

Recommendations for next 6 months: Provide training, supervision and monitoring of this SA provision.

4. Suicide Prevention Training.

a. LCJ shall review and, to the extent necessary, revise LCJ's suicide prevention training curriculum to include the following topics:

i. the suicide prevention policy as revised consistent with this Agreement;
ii. why facility environments may contribute to suicidal behavior;
iii. potential predisposing factors to suicide;
iv. high risk suicide periods;
v. warning signs and symptoms of suicidal behavior;
vi. observation techniques;
vii. searches of inmates who are placed on Suicide Precautions;
viii. case studies of recent suicides and serious suicide attempts;
ix. mock demonstrations regarding the proper response to a suicide attempt; and
x. the proper use of emergency equipment, including suicide cut-down tools.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

April 2012 Assessment:

As reported during September 2011, although the Settlement Agreement does not specify a required length, the decision was made that all staff receive eight (8) hours of initial suicide prevention training, followed by two (2) hours of annual training. The policy implemented, curriculum was developed, and trainings with Lindsay Hayes occurred from 9/12 – 13 and 9/19-20, 2011 for any staff having regular contact with LCJ inmates.

The training curriculum was reviewed, and as expected, Mr. Hayes training program was excellent.

Recommendations for next 6 months: None

b. Within 12 months of the effective date of this Agreement, all LCJ staff members who work with inmates shall be trained on LCJ's suicide prevention program. Staff shall demonstrate competency in the verbal and behavioral cues that indicate potential suicide, and how to respond appropriately. Initial and at least annual training shall be provided.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

April 2012 Assessment:

Since the September 2011 suicide prevention training workshops, additional correctional and mental health staff have been hired, as well as a new medical services vender. All of these staff are scheduled to receive the 8-hour training by a QMHP in the near future.

The training for new hires is scheduled but not yet completed as originally planned.

Recommendations for next 6 months: Complete the training as planned.

D. FIRE SAFETY: Settlement Agreement Part III Section D.

Overall Comments: The specific areas of the SA that I, Manuel Romero, am responsible for monitoring are: Fire Safety; Sanitation and Environmental Conditions; and Protection From Harm. In general, I continue to see improvements in all of these areas. The most significant issues that need to be addressed in order to achieve substantial compliance in my areas of the SA are to obtain the proper staffing levels of correctional staff in order to be able to properly supervise the housing units, perform the necessary housekeeping and sanitation duties and to be able to provide adequate laundry services. Equally important is to have a sufficient number of correctional staff to assist medical and mental health care staff in supervising and escorting inmates to and from the housing units.

1. Fire Safety.

a. LCJ shall develop and implement a comprehensive fire safety program and ensure compliance is appropriately documented. The initial fire safety plan shall be approved by the State Fire Marshal or the Crown Point Fire Chief or Inspector. The fire safety plan shall be reviewed thereafter by the Marshal, Fire Chief or Inspector at least every two years, or within six months of any revisions to the plan, whichever is sooner.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

Based upon my review of fire safety related documents, staff interviews and personal observations, I found that LCJ has made considerable progress in the development and implementation of a comprehensive fire safety program. The written comprehensive fire safety program has been developed and implemented that includes: a fire safety policy and procedure; a location guide; fire safety forms; a training schedule; a training component; a written test; a practical test; and information regarding fire extinguisher maintenance. The fire safety plan also includes an inspection process and record keeping requirements. A new full-time Fire Safety Officer has been appointed for LCJ and has substantial training and experience in fire safety matters. The initial fire safety plan was reviewed and approved by the Crown Point Fire Inspector on March 29, 2012.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. Lake County Jail staff should include the Crown Point Fire Department crew in some of their evacuation drills as recommended by the Fire Inspector in his March 29, 2012 letter to Lake County.
2. Lake County Jail staff need to ensure that the fire sprinkler system is tested annually and maintain records of those inspections.

b. LCJ shall ensure that comprehensive fire drills are conducted every three months on each shift. LCJ shall document these drills, including start and stop times and the number and location of inmates who were moved as part of the drills.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

Based upon my review of documents and interviews with staff and inmates, I found that the facility has developed a comprehensive fire drill program for the jail. LCJ staff continue to make improvements to the fire drill program. In April 2012 a full-time Fire Safety Officer was appointed. The Fire Safety Officer is charged with the responsibility for ensuring that the fire drill schedule is fully implemented. However, in order to achieve substantial compliance with this paragraph of the SA, Lake County staff will need to ensure that comprehensive fire drills are conducted every three months on each shift as well as documenting the start and stop times and the number and locations of inmates who were moved as part of the drills.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. Lake County staff need to ensure that they stay on schedule with respect to their fire drill program.
2. During the next compliance visit I will be reviewing the fire drill schedule and the results of the documented fire drills.

c. LCJ shall ensure that LCJ has adequate fire and life safety equipment, including installation and maintenance of fire alarms and smoke detectors in all housing areas. Maintenance and storage areas shall be equipped with sprinklers or fire resistant enclosures.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

All of the housing areas and other areas of the facility are equipped with fire and smoke alarm systems. Maintenance and storage areas are equipped with fire sprinklers as well as food service areas. Facility staff continue to ensure that AED's and SCBA's are present in strategic areas of the jail. There were fire extinguishers available in all areas of the jail. The Maintenance Shop

was better organized, but efforts should continue to be made to further reduce the amount of materials, equipment and other items that are stored within.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ staff should continue to adequately maintain their fire and life safety equipment as required by this paragraph of the SA.
2. LCJ staff should continue to reduce the amount of materials, equipment and other items that are stored in the Jail Maintenance Shop.

d. LCJ shall ensure that all fire and life safety equipment is properly maintained and routinely inspected.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

Based upon my review of documents and staff interviews, I found that LCJ staff have continued to conduct inspections of all fire and life safety equipment as well as ensuring it is properly maintained. The LCJ Fire Safety Officer has now been assigned on a full-time basis to oversee the fire safety program. The duties and responsibilities of the Fire Safety Officer, including the provisions of this paragraph of the SA were approved by the Sheriff on May 2, 2012.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ staff should continue to conduct inspections of all fire and life safety equipment and ensure it continues to be properly maintained.

e. LCJ shall ensure that emergency keys are appropriately marked and identifiable by touch and consistently stored in a quickly accessible location, and that staff are adequately trained in use of the emergency keys.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

Facility staff continue to work diligently in developing and implementing a system for emergency key management. The emergency keys have been inventoried. Emergency keys have been placed in all facility control rooms and the radio room. The number of emergency keys assigned to each key ring is manageable. An emergency set of keys has been placed in the Sheriff's Communication Center which is located outside of the Jail. A system of identifying emergency keys by touch has not yet been developed, but LCJ staff are reviewing various options for complying with this requirement. During my previous tour, I observed that the Central Control Center door could not be closed manually due to the positioning of the emergency release component. However, during this tour I found that LCJ staff had addressed the problem and the Central Control Center door can now be closed completely and can be

locked. LCJ staff have developed and implemented a Key Control policy and a key inspection program. LCJ staff are still working on numbering all facility doors in order to match them with the proper keys. Once this process is completed and staff become familiar with the evacuation process, staff will need to be trained in the use of the emergency keys.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ staff need to develop a system of identifying emergency keys by touch.
2. Jail staff need to be trained in the use of emergency keys.

f. LCJ shall ensure that staff are able to manually unlock all doors (without use of the manual override in the event of an emergency in which the manual override is broken), including in the event of a power outage or smoke buildup where visual examination of keys is generally impossible. LCJ shall conduct and document random audits to test staff proficiency in performing this task on all shifts, a minimum of three times per year. LCJ shall conduct regular security inspections and provide ongoing maintenance to security devices such as door locks, fire and smoke barrier doors, and manual unlocking mechanisms to ensure these devices function properly in the event of an emergency.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

During the inspection, jail staff were knowledgeable on how the manual door unlocking system operates. During the tour I inspected and tested several locking mechanisms and doors and all were operable. LCJ staff have developed and implemented a door inspection policy. Staff are now conducting proficiency audits of staff in conjunction with fire safety drills; however, this process needs to be formalized and these audits need to be conducted on all shifts at least three times per year. Also, a full-time Fire Safety Officer is now in place and can ensure that these requirements are met and documented.

RECOMMENDATION FOR THE NEXT 6 MONTHS:

1. LCJ officials should commence formal random audits for testing staff proficiency in performing manual unlocking of all doors with the use of manual override system. The results of these audits should be documented.

ADDITIONAL INSTRUCTIONS/DOCUMENTS FOR NEXT TOUR:

I would like to see documents that demonstrate the results of the inspections/audits that were conducted for the emergency unlocking system and staff response.

g. LCJ shall imple ment competency-based testing for staff regarding fire and emergency procedures.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

With the assistance of the Crown Point Fire Inspector, LCJ staff have developed a training curriculum for fire and emergency procedures. The next step in this process is to ensure that staff are trained in fire and emergency procedures. LCJ staff reported that training in this area is scheduled to commence on July 10-14, 2012.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ staff s hould ensure that com petency-based testing for staff regarding fire and emergency procedures is provided.

h. LCJ shall ensure that fire sa fety officers are trained in fire safety an d have knowledge in basic housekeeping, emer gency preparedness, basic applicable codes, and use of fire extinguishers and other emergency equipment.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

LCJ has assigned a full-time staff member to serve as the facility Fire Safety Officer. The duties and responsibilities for this position were articulated in writing by the Sheriff on May 2, 2012. The duties and responsibilities for this position are included as part of the fire safety plan. The person appointed for this position has an extensive background in fire safety and emergency management. She is a certified fire fighter and has attended numerous trainings in emergency management.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The LCJ Fire Safety Officer should continue to avail herself of available training on fire safety, basic housekeeping, em ergency management, the basic applicable codes , the use of fire extinguishers and other emergency equipment.

E. SANITATION AND ENVIRONMENTAL CONDITIONS.

1. <u>Sanitation and Maintenance of Facilities</u>.

a. LCJ shall revise and implement written housekeeping and sanitation plans to ensure the proper routine clean ing of housing, shower, and medical areas. Such policies should include oversight an d supervision, including meaningfu l

inspection processes and documentation, as well as establish routine cleaning requirements for toilets, showers, and housing units.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

LCJ has implemented some components of their housekeeping and sanitation plans. LCJ plans to have their overall sanitation plans and policies and procedures approved by May 15, 2012. Some of the inspection forms have been developed and are being utilized; however, the daily inspection forms for unit officers have not yet being implemented, primarily due to staff shortages. The sanitation officers are performing monthly sanitation inspections as well as being involved in special housekeeping projects such as removing graffiti from walls, cleaning out pipe chases and power washing various areas of the jail. Sanitation staff have also being involved in replacing shower curtains. Housing unit vents were much cleaner this tour than in past tours; however, this is an on-going process that needs to be made part of the cleaning and sanitation program. The medical area was much cleaner than from previous tours. However, more emphasis needs to be applied to the patient cells, particularly in the mental health areas. During the tour, I observed staff and inmates working diligently to clean and sanitize the jail, particularly the booking area. In general, because the booking area is in constant use, it needs intensified and sustained cleaning and sanitation with particular emphasis in the booking cells and shower areas. A sustained cleaning program, however, cannot be maintained without sufficient staff to provide adequate inmate supervision within the housing units and for the inmate work crews.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ should continue to implement their written housekeeping and sanitation plans for the jail as well fully implementing the inspection program.
2. LCJ staff must ensure that the housing unit inmate workers and inmate work crews are adequately supervised by detention staff at all times.

b. LCJ shall implement a preventive maintenance plan to respond to routine and emergency maintenance needs, including ensuring that shower, toilet, and sink units are adequately maintained and installed.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

LCJ staff continue to make strides in refurbishing the physical plant and making needed repairs to the plumbing system, including the shower areas, cell plumbing, refuge pits and grinders. Ceiling tiles that had been damaged by roof leaks have been replaced. The roof leaks have been repaired. There are continuous painting projects underway. The lighting system was in a good state of repair. A work order process continues to be in place and work orders can be tracked.

LCJ staff have developed a preventative maintenance plan for the plumbing system to address immediate plumbing needs as well as long term needs.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ should continue to conduct needed repairs to the physical plant and plumbing system.
2. LCJ staff should fully implement their written preventative maintenance plan including the schedules for preventative maintenance inspections and repairs, staff assignments that are responsible for inspection and repairs, a description of the work order system and an inventory of regularly needed spare parts and plumbing fixtures.
3. The above requirements should be addressed in a facility policy and procedure.

c. LCJ shall ensure adequate ventilation throughout LCJ to ensure that inmates receive an adequate supply of airflow and reasonable levels of heating and cooling. LCJ shall review and assess compliance with this requirement at least twice annually.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

During the inspection I observed that several inmate cells had the air vents covered with materials thus obstructing air flow. However, I did note continued improvement in this area from my previous inspections. I also observed that in many of the housing unit dayroom areas the return air flow vents were much cleaner and free of lint and debris. However, in order to maintain the ventilation system clean, it requires intense cleaning and staff supervision over the inmate crews that are performing these types of tasks. However, if detention officers are not available in the housing units to properly supervise inmates, it will be difficult, if not impossible to attain and maintain substantial compliance with the requirements of this paragraph.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. Staff should continue to intensify their efforts to ensure that cell vents are not covered by the inmates. This can be partly accomplished by conducting daily cell sanitation inspections. However, there must be sufficient numbers of detention officers available in the housing units in order to accomplish these tasks.
2. Maintenance and the environmental vendor staff should continue to keep records of temperature readings of the housing units and other areas of the jail.
3. The return air vents in the housing unit dayrooms should be regularly cleaned and made free of debris.

ADDITIONAL INSTRUCTIONS/DOCUMENTS FOR THE NEXT TOUR:

During the next tour, I will be reviewing LCJ efforts in attaining adequate staffing levels for providing supervision within the inmate housing units and over the inmate work crews.

d. LCJ shall ensure adequate lightin g in all inmate housing and work areas and cover all light switches with exposed wires.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

During this inspection I did not detect problems with the lighting system. LCJ staff have continued to work diligently on making repairs to the lighting system and replacing light bulbs and fixtures. I did not detect any exposed wiring during my inspection. Lighting in inmate cells and dayrooms was adequate. I did not detect rain water seepage into any light fixtures during this inspection.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ staff should continue to m aintain the lighting and electrical system in a good state of repair. For sustai nability purposes, LCJ staff should m ake the inspection of the lighting system part of their da ily housekeeping inspection program and preventative maintenance program.

e. LCJ shall ensure adequate pest co ntrol throughout the housing units, medical units, and food storage areas.

OVERALL COMPLIANCE RATING: SUSTAINED COMPLIANCE

ASSESSMENT:

During the inspection of inmate housing units, program areas, the food service department, the medical area and general areas of the Jail, I did not detect a problem with pest control. LCJ continues to maintain pest control services that provides for regular inspections and pest control.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ should continue with their pest control program.

f. LCJ shall ensure that all inmates have access to needed hygiene supplies.

OVERALL COMPLIANCE RATING: SUSTAINED COMPLIANCE

ASSESSMENT:

During the inspection I did not observe a problem in this area. Inmates had in their possession needed hygiene supplies, both at intake and in the housing units. LCJ staff continue to maintain a significant amount of hygiene supplies in storage areas.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. Continue to issue inmate hygiene supplies at intake to inmates and as needed.
2. Include in the revised Inmate Handbook hygiene issue quantities and frequency of issue.

g. LCJ shall develop and implement policies and procedures for cleaning, handling, storing, and disposing of biohazardous materials. LCJ shall ensure that any inmate or staff utilized to clean a biohazardous area are properly trained in universal precautions, are outfitted with protective materials, and receive proper supervision when cleaning a biohazardous area.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

There still does not appear to be a comprehensive coherent policy and procedure that addresses this area of operation. There are several policies that in part address this area. I observed during this inspection that spill kits continue to be made available in various areas of the facility. I also observed in the medical area (exam rooms) that biohazard containers with enclosures were available. I also observed that in the biohazard room in the medical area, the containers with biohazard materials were properly covered with lids. LCJ staff reported that a training program is currently under development for addressing the requirements of this paragraph of the SA. However, LCJ staff provide inmates with informal training in the handling and cleaning of biohazard spills and on how to access the cleaning supplies.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ should have their own policy, procedure and staff and inmate training program for this area of operation, including the specific areas of the jail where spill kits and biohazard supplies are kept.

h. LCJ shall provide and ensure the use of cleaning chemicals that sufficiently destroy the pathogens and organisms in biohazard spills.

OVERALL COMPLIANCE RATING: SUSTAINED COMPLIANCE

ASSESSMENT:

The facility continues to use universal cleaning chemicals for cleaning biohazard spills as well as a bleach solution.

RECOMMENDATIONS FOR THE NEXT VISIT:

1. LCJ supervisory staff should continue to ensure that staff and inmates that clean biohazard spills follow the recommended instructions of the chemicals used for the cleanup.

i. LCJ shall inspect and replace as often as needed all frayed and cracked mattresses. LCJ shall destroy any mattress that cannot be sanitized sufficiently to kill any possible bacteria. LCJ shall ensure that mattresses are properly sanitized between uses.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

During the inspection I did not detect any frayed or cracked mattress. There continues to be ample supplies of inmate mattresses in storage for replenishment purposes. Inmates are assigned to clean mattresses between uses. Staff and inmates continue to use sanitation chemicals in accordance with the sanitizing chemical instructions. LCJ staff continue to provide written directives to the trustees and to all inmates as to the proper method of cleaning and sanitizing of mattresses.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ supervisors should continue to train and instruct staff and inmates that are responsible for sanitizing mattresses on the proper use of the sanitizing chemicals. Supervisory staff should continue to inspect and review the mattresses sanitization process and ensure it is done correctly.

j. LCJ shall ensure adequate numbers of staff to perform housekeeping duties.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

LCJ has two full-time and one part-time sanitation officers. These officers continue to provide cleaning materials to inmates and to some extent they also supervise trustee workers. However, inmate workers within the housing units continue to receive little, if any, instruction and supervision for their cleaning duties. I found that sanitation in the housing units has improved from my last tour, but not significantly. The bigger problem continues to be the general lack of supervision of inmates in the housing units. For example, I observed one floor officer trying to provide supervision to inmates in eight pods or two housing units in the new part of the jail, identical to my previous finding. In the old part of the jail, I observed one officer trying to provide supervision of inmates in three to six living units (pods). It is unrealistic to expect that one officer can perform all the duties required of a floor officer and be able to perform them in a qualitative manner. I also observed that officers do not normally enter the actual inmate living

areas, but rather patrol the outside of the dayrooms and the catwalks. If inmates are out of their cells, the officer does not go into the actual living area. I reviewed the Estimated Functional Bed Capacity Report 2010 authored by RJS and noted that the correctional officer force complement was inadequate. The report reflected a shortage of approximately 68 correctional officers. I noted a similar inadequacy as I toured the housing units as described above. Additionally, during my previous tour, the Sheriff's Office presented a comprehensive Staffing Analysis that reflected a shortage of 65 detention officers in order to be able to operate the LCJ in a safe and secure manner as well as to be able to achieve substantial compliance with various provisions of the SA. Since my last tour, LCJ received approval from the Lake County Council to hire 12 additional correctional officers which is step in the right direction. There are simply an inadequate number of detention officers deployed into the housing units to properly supervise inmates and in particular, for supervising inmates that are performing housekeeping duties.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ officials should continue to closely examine their correctional officer staffing levels and move towards providing direct inmate supervision in the inmate housing units in order to better supervise inmates and the housekeeping and sanitation program.

ADDITIONAL INSTRUCTIONS/DOCUMENTS FOR THE NEXT TOUR:

It is expected that LCJ officials continue to work with the Lake County Council in obtaining the proper staffing levels in the correctional officer ranks in order to be able to comply with the requirements of this paragraph of the SA.

2. Sanitary Laundry Procedures.

a. LCJ shall develop and implement policies and procedures for laundry procedures to protect inmates from risk of exposure to communicable disease.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

LCJ has implemented appropriate procedures for the laundry to protect inmates from risk of exposure to communicable disease. The revised policies governing this area of operation have been approved by the Sheriff. As I have reported previously, this area of operation also has staffing implications. In order for LCJ to be able to maintain the laundry operation at this level and in order to be able to implement the proposed laundry schedule, as well as to be able to adequately distribute and pick-up laundry services to inmates in an orderly fashion, the laundry operation will have to expand its hours of operation as well as ensuring that there are ample numbers of detention officers in the housing units to assist in the laundry process. Since my last tour, LCJ officials have implemented a twice weekly laundry exchange program for the female population. This is certainly a step in the right direction.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ should ensure that there ar e adequate levels of detention officers available to be able to implement the revised laundry schedule.

b. LCJ shall ensure that inma tes are provided adequate clean clothing, underclothing and bedding, cons istent with generally a ccepted correctional standards (e.g., at least twice per week), and that the laundry exchange schedule provides consistent distribution and pickup service to all housing areas.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

Based upon my review of purchasing records and observation, LCJ officials continue to maintain a substantial amount of inmate clothing, bedding and towels in order to satisfy this requirement of the SA. However, due to inadequate detention officer staffing levels, LCJ officials have not distributed or issued these items to inmates in accordance with the revised inmate laundry schedule, with the exception of the female population as previously noted above. Based upon my observations, review of documents and staff and inmate interviews, inmates are still not being provided with adequate quantities of clean clothing, underclothing and bedding. For example, laundry exchange still only occurs once per week instead of the required two exchanges per week for the male population. Inmates are only provided with one uniform, one sheet, one towel, one blanket, one mattress and a laundry bag. It appears that blankets are now being exchanged at least once per month which is an improvement from previous tours.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. It is my recommendation that the inmate initial issue for bedding and hygiene consist of: one mattress; two bed sheets; two towels; and one blanket. The sheets and towels should be exchanged at least once per wee k, unless inmates are only issued one sheet and one towel, then they should be excha nged twice per week. Records of services should be maintained.
2. LCJ should ensure that there are sufficient numbers of correctional officers available in order to implem ent the revised laundry sc hedule and to distribute adequate levels of clothing and bedding items to inmates.

c. LCJ shall train staff and educate inmates regarding laundry sanitation policies.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

It appears that a private vendor has continued to provide training to laundry staff. Security staff were provided training on the provisions of the SA as it relates to laundry issues. A system has not yet been developed and implemented for educating inmates regarding laundry sanitation

policies. Staff reported that the Inmate Handbook could be used as one avenue for educating inmates on laundry sanitation policies; however, formal revisions to the Inmate Handbook are still pending. LCJ staff also reported that they intend to post laundry and sanitation expectations for inmates in the housing unit areas.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ staff should include the provisions of the SA in their basic and on-going staff training program so that security and laundry staff are fully aware as to their obligations regarding the facility sanitation policies.
2. The Inmate Handbook should be revised, finalized and include the expectations of inmates regarding laundry sanitation policies.

d. LCJ shall ensure that laundry delivery procedures protect inmates from exposure to communicable diseases by preventing clean laundry from coming into contact with dirty laundry or contaminated surfaces.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

LCJ staff have developed practices that protects inmates from exposure to communicable diseases. The laundry carts are cleaned and sanitized between uses. Staff and inmates are following the manufactures recommended instructions for the proper use of sanitizing chemicals. Facility staff have received training on the proper use of chemicals. Material Safety Data Sheets continue to be made available in various areas of the jail. I did not detect that clean laundry was coming into contact with dirty laundry or contaminated surfaces. LCJ staff have provided written instructions to inmates on the proper use of sanitizing chemicals.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ officials should continue to provide instructions and oversight to staff and inmates on the proper use of sanitizing chemicals and on cross-contamination precautions.
2. LCJ staff should continue to maintain Material Safety Data Sheets in strategic areas of the jail where chemical are used and maintained.

e. ***LCJ shall require inmates to provide all clothing and linens for LCJ laundering and prohibit inmates from washing and drying laundry outside the formal procedures.***

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

The Inmate Handbook has not been revised to include provisions on prohibiting inmates from washing and drying laundry outside the formal procedures. During this tour, I did not observe

inmates washing undergarments, clothing and towels in the sinks, showers or toilets. At least for the female population, LCJ has started to provide laundry exchange twice per week which is an improvement from previous visits. However, the laundry exchange for the male population still only occurs once per week. LCJ staff have not fully implemented the revised laundry schedule due to the lack of staffing.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The Inmate Handbook should contain a prov ision prohibiting inmates from washing and drying laundry outside the formal procedures.
2. Inmates should be issued sufficient quantitie s of clothing and towels to provide for proper hygiene and laundered as previously recommended in this report.
3. LCJ officials should implem ent the re vised laundry schedule and inmate issue provisions concomitant with an adequate facility staffing deployment plan.

3. Food Service.

a. ***LCJ shall ensure that food service at LCJ is operated in a safe and hygienic manner and that foods are served and ma intained at safe temperatures, and adequate meals are provided.***

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

From my observations and interviews with staff and inmates, I found that adequate meals continue to be provided. Meals are prepared in a safe and hygienic manner. LCJ food service staff have made improvements in the area of food temperatures. Temperature readings of meals are taken and recorded. These temperatures are satisfactory. Food carts continue to be delivered to the housing units in a more prompt manner which has immensely helped in maintaining proper food temperatures at serving time. Once the carts are delivered to the housing units I observed that the meals were promptly provided to the inmates. However, this area will need to be monitored closely due to the typical shortage of staff in the housing units.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. Supervisory staff should continue to m onitor food service operations and ensure that food service staff obtain and document food temperatures.
2. Management staff and food service staff need to ensure that m eals continue to be delivered and provided prom ptly to inm ates so that problem s are not encountered with food temperatures.

b. ***LCJ shall ensure that all food service st aff, including in mate staff, must be trained in food service operations, safe food handling procedures, an d appropriate sanitation.***

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

During the inspection I met with food service staff and the dietician as well as conducting an inspection of the kitchen. Many improvements continue to be made in this area since my last inspection. For example, the dumpsters are cleaned on a weekly basis, bumper guards were installed throughout the kitchen, and the kitchen was repainted, among many other improvements. The dietician has continued to train staff as well as inmates on food service operations, the safe handling procedures and on appropriate sanitation. Records of these trainings are maintained. Material Safety Data Sheets continue to be made available in the kitchen.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ should continue to maintain their training records for food service staff and document all training provided, including food service staff orientations. Copies of these staff training sessions should be provided to the LCJ Training Coordinator.

c. LCJ shall ensure that kitchen(s) are staffed with a sufficient number of appropriately supervised and trained personnel.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

The food service department continues to be staffed with nine food service workers. The food service operation continues to be supplemented with inmate workers. The number of staff assigned to the kitchen appears to be sufficient; however, any reduction on the current staffing levels could have negative implications on the food service operation.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ staff should continue to maintain at the very least, the current food service staff complement.

d. LCJ shall ensure that dishes and utensils, food preparation and storage areas, and vehicles and containers used to transport food are appropriately cleaned and sanitized.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

During this tour, I found that dishes and utensils, food preparation and storage areas continue to be clean and sanitary. I also noted that the food service delivery carts and food tray storage carts continue to be appropriately cleaned and sanitized.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. It is recommended that the daily, weekly and monthly sanitation inspection program continues to be part of the food service system.

e. LCJ shall check and record, on a regular basis, the temperatures in the refrigerators, coolers, walk-in-refrigerators, the dishwasher water, and all other kitchen equipment with temperature monitors to ensure proper maintenance of food service equipment.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

LCJ staff have developed and continue to maintain a system for checking and recording temperatures of the refrigerators, coolers, walk-in refrigerators and the dishwasher. LCJ staff are maintaining logs of these checks.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. It is my recommendation that temperatures of all refrigerators, coolers, walk-in refrigerators and the dishwasher water continue to be checked and recorded. This will allow food service staff to detect a temperature problem promptly so it can be corrected.

F. QUALITY IMPROVEMENT PROGRAM: Settlement Agreement Part III Section F.

1. LCJ shall develop and implement written quality management policies and procedures to regularly assess, identify, and take all reasonable measures to assure compliance with each of the provisions of this Agreement, as applicable.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

Basic policies and procedures are in draft form re: a quality improvement program. Little change since September 2011.

Recommendations for next 6 months: Complete and implement the needed policies and procedures.

2. ***LCJ shall develop and implement policies to address and correct deficiencies that are uncovered during the course of quality management activities, including monitoring corrective actions over time to ensure sustained resolution.***

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

F.1 policy needs to be implemented in order to implement this provision of the SA.

The February 2012 QI audit by Lindsay Hayes was a very useful QI activity. Dr. Harmann has also initiated some audits for management purposes.

Recommendations for next 6 months: Complete and implement the needed policies and procedures.

3. ***LCJ shall institute a Quality Improvement Committee and ensure that such committee meets on a monthly basis and that this committee includes representatives from medical, mental health, and custody staff.***

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

April 2012 Assessment:

A QI committee has been established, which has met on one occasion during February 2012.

Recommendations for next 6 months: The QI committee should meet on a monthly basis and maintain adequate minutes.

4. ***Quality management programs related to medical and mental health care will utilize performance measurements to assess quality of care and timely access to care with quantitative and qualitative data analysis and trending over time and specifically shall address:***
    - ***a. the effectiveness of the intake assessment, referral, and sick call process;***
    - ***b. the management and utilization of psychotropic medications;***
    - ***c. suicide prevention, including assessment of suicide risk, review and tracking of suicide attempts, monitoring of inmates on suicide observations or precautions;***
    - ***d. the appropriateness of physical plant facilities such as safe cells for management of at risk inmates, and follow-up and treatment for those who may have engaged in suicidal or self-harm activities;***
    - ***e. the appropriateness of treatment planning and treatment interventions for inmates in the mental health program;***

f. discharge planning for the effective management and continuity of care for inmates leaving the system; and

g. the quality of medical records and other documentation.

OVERALL COMPLIANCE RATING: NON-COMPLIANCE

April 2012 Assessment: Very little progress has occurred re: these SA provisions.

Recommendations for next 6 months: Complete and implement the needed policies and procedures as previously referenced.

G. PROTECTION FROM HARM: Settlement Agreement Part III Section G.

5. Use of Force by Staff.

a. LCJ shall develop and maintain comprehensive and contemporary policies and procedures surrounding the use of force and with particular emphasis regarding permissible and impermissible use of force.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

LCJ staff have developed and are maintaining comprehensive and contemporary policies and procedures surrounding the use of force and emphasizes permissible and impermissible use of force. The revised Use of Force policy was signed by the Sheriff on September 14, 2011.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The finalized policy concerning the Use of Force should continue to be implemented.

b. LCJ shall address the following impermissible uses of force in its use of force policy and in the pre-service and in-service training programs for correctional officers and supervisors:

(1) use of force as an initial response to verbal insults or inmate threats;

(2) use of force as a response to inmates' failure to follow instructions where there is no immediate threat to the safety of the institution, inmates, or staff, unless LCJ has attempted a hierarchy of nonphysical alternatives that are documented;

(3) use of force as punishment or retaliation;

(4) striking, hitting, or punching a restrained inmate;

(5) use of force against an inmate after the inmate has ceased to offer resistance and is under control;

(6) use of choke holds on an inmate; and

(7) use of unnecessary or excessive force.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

The final Use of Force Policy and Procedure contains the provisions of paragraph b. and sub-paragraphs 1-7 of the SA.

The Use of Force pre-service and in-service training program on the Use of Force Policy and Procedure has been initiated. LCJ has provided training on the Use of Force policy to six instructors. Since my last visit, 24 correctional officers have received training on the Use of Force Policy. Training on the Use of Force policy is now part of the pre-service and in-service staff training program. LCJ staff are working diligently on implementing the revised use of force program, but it will take some time to train and retrain all LCJ staff on this new program.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ officials need to continue to train correctional staff on the Use of Force policy.

c. LCJ shall develop and implement a policy to ensure that staff adequately and promptly report all uses of force.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

The revised Use of Force Policy and Procedure has been developed and finalized. The policy contains this provision of the SA. LCJ staff have commenced the process of providing training on the Use of Force policy to staff as noted previously above.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ officials should commence a process of monitoring this requirement of the SA internally.
2. LCJ staff should start to qualitatively track, review and analyze use of force incidents for conformance with the SA.

d. LCJ shall ensure that use of force reports will:

(1) be written in specific terms in order to capture the details of the incident;

(2) contain an accurate account of th e events leading to the use of force incident;

(3) include a description of the weapon or instrument(s) of restraint, if any, and the manner in which it was used;

(4) be accompanied with the inmate disciplinary report that prompted the use of force incident, if applicable;

(5) state the nature and extent of in juries sustained both by the inmate and staff member;

(6) contain the date and time medical attention was actually provided;

(7) describe, in factual terms, the type and amount of force used and precise actions taken in a particular incident and avoid use of "boiler plate" descriptions for describing force, such as, "inmate taken to the grou nd with the force that was necessary;" and

(8) note whether a use of force was videotaped. If the use of force is no t videotaped, the reporting correctional officer and supervisor will provide an explanation as to why it was not videotaped.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

The revised Use of Force Policy and Procedure contains the elements of this provision of the SA including sub-paragraphs d. 1- 8. The revised Use of Force Policy and Procedure has been approved and signed and implementation has commenced.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The revised Use of Force Policy and Procedure should continue to be implemented.
2. I would also recommend that a n ew use of force report f orm be developed and implemented that includes all the elements of this provisions of the SA.

e. LCJ shall require prompt administrative r eview of use o f force repo rts. Such reviews shall include case-by-case review of individual incidents of use of force as well as more sy stemic review in order to identify patterns of incidents. LCJ

shall incorporate such information into quality management practices and take necessary corrective action.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

The revised Use of Force Policy an d Procedure contains the provisions of this paragraph of the SA. LCJ staff have commenced the process of training staff on the revised Use of Force policy.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The revised Use of Force Policy and Procedure should continue to be implemented and continue to train security staff and supervisors on it.
2. It is also my recommendation that all use of force incidents continue to be reviewed by the Deputy Warden of Security and the Warden.
3. During my next review I will be review ing use of force reports and the review process of use of force incidents.

f. LCJ shall ensure that Qualified Medi cal Staff reques t that inma tes sign arelease of medical records for the limited purpose of adminis trative and investigative review o f any inciden t involving an inmate injury. Q ualified Medical Staff will docu ment the re quest and the inmate's response. LCJ will ensure that inmates receive adequ ate medical care regardless of whether they consent to release their medical records.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

This provision of the SA is addressed in the re vised Use of Force Policy and Procedure. LCJ staff and their consultants are working with Dr. Ron Shansky on ensuring that these requirements of the SA are met and are also addressed in medical policy and procedure.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. It is recom mended that the m edical policies and procedures be developed and finalized and include these prov isions of the SA and that both security and medical staff start receiving training on them.

g. LCJ shall ensure that managemen t review of use of force reports an d inmate grievances alleging excessive or inappropr iate uses of force includes a timely review of medical docu mentation of inma te injuries as rep orted by Qualified Medical Staff, includ ing documentation sur rounding the initia l medical encounter, an anatomical drawing that depicts the areas of sustained injury, and information regarding any further medical care.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

These provisions of this paragraph of the SA are addressed in the revised Use of Force Policies and Procedures. RJS consulting staff are working with the medical staff in ensuring that the medical policies and procedures address these provisions of the SA as well.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ Staff should continue with the implementation the revised Use of Force Policy and Procedure.
2. The medical policies and procedures should be developed and implemented and should contain the provisions of this paragraph of the SA.

h. LCJ shall establish criteria that trigger referral for use of force investigations, including but not limited to, injuries that are extensive or serious; injuries involving fractures or head trauma; injuries of a suspicious nature (including black eyes, broken teeth, injuries to the genitals, etc.); injuries that require treatment at outside hospitals; and reports of events by staff and inmates that are inconsistent.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

The revised Use of Force Policies and Procedures contain the provisions of this paragraph of the SA. As addressed previously in this report, some staff training has already been conducted regarding this provision paragraph of the SA. However, all staff need to be trained on it as part of the pre-service and annual in-service staff training program.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ staff should continue to train all correctional staff on the revised Use of Force Policy and Procedure.
2. During the course of use of force reviews management staff should start to qualitatively assess the triggering criteria for use of force investigations and make the necessary referral to IA.

i. LCJ shall develop and implement a system to track all incidents of use of force that, at a minimum, includes the following information:

(1) a tracking number;
(2) the inmate(s) name;
(3) housing assignment;

(4) date;
(5) type of incident;
(6) injuries (if applicable);
(7) if medical care is provided;
(8) primary and secondary staff involved;
(9) reviewing supervisor;
(10) external reviews and results (if applicable);
(11) remedy taken (if appropriate); and
(12) administrative sign-off.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

These provisions of this paragraph of the SA have been incorporated into the revised Use of Force Policy and Procedure. The revised Use of Force Policy and Procedure has been approved, signed and partially implemented. The system to track all incidents of use of force has not been developed or implemented. RJS Consultants should be able to provide guidance in this critical area of the use of force program.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The revised Use of Force Policy and Procedure should continue to be implemented.
2. The system for tracking all incidents of use of force should be promptly developed and implemented.

j. LCJ shall ensure that as part of a use of force incident package, security supervisors shall ensure that photographs are taken of any and all reported injuries sustained by inmates and staff promptly following a use of force incident. The photographs will become evidence and be made part of the use of force package and if, applicable, used for investigatory purposes.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

These provisions of this paragraph of the SA are contained in revised Use of Force Policy and Procedure. The revised Use of Force Policy and Procedure has been approved and signed and partially implemented. There has been some training provided on these provisions to LCJ staff. Video recordings of use of force incidents are maintained by the Deputy Warden. Supervisors are required to obtain photographs of reported injuries sustained by inmates during a use of force incident.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The revised Use of Force Policy should continue to be implemented in order to be able to fully evaluate compliance with the SA.
2. During the next tour, I will be reviewing video recordings and photographs taken following use of force incidents.

k. LCJ shall establish an "early warning system" that will document and track correctional officers who regularly employ force on inmates and any complaints related to the excessive use of force, in order to alert LCJ administration to any potential need for retraining, problematic policies, or supervision lapses. Appropriate LCJ leadership, supervisors, and investigative staff shall have access to this information and monitor the occurrences.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT: An early warning system is addressed in the revised Use of Force Policies and Procedures. The revised Use of Force policy and procedure has been approved and signed and implemented. It is too early to evaluate the overall requirements of these provisions of this paragraph of the SA because the overall system is not yet developed and implemented. Currently, there is an informal process in place whereby the Deputy Warden reviews and monitors use of force reports.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The revised Use of Force Policy and Procedure should continue to be implemented.
2. Concomitant with the implementation of the Use of Force Policy and Procedure, LCJ staff should start developing and implementing the early warning system described in the revised Use of Force Policy and Procedure. RJS Consultants can assist LCJ in this endeavor.

l. LCJ shall ensure that a supervisor is present during all planned uses of force.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

This provision is addressed in the revised Use of Force Policy and Procedure. The revised Use of Force Policy and Procedure has been approved and signed and partially implemented. It appears that a supervisor is deployed to planned uses of force events.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The revised Use of Force Policy and Procedure should continue to be implemented.

2. During the next tour I will be reviewing planned uses of force for compliance with this provision of the SA.

m. Where there is evidence of staff misconduct related to inappropriate or unnecessary force against inmates, LCJ shall initiate appropriate personnel actions and systemic remedies, as appropriate. LCJ shall discipline appropriately any correctional officer found to have:

(1) engaged in use of unnecessary or excessive force;
(2) failed to report or report accurately the use of force;
(3) retaliated against an inmate or other staff member for reporting the use of excessive force; or
(4) interfered or failed to cooperate with an internal investigation regarding use of force.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

The revised Use of Force Policy and Procedure contains the provisions of this paragraph of the SA. The revised Use of Force Policies and Procedures have been approved, signed and partially implemented.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. It is recommended that the revised Use of Force Policy and Procedure continue to be implemented so that full compliance can be evaluated with respect to discipline of staff that have used inappropriate or unnecessary force against inmates.

n. LCJ shall develop and implement accountability policies and procedures for the effective and accurate maintenance, inventory and assignment of chemical and other security equipment.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

The revised Use of Force Policy and Procedures address incapacitating agents, electronic control devices and the use of the restraint chair. The procedure for the maintenance, inventory and assignment for the electronic control device is addressed in the use of force policy. However, the policy does not contain those controls for restraint equipment such as handcuffs and leg irons. However, LCJ maintains other policies and procedures governing all security equipment and have been cross-referenced with the Use of Force Policy and Procedure and contain the specific provisions of this paragraph of the SA. [1] During this tour I reviewed use of force incidents. I

[1] During the course of my inspection I noted that detention staff are required to purchase their own OC spray. I also noted that some officers carry OC spray that has expired. In most jurisdictions, the facility provides detention staff

noted that in many instances where the Taser was deployed, it was generally used on mentally ill inmates or in the intake area. In my review of the use of the Taser incidents, I noted that it is not always deployed in a safe manner. For example, the target area should not be in chest area, but some inmates were tased in that area of the body and in some instances, while not necessarily intended, were tased to the neck or face area. I further noted that some inmates were tased multiple times with both the electronic prongs and in the drive stun mode with the Taser in conjunction with physical force and restraint operations.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The revised Use of Force Policy and Procedures should continue to be implemented.
2. RJS staff indicated that they would be working with LCJ staff in addressing the proper use of the Taser and its application on mentally ill inmates. During the next tour I will be reviewing use of force reports and also assessing efforts LCJ staff have made on the proper use of the Taser.

o. Use of Force Training:

(1) LCJ shall develop an effective and comprehensive training program in the appropriate use of force.

(2) LCJ shall ensure that correctional officers receive adequate training in LCJ's use of force policies and procedures.

(3) LCJ shall ensure that correctional officers receive adequate training in use of force and defensive tactics.

(4) LCJ shall ensure that correctional officers receive pre-service and in-service training on reporting use of force and completing use of force reports.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

The staff training provisions for the requirements of this paragraph of the SA have been developed and the implementation process has commenced. Six use of force instructors have been identified and have received an 80 hour training course on the use of force. A 40 hour training course on the use of force for officers and supervisors has been developed and partially implemented. The 40 hour block of use of force training will be provided to all new correctional officers as well as a 4 hour annual refresher course on the use of force.

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with all security equipment including OC spray. It is difficult for LCJ supervisors to maintain strict accountability and control of chemical agents when detention staff are required and allowed to purchase their own OC spray. As the new Use of Force policy is implemented it will be difficult for LCJ to comply with the provisions of this paragraph of the SA under the current practice of OC spray issuance.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ should continue to provide staff training to all officers and supervisors on the use of force in accordance with their training schedule.

p. LCJ shall ensure that inmates may report allegations of the use of excessive force orally to any LCJ staff member, who shall reduce such reports to writing.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

The revised Use of Force Policies and Procedures contain the provisions of this paragraph of the SA. The revised Use of Force Policies and Procedures have been approved signed and partially implemented. LCJ officials should monitor this provision during the course of use of force reviews. Also, this reporting provision should be addressed in the Inmate Handbook so that inmates are fully aware of reporting avenue.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The revised Use of Force Policies and Procedures should continue to be implemented.
2. LCJ staff should revise the Inmate Handbook and insert language that allows inmates to report allegations of the use of excessive force orally to any LCJ staff member.

q. LCJ shall ensure that Qualified Medical Staff question, outside the hearing of other inmates or correctional officers if appropriate, each inmate who reports for medical care with an injury, regarding the cause of the injury. If, in the course of the inmate's medical encounter, a health care provider suspects staff-on-inmate abuse, that health care provider shall immediately:

(1) take all appropriate 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 LCJ administrator;

(3) adequately document the matter in the inmate's medical record; and

(4) complete an incident report.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

These provisions of this paragraph of the SA are addressed in the revised Use of Force Policy and Procedure. The revised Use of Force Policy and Procedures has been approved signed and partially implemented. LCJ staff are working with the medical staff to ensure that the medical policies and procedures also contain the provisions of this paragraph of the SA.

RECOMENDATIONS FOR THE NEXT 6 MONTHS:

1. The revised Use of Force Policies and Procedures should continue to be implemented.
2. These provisions should also be addressed in the medical policies and procedures.

r. LCJ shall develop, assign, and train a team of specialized use of force investigators that will be charged with conducting investigations of use of force incidents. These use of force investigators shall receive at the outset of their assignment, specialized training in investigating use of force incidents and allegations.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

These provisions of this paragraph of the SA are addressed in the revised Use of Force Policies and Procedures. The revised Use of Force Policies and Procedures have been approved, signed and partially implemented. The Sheriff has designated two Lake County Police investigators to serve as the specialized use of force investigators as required by this paragraph of the SA. During the tour I interviewed the Chief Investigator and noted that he has substantial experience in both criminal and administrative investigations and had served as Deputy Commander of Investigations for the Lake County Policy Department for approximately 6 1/2 years in addition to other law enforcement experience. The second investigator also possesses substantial investigative experience. LCJ staff reported that they are in the process of developing an investigative guideline manual for use by the specialized use of force investigators.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The revised Use of Force Policy and Procedures should continue to be implemented.
2. It is further recommended that LCJ officials develop and implement their investigative guideline manual for the use of force investigative process.
3. I also recommend that the specialized use of force investigators receive formal training on the revised Use of Force policy to further assist them in their investigative duties.

s. LCJ shall ensure that incident reports, use of force reports and inmate grievances are screened for allegations of staff misconduct and, if the incident or allegation meets established criteria, that it is referred for investigation.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

The revised Use of Force Policies and Procedures address the provisions of this paragraph of the SA. The revised use of Force Policies and Procedures have been approved, signed and partially implemented. Supervisory staff reportedly screen inmate grievances for allegations of abuse as well as incident reports and use of force reports.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The revised Use of Force Policies and Procedures should be implemented.
2. During the next tour I will be reviewing the process for screening inmate grievances, incident reports and use of force reports for allegations of staff misconduct for conformance with this provision of the SA.