FOURTH COMPLIANCE REPORT
LAKE COUNTY JAIL
DECEMBER 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 been in place since January of 2012 and in general is performing well. The organization is still challenged in attempting to measure performance against the Agreed Order due to in ability to obtain data from the electronic record. A notable change in the program is the beginning of charging inmates for evaluation of health services requests. We discussed the metrics listed below. The program was able to provide data on several items but not all.

- The length of time from intake screening to provider assessment by acuity status.
  - This item should include acuity status. Only 28% of intake screenings get a 14 day assessment, ostensibly because so many people are discharged before 14 days. As discussed, the 14-day assessment is less meaningful than promptly evaluating high priority patients. For this reason, it is important to provide the length of time it takes to evaluate those with chronic illness after intake screening. Also, approximately 7% of patients refused an initial assessment after screening. This is not a credible excuse.
- Percent of incarcerated detainees who receive intake screening.
  - 97% were done
- Percent of incarcerated detainees who receive tuberculosis screening.
  - I was told that all incoming inmates receive a Mantoux skin test, but data needs to be provided.
- Number of health care slips picked up daily.
  - 99% are paper triaged or FTF triaged within 24 hours but only 36% have a FTF assessment within 72 hours. Few patients are getting follow up provider visits.
- Number and percent of health care slips picked up which are triaged with 24 hours.
  - 99% are triaged in 24 hours.
- Number and percent of symptomatic complaints on health care slips which have a face-to-face evaluation within 72 hours.
  - 36% of symptomatic complaints are evaluated face-to-face by a nurse. This is largely due to lack of movement officers.
- Average time from physician order to administration of medication for prescription medication.
  - The organization is having a hard time getting data for this. From chart reviews it appears that patients coming in from intake are receiving medication within 24

hours of order. The organization should study how to obtain this data.

- 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.
    - This was not provided but we discussed this report. The data must show all scheduled appointments and all no shows including the reason for no show.

Quality improvement metrics have not yet been developed. I would suggest that the group work with Dr. Shansky in developing these. I would include quality of primary care medical notes as one of these audits.

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:

Much work has been done on policies but the work has not been specifically focused on the 15 required policies for this agreed order.

The team needs to focus on the 15 policies required in the Agreement. The policies need to be:

- Simplified
- Written for line staff
- Focused on the items in the Agreed Order

- Written as combined policy and procedure (when a lengthy procedure subject to change is part of the procedure, include it as an appendix rather than incorporate it into the document)
- Addresses all areas of concern in monitoring

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 inter-agency 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. <u>Intake Screening and Health Assessments</u>.

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. There is a separate policy and procedure. These should be combined. I was shown a draft policy but a finalized product is pending. The procedure includes acuity rankings but no direction is given as to where this acuity ranking is to be documented. I had trouble locating this in the electronic record. I discussed with medical leadership the acuity ranking system. The process of assigning acuity and follow up with a primary care provider should be included in the procedure; however, how the provider sees the patient isn't clear and based on chart reviews wasn't always happening. This should include timeframes for assessments. Also, it isn't clear how the detoxification protocol will work in practice. There should be direct provider involvement in starting a detoxification protocol. TB screening and criteria for entering someone into detoxification should be included or should reference other policy.

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. Demolition has started on this area.

3 b. (1-7)

The existing medical intake form in electronic format is adequate for purposes of screening.

3 c.

The policy on health assessments needs to be re-worked. What should be addressed is how acuity rankings assigned by nurses in intake are addressed by providers. What should be included is the timeframe to accomplishing the assessment based on the acuity ranking. The extent of the evaluation by providers should be addressed based on their acuity ranking. Training of staff should be undertaken. After training, audits should focus on appropriate assignment of acuity by intake nurses, timeliness of provider assessments, and the quality of the assessments.

3 d.

Nurses are appropriately and reasonably obtaining medication history from incoming detainees.

3 e.

From a sample of records reviewed, patients coming into intake on medication received their first dose at the facility within a day. This occurs apparently via a telephone order. However, there is no documentation that a telephone order was taken and providers often do not sign these orders. Unsigned orders can be listed in a report. If such reports were used and managed, these

unsigned orders could be substantially reduced. This must be done, because in CorrectTek, a nurse can write an order under a provider's name. If not signed, it appears as if the provider is writing a prescription when, in effect, it is a nurse.

3 f.

Refer to Dr. Metzner's report.

3 g.

The current procedure for alcohol withdrawal does not give sufficient guidance to the intake nurse. After performance of the CIWA, the nurse will need to know at what score should a patient be sent to a hospital and below what score can patients safely be housed at the jail? Also, the housing location needs to be specified. As well, the frequency of nurse follow-up needs to be specified.

Also, the choice of medication for alcohol withdrawal should be re-evaluated. Phenobarbital is not recommended for first line alcohol withdrawal. It should be reserved for refractory delirium tremens which would not be treated at the jail. Anti-epileptics generally also have no place in routine withdrawal treatment. Benzodiazepines remain the drug of choice for these patients.

Finally, specific directions for intoxication (specifically alcohol intoxication) are not present in current procedures. What is a nurse to do when an intoxicated individual is arrested?

3 h.

The intake screening information is electronically incorporated into the medical record and all records were accessible to me upon inspection. It is still possible for an individual to have two separate records. Merging records is done daily, yet this problem requires identification by a provider who notices two separate records; it should be automatically performed by the electronic medical record software.

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 interagency 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. A standardized system of review of the intake evaluations should be put in place. These documented reviews should be discussed with nurse staff and placed in their personnel record.
3. Privacy should be established for intake screening evaluations.
4. Standardized alcohol and opiate withdrawal procedures should be developed and synchronized with orders in the electronic record. These procedures should be approved by the Medical Director and should be consistent with standardized treatment of withdrawal syndromes. Existing procedures must address how to use the CIWA scale to determine who should be sent to a hospital, how to start or continue medication, where patients in detoxification should be housed, and how follow up of detoxification is to occur.
5. Re-evaluate medication used in the withdrawal procedures.
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.
8. Develop a procedure for alcohol intoxication.
9. Include in the detoxification procedure opiate withdrawal and how it will be handled.

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:

The policy on emergency medical response and admission to hospitals is not completed. There should be a procedure for emergencies which require hospitalization and how a detainee would be evaluated and sent to a hospital. As well, there should be a procedure for onsite urgent care evaluations. There should be a log of onsite and offsite urgent or emergent responses. The policy should indicate what hospitals the Jail has arrangements with for care.

A paper hospital log is in place. This log is generally satisfactory. There is a log of urgent responses from data derived from CorrectTek. This data is formatted into an Excel spreadsheet and lists details of the nursing note including physical findings and treatment. Disposition is embedded in the note but is not documented as a separate field.

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.
3. The urgent care log should include a disposition.

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.

A chronic illness policy and procedure was available but needs work. The policy should include how inmates are enrolled into and out of the program; the frequency of visits; a method of including uncommon diseases; when laboratory testing is to be done for the first time; how the disease roster is to be used; and reporting methods.

5.b.

Clinical practice guidelines for chronic illness are not yet completed. I continue to recommend using Dr. Shansky to assist in this process and to use, as applicable, established NCCHC guidelines.

5.c.

A chronic illness spreadsheet exists but is incomplete. When I checked the list, I found people on the list who did not have a chronic illness and some individuals were inaccurately labeled. In

part, this problem is exacerbated because the electronic record does not provide a list of persons with their diseases. CorrectTek only lists one disease per person even if the person has multiple diseases. This requires staff to spend additional time to perform this task.

Also, the list sent to me includes every person ever admitted over the past year who has a chronic disease. To be useful, the roster should include active detainees with disease. Also, the disease type is not related to the diagnosis of the patient but to a generic disease category which does not necessarily help in managing the patient. For example, diabetics are placed in the hypertension category and asthmatics are placed in the pulmonary category. To the extent possible, inmates should be placed in the roster based on their diagnosis.

CorrectTek remains problematic as it does not satisfy the need of the organization in classifying patients by diagnosis and producing a roster of these patients.

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

1. The roster is still derived manually by a chronic disease nurse from CorrectTek and a variety of sources (CorrectTek, shift reports, nurse intake reports, booking information, direct provider reports) and it appears that many errors exist. All of this should be generated automatically but this occupies a full time chronic illness nurse to obtain this information. The chronic illness nurse's time could be more productively spent. As well, CorrectTek only lists the first diagnosis entered as the diagnosis. Thus if a patient has three chronic illnesses, only the first will be listed. This creates a defective list as the remaining two diagnoses are not recognized.
2. The providers are inconsistently entering the problem into the EMR. 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 designations 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. Unusual diseases are not specifically tracked except by appointment. They should have a general medical list with the name of the disease.
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. The current disease categories are HTN, DM, pulmonary, seizure, hyperlipidemia, hepatitis C, HIV, TB, scabies, MRSA, and pediculosis.
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. However, this nurse spends 50% of her time doing the clerical work just tracking patients. About 50% of time is spent on clinical management. I was told a provider will see a patient within 5-7 days from intake, but I couldn't verify this.

Labs are performed by a vendor, CareEvolve, and lab data is now interfaced into CorrectTek.

Review of medical records of persons with chronic illness still demonstrate missing diagnoses, dropped appointments, follow up errors, and lack of continuity. As part of the Quality Improvement program, medical leadership should review samples of at-risk chronic illness patients to test the performance of the system and chronic illness program.

5.f.

There is no infirmary in the jail. The 4th floor of the old jail is considered medical housing. However there is no program of identification or management of inmates with special 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.

There is a policy on infirmary care but it states that the 4th floor is not an infirmary but in all respects it is used as an infirmary. For example, the policy explains that the 4th floor is to be used for respiratory isolation even though there are no negative pressure cells on the unit. The program has established procedures for monitoring on this unit but they are not written. I was told that anyone needing infirmary care goes to a hospital but based on the hospital log, this is not credible information.

RECOMMENDATIONS FOR NEXT 6 MONTHS:

1. Policy and procedure and clinical guidelines for chronic illness management and special needs management must be developed.
2. Management of chronic illness should begin in intake with identification, acuity ranking and appropriate referral to a provider. There must be a mechanism to enroll patients and dis-enroll patients in the chronic illness program.
3. Transportation issues involving getting patients to clinics must be resolved.
4. The providers must use a standardized method of recording problems in the electronic record which permits maintaining a roster of persons with chronic illness.
5. Physicians must manage chronic illness by seeing patients at appropriate intervals, renewing medication, and performing 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 management of patients with disabilities and serious medical problems equivalent to infirmary care must be established and codified in a procedure. 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 adequate testing, monitoring, and treatment programs for management of communicable diseases, including tuberculosis ("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, including TB, skin infections, 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 inmates for TB upon booking at LCJ and follow up on test results as medically indicated, pursuant to Centers for Disease Control ("CDC") Guidelines. LCJ shall follow current CDC guidelines for management of inmates with TB infection, including providing 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 pressure and ventilation systems function properly. Following CDC guidelines, LCJ shall test daily for rooms in-use and monthly for rooms not currently in-use. LCJ shall document results of such testing.***

e. ***LCJ shall develop and implement adequate guidelines to ensure that inmates receive appropriate wound care. Such guidelines will include precautions to limit the possible spread of Methicillin-resistant Staphylococcus aureus ("MRSA") and other communicable diseases.***

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

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

6.a.

CHI has an infection control nurse. She tracks TB skin tests and is currently working with CHI leadership in development of the program.

6.b.

The infection control policy and procedure and the infection control manual are still being developed. The TB screening policy and procedure is complete and is acceptable if minor changes are made. The document references respiratory isolation, yet there is no ability at the jail to place anyone in respiratory isolation as there are no negative pressure cells. Also, for persons who refuse testing, the current policy calls for placement in a single cell. Because none of these cells are negative pressure vented, the detainee should probably wear a mask until the chest film is performed. Also, persons who refuse TB skin testing are given a chest x-ray only if they are symptomatic. The policy for influenza uses dated guidelines for who should be vaccinated. The current recommendation is that all individuals over 6 months should be vaccinated annually with a priority given to health care staff and individuals at risk.

6.c.

A policy and procedure has been written for TB screening. The current procedure is everyone gets symptom screening at intake and a skin test in intake since September 8th. If they have a disqualifier (BCG) they get a quantiferon. Reading is done at 72 hours. 75% of inmates are gone within 72 hours. Some patients refuse the test. Symptomatic persons who refuse skin testing are given a chest x-ray or quantiferon. Those who get chest films get a film within 24 hours and are isolated until the film is done. That isolation is ordered and documented. However, there are no isolation cells at the jail. These detainees should wear a mask until the chest film is done. The program should track the number of persons screened, the % positive skin tests, the number of refusals (including their names), and the time to completion of screening.

6.d.

There is no negative pressure ventilation system at the jail. Nevertheless, current policy references placement in respiratory isolation at the jail which is not possible under existing conditions. The policy can state to place suspect individuals in a single cell but these individuals should wear a mask.

6.e.

A wound care and MRSA procedure was written. This procedure does not have facility specific directions. For example, this procedures calls for intake nurses to screen inmates for skin infections but does not say how this is to be done. The current intake area does not permit privacy examinations so I am not sure how this would be done. Also, contact isolation is recommended, but what does this actually mean? Will a nurse know where to house such a patient? The procedure calls for immediate treatment even though there is no 24/7 provider coverage. There is no mention of sanitizing cells after a MRSA diagnosis.

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 TB skin test results, a medical assistant reads the test and reports to infection control. The Infection Control nurse keeps that data. For MRSA, clinicians report presumptive cases to the Infection Control nurse via a message within the EMR. The Infection Control nurse checks whether a culture was done. The nurse sees all patients and if a culture wasn't done, she orders it. I did not have time to verify the data maintained by the Infection Control nurse. This data should be sent to the Quality Improvement Committee as regular reports.

No cases of influenza have been identified. Vaccination for influenza is offered at intake, but has not yet started this year.

For tuberculosis, surveillance consists of skin testing and is done. Surveillance data for TB should be reported to the QI committee on a regular basis. This should include all refusals and discharges prior to testing.

Finally, it would help if 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. Review and edit the vaccination procedures for influenza in consideration of existing ACIP guidelines.
3. Develop airborne isolation procedures consistent with Centers for Disease guidelines..
4. Establish surveillance tracking of tuberculosis, skin test rates, conversion rates, employee conversion rates, and MRSA rates. These data should be sent routinely to the Quality Improvement committee at least quarterly.

7. ***Access to Health Care.***

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-b

Progress continues on this item. The procedure for this process is in draft. I reviewed the existing written procedure. Currently, elements of the non-emergency access procedure are described in a scheduling procedure. The sick call (non-emergent access procedure) should be all inclusive. Several items still need to be addressed:

- Confidentiality of collection 7 days a week. The current procedure addresses confidentiality, but not pick up
- Slips with Spanish and English language need to be addressed in the policy and procedure including who will review these slips.
- Method of access for cognitively impaired and illiterate needs to be addressed.
- A methodology for tracking timeliness of triage and follow up.
- How mental health, dental, urgent medical, and routine cards are processed needs to be described.
- 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.

The current system of access is still deficient in that it is not available to all inmates. "Medical Cards" are now available in Spanish but it was not clear who evaluates these requests. I also 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 as-use basis. The procedure also does not include how segregation, the illiterate and those who are mute or otherwise can't communicate will access care.

7.c-d

A reasonable 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. On review of a sample log, there were days when slips were not logged, so it appears that this activity is not always occurring on days when the sick call nurse is off. Officers are still not available to transport inmates for face to face evaluation on a daily basis so only 36% of face to face evaluations occur on time. As a result of this lack of transportation, the sick call nurse does a cell side triage which does not permit a complete evaluation.

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 sick call log has a space for triaging and face-to-face evaluation. However, the face-to-face column is almost never filled in, meaning that either almost no face-to-face encounters are being done or that this event is not tracked. The face-to face encounters should be tracked on the log. Also, the name of the person completing the evaluation is not entered into the log. Acuity levels columns are in the tracking log but are seldom used.

7.e.

Nurses still perform most 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 insufficient officers to bring inmates to these rooms, nurses still go to tiers to see inmates.

7.f.

There are still insufficient officers to transport detainees for evaluations. The Sheriff agreed to correct this problem.

7. g.

This area was compliant based on the last visit review. I did not review this item on this visit.

7. h.

Lake County Jail has a co-pay policy which requires a $15 payment for evaluation of sick call requests as well as doctor visits. There was a 50% reduction in sick call visits after the co-pay started. The policy does not address providing care under co-pay requirements and how inmates without funds will access care. The procedure for implementing a co-pay is not developed and standardized. It is not clear that appropriate exclusions are built into the program.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. Sick call policy and procedure must be completed.
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. The tracking log needs to have all required elements and needs to be accurately 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. Co-pay procedures should be incorporated into the sick call policy.

5. Follow-Up Care.

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 hospital policy is in place but does not address where returning patients are seen, how new medication is started, or how the follow up physician visit is scheduled and when the follow up visit is scheduled.

Inmates returning from offsite visits are returning to intake and are seeing a nurse but the follow up physician visit is not always taking place. Based on a few charts reviewed, patients were noted to be seen at intake. However, based on these records reviewed the physician in follow up did not know why the patient was coming to the clinic and saw the patient for a different reason than for review of the offsite visit. Nurses are renewing medication changes but these phone orders are not always signed by a provider.

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.

There are two existing policies on urgent response within the jail. Neither completely describes appropriate procedures. These policies should be combined into a single policy and procedure.

A blood borne pathogen power point is done but an emergency response power point is not yet completed. The training has not yet been initiated. The Medical Director is planning a training power point for officers on medical emergencies but this has not yet been completed. Health care staff were trained on emergencies at the beginning of the new medical contract. There was no written course work for this training. Officer CPR training was provided to all be two officers.

9.b.

I randomly checked the control stations on the 3rd floor of the new jail and 3rd floor south of the old jail on the last visit. 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 likely to be encountered at the jail (seizure, wheezing, low or high blood sugar, intoxication, drug withdrawal, etc.) and blood borne pathogen issues. Officers should be trained and their training should be verified in a tracking log. The tracking log should be included in documents sent to the Monitor.

10. <u>Record Keeping</u>.

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. More importantly, there are patient safety issues including:

- There can still be two or more authors for a single log on. This is a serious problem. For example, a nurse can enter a prescription under Dr. Forgey's name under her log on.
- Diagnoses are still difficult to record. For patients with multiple diagnoses, only the first diagnosis will be listed in a data search. This makes it impossible to use as a chronic illness roster.
- The electronic MAR must be disconnected from the medical record because of connectivity issues. Certain parameters of an order are not passed in the electronic record on the "disconnected MAR". The disconnected MAR only has medication orders for the shift and day but does not include any other pertinent orders such as vital signs, dressing change, certain checks required based on medication orders, etc. This is a serious defect. Nurses administering medication keep a paper copy of the MAR but this is only refreshed weekly. However, a weekly refresh may miss critical medication changes that result in patient safety issues. The refresh should be daily at a minimum. As well re-synchronization back to the electronic MAR from the "disconnected MAR" is occasionally defective or doesn't occur. This is also a problem.
- The record is not HIPPA compliant.

The interface with pharmacy has improved and is considered resolved. The lab interface has also been corrected. 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. The laboratory interface has been corrected and lab values are now integrated into the electronic record.

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 now electronically interfaced with the record.

10.d.

When a patient goes out to a hospital, a MAR is sent with them along with "hospital transfer paperwork" which includes medical history filled in by a nurse who may or may not know the reason for sending the patient to the hospital or specialist. Medications are also included.

The facility has continued problems getting medical information back from the hospital. Much time is spent getting this information. When software issues occur, they should be tracked as part of CQI. This tracking should be formal so that all existing software issues are logged and managed. Also, the downtime procedure is incomplete. Staff should all be on the same page as to what the existing procedure is and downtime paper forms must be in a location which is understood by all staff.

10 e.

The electronic record is unified but is not completely electronic. Some elements are scanned into the record. This record is not HIPPA certified according to staff.

RECOMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ should consider an alternate electronic record or definitively correct existing patient safety issues.
2. Software training should occur when new employees start work as part of the orientation.
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 distribution.*

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.

Prior problems with the pharmacy vendor were discovered to be problems with the software vendor CorrectTek. Apparently, the HL-7 data configuration was incorrect causing missing information. This problem was corrected. The medication renewal process is not codified in a standardized procedure. This should be done. Based on chart reviews, patients do appear to be getting their medication within 24 hours of prescription.

11.b.

There is a procedure for medication issues. However, this policy/procedure is not written for this specific facility. As an example, the medication renewal section states that 14 days before expiration of a medication the chart is to be pulled and given to the provider to review. There are no paper records used at the facility. Clearly, this policy was written for a different facility. The policy and procedure must be vetted so as to conform to practices at this facility. The existing practices must be codified in the procedure.

Also, the policy does not explicitly describe the procedures that the medication assistants follow when they pass medication. This should be corrected.

11.c.

Medication administration procedures must involve custody staff. 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. 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. Warden Stuart agreed to work with medical and Mr. Ray on an interagency procedure. The five rights are not clearly seen in the current procedure and this should be corrected.

11.d.

Medication administration is mostly performed by medical assistants. These individuals all have a certificate on file. I still have not yet been provided with State regulations which permit use of medication assistants as capable of administering medication. 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. One suggestion is for the program to provide an exception report of verbal orders which are not signed as a way of improving this process.

11.e.

LCJ states that it provides 7 days of medication to inmates who are discharged. This should be described in the policy and procedure.

11.f.

There is a pharmacy and therapeutic committee meeting with minutes. A formulary is in place. Minutes of the meeting are missing for some months for 2012. The P & T meeting is occurring in conjunction with the CQI meeting. While this is acceptable, the minutes should clearly indicate agenda and minute items distinguishing CQI and PT items.

11.g.

There is a procedure for medication refusal. However the procedure does not address how an inmate is allowed to refuse. When nurses administer medication nurses accept refusals from the officer that an inmate doesn't want medication. The inmate should present to the medication cart and refuse to the nurse. This should be codified in the interagency procedure which custody has committed to doing.

11.h.

The medication room is significantly cleaner at this visit. This is largely due to fixing the CorrectTek interface issue, which has resulted in accurate medication deliver. Because medication is now timely delivered, the amount of stock has been significantly reduced. The drug supply room is now neat. I did checked several narcotic verification sheets and there were some errors on them which I pointed out to LCJ leadership. The medication carts are still in the nursing station and these carts have medications in envelopes on the carts. The carts are left unattended at times. I was able to walk into the room with a leadership staff. No other nurses were present and it would be very easy to take medication off the cart. Securing these carts is still a problem.

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. A start has been made on the policies but some additional work needs to be done. I did speak with the Warden on the interagency policy.
3. Medication administration must be standardized and facility specific.
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 and should be facility specific and codified in procedure.

12. Medical Facilities.

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: Partial 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. Also, American with Disabilities Act (ADA) accommodations for disabled do not appear to be available on the 4th floor housing units.

The dental unit remains unacceptable.

Work has started on the intake area but only the demolishing piece has started. The 4th floor clinic space renovations have not started. There are plans to renovate the dental area but this has not started. There are no plans for changing the 4th floor medical unit. Plans were provided to me of the planned dental clinic and the 4th floor clinic; construction is contemplated to start within a month or two. There is no existing plan to address ADA or infirmary care issues.

12.b.

The main clinic sanitation is still unacceptable. There were 8 people in the clinic; 3 patients, 3 providers, a nurse and an officer all of whom could listen to any one encounter. The crowding increases needle stick risk, is not private, and encourages incomplete evaluations.

12.c.

The biohazard containers in the clinic are not all in locations which would minimize needlestick injury. As it is, someone with a sharp might have to cross into another area to deposit the sharp which is a staff safety issue. All bio hazard containers should be located adjacent to the area of use so as to reduce moving across staff areas with a sharp.

12.d.

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

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 that is ADA compliant.
4. Remedy the dental clinic situation.

13. Specialty Care.

a. ***LCJ shall ensure that inmates whose serious medical or mental health needs extend beyond the services available at LCJ shall receive timely referral 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 specialty care provider are scheduled for timely outside care appointments and transported to their appointments. Inmates awaiting outside care shall be seen by Qualified 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 maintain a current log of all inmates who have been referred for outside specialty care, including the date of the referral, the date the appointment was scheduled, the date the appointment occurred, the reason for***

any missed or delayed appointments, and information on follow-up care, including the dates of any future appointments.

d. ***LCJ shall ensure that pregnant inmates are provided adequate pre-natal care. LCJ shall develop and implement appropriate written policies and protocols for the treatment of pregnant inmates, including appropriate screening, treatment, and management of high risk pregnancies.***

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

13.a-b.

There have been no recent problems with scheduling due to payments. However, there are still no contracted providers for several necessary subspecialty providers including nephrology, cardiology, or dermatology. There hasn't been a dialysis patient incarcerated since January. However, there is no plan to care for such a patient if one were to be incarcerated. The jail attempts to get the patient released. Most appointments can be arranged within a week, however, if someone were to need cardiology or nephrology LCJ would encounter difficulties.

Patients scheduled for offsite specialty appointments are still routinely cancelled because of no available movement officer. These events are not tracked; the appointment is merely rescheduled. 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 but does not track cancelled appointments. The log entry should begin with the date of provider order not the date the scheduler starts the appointment process. This log should contain the date of the provider order for specialty care and this order should document re-scheduled 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. The standardized procedure should adhere to ACOG standards. The timeliness of appointments to the Obstetrician should be delineated in the procedure. As well, the onsite management of the pregnant detainees should be delineated.

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. The date of provider order for specialty care should be tracked on the specialty log.
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. Clinical assessment items should be standardized so that onsite staff know what to evaluate.

14. Staffing, Training and Supervision.

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.

CHI has been providing services for about 10 months. They have a good leadership team and lines of authority are clear and understood by all. The program would benefit by structured performance reviews of providers and nurses.

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. One possibility may be to contract out dental services. There are dental contractors who will also provide a portable dental unit which may save renovation money.

Additionally, the withdrawal procedures and infirmary care management have not yet been started. This may require additional nursing staff. There are now 4 mid-level providers which is a very positive change. Using medical assistants to administer medication is cost effective but it must be shown that this is acceptable in regards state regulations.

14.c.

A spreadsheet is maintained which lists whether training and personnel items are up to date. This sheet includes credentials, license, blood borne pathogen training, CPR training, suicide prevention training, and emergency response training. An employee orientation occurs but there is no documentation of orientation to job duties. One suggestion is to have the employee sign their job description as evidence of orientation to their duties.

14.d.

The process of provider evaluation is just getting started. The supervising physician is available full time at the site. Some suggestions were given regarding provider performance evaluations.

14.e.

All licensure information for clinical staff is maintained up to date in an “employee credentials” notebook which was reviewed and is up to date. For physicians, national practitioner databank data is not obtained but should be done.

14.f.

Training records were provided and demonstrated CPR and officer training. However, CHI still needs to develop a training program for officers on how to recognize medical emergencies. A way to track this will need to be developed as well.

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 include National Practitioner Databank information.
4. Officer training must be tracked including name of officer, dates training occurred, and type of training given.

15. Dental Care.

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: Partial Compliance

ASSESSMENT:

15.a-b

This has moved up to partial compliance only on the basis of plans for renovation of the dental unit. 2-4 hours of dental care a week is insufficient for this population of almost 1000 inmates. The program should consider contract dental services.

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 pattern 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: Partial Compliance

ASSESSMENT:

16.a-c.

An autopsy is performed on every death. I was able to review the autopsy of the last death.

There is a policy which I was shown during the visit. It needs minor modifications but is a major improvement over the previous version. It can be simplified further so that the policy and procedure are not written as separate documents. Current diagnoses, medications, and demographic data need to be included in the information which is collected on all deaths. Also, because everyone at the site in supervisory positions is probably involved in care of the patient, CHI should find an objective outside party to perform these reviews. The policy should state that the complete medical record will be reviewed as part of the review. I discussed problems with the prior mortality review with leadership.

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. See Section III. A.***

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

October 2012 Assessment:

As of August 15, 2012, the QMHP FTE allocated positions were allocated as follows:

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

The psychiatrists' allocation will be further discussed in a later SA provision of this report (see section B.3.e.).

CorrecTek (CT) issues preventing the statistical analysis of the percentage of inmates booked with a positive mental healthcare screening have partially been resolved, but there remains significant limitations—at least as the data is currently reported. For example, the current report summarizes on a monthly basis the number of mental health referrals generated through the screening process. However, the report does not distinguish between referrals generated due to suicide risk concerns versus other mental concerns (such as current need for treatment) and does not provide a summary for the reasons that various referrals are not completed in a timely manner. Some of this information is available via an individual chart review although this information has not been aggregated in a report format.

In general, it appears that the current staffing allocation is adequate for LCJ to perform the required mental health screening process (if the timeframes for routine referrals are changed) but not adequate to provide services to address the serious mental health needs of all inmates for reasons that will be summarized elsewhere in this report.

October 2012 Recommendations for next 6 months:

1. Need a staffing analysis re: the number of FTE mental health positions necessary to comply with the various provisions of this Settlement Agreement.
2. Such an analysis should be referenced in the staffing policy and procedure to be developed as referenced in the next section.

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

October 2012 Assessment:

During our April 2012 site visit the findings included the following:

> 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) [staffing plan]
> 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

The recommended draft policies and procedures have not yet been completed.

Policies and procedures that had been revised and finalize since the last site assessment were reviewed which included the following areas:

> Notification and review of an inmate deaths
> Receiving screening (mental health)
> Mental health evaluation
> Segregated inmates
> Basic mental health services
> Individualized Mental Health Treatment Planning
> Restraint (completed during site assessment)

During the site visit we again discussed issues related to the draft restraint policy. It was emphasized to LCJ staff that policies and procedures relevant to restraint use for mental health

reasons needs to be operationalized in a healthcare policy that is separate from the correctional policy relevant to the use of restraints for security/correctional purposes.

October 2012 Recommendations for next 6 months:

1. Develop the previously referenced 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

October 2012 Assessment:

Since the last site assessment, there is no longer a backlog of inmates waiting for an initial mental health evaluation.

Refer to section B.1 re: issues relevant to analysis pertinent to the mental health screening process. As is apparent by reviewing the intake mental health assessment statistics, it is very clear that a very high percentage (generally greater than 70%) of inmates receiving mental health/suicide prevention screenings are referred to mental health for further assessment. This is problematic from a screening perspective due to a very high false-positive rate that results in the use of scarce mental health resources. In addition, there were a variety of issues related to many of these assessments either not being completed or not being completed in a timely manner. The reasons for such problems had not yet been systematically assessed although it appears that some of the statistics were misleading. For example, some of these assessments were not completed in a timely manner because the inmate had recently been sent to court or the inmate had been discharged from the facility prior to the timeframe expiring.

Another problem with the intake mental health screening process, which is performed by the nursing staff in the booking area, has to do with the triage process in the context of whether referrals are emergent, urgent or routine. The mental health staff reported that it was not uncommon to have urgent and/or emergent referrals that should have been triaged as being routine.

I spoke with Dr. Harman and Mr. Hayes concerning the above issues and provided specific details concerning the nature of the data that should be gathered, reviewed, and analyzed. We also discussed issues related to both the threshold for making referrals based on the intake mental health screening and the triage process.

October 2012 Recommendations for next 6 months:

1. 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.

2. The intake mental healthcare screening process needs to be revised from the perspective of raising the threshold for referral to mental health. The current Settlement Agreement (B.3.a) has been mistakenly interpreted to require any positive mental health intake screening question to require a mental health referral. In addition, training needs to be provided to the nursing staff relevant to the above changes that will be made in addition to issues regarding the triage concerning the acuity of the referral.

3. After the recommendations in #2 have been implemented, a QI should be performed relevant to both the initial healthcare screening and subsequent mental health evaluations resulting from positive initial healthcare screening. Issues related to the triage process relevant to the acuity of the referral should also be examined. The QI should determine the reasons for lack of compliance with meeting Settlement Agreement timeframes in the context of emergent, urgent and routine mental health referrals along with a corrective action plan as appropriate.

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: SUSTAINED COMPLIANCE

October 2012 Assessment: The mental health intake screening process continues to include inquiry regarding the above reference elements, which is unchanged from the previous site assessment.

3. ***Assessment and Treatment.***

a. ***LCJ shall ensure that any inmate who 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, including 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 serious mental illness, they shall refer the inmate for appropriate treatment. LCJ shall review available information regarding any diagnosis made by the inmate's community or hospital treatment provider, and shall account for the inmate's psychiatric history as a part of the assessment. LCJ shall adequately document the comprehensive mental status evaluation in the inmate's medical record.***

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

October 2012 Assessment:

Timeliness issues have already been addressed in prior sections.

During the April 2012 site visit, the following was reported:

> Staff reportedly they were frequently not using the mental health evaluation form due to it being very unwieldy and related to past staff vacancies that created workload issues.

Although the form has not been revised since April 2012, training and supervision have been provided to the line staff, which has reportedly resulted in the forms being completed as required. The staff has provided narrative responses to many of the sections on the mental health evaluation (MHE) forms. The training has been provided via weekly training in-services and the supervision via regular review by the mental health director.

These measures have increased CorrecTek MHE completion rate to an overall 76 percent for suicide MHE referrals and 36 percent for non suicide MHE referrals. Seventy-four (74) percent of SRA referrals were completed within 24 hours (100% completed for those referred for an emergent (i.e., 3 hour timeframe) suicide MHE, 62 percent for an urgent (i.e., 24 hr) referral. Sixty-two (62) percent of non-suicide MHE 3 hour referrals were done within that time frame; 10% for 24 hr; and 57 percent for 72 hour.

The outcome measures summarized above are the underlying reason for the need for a QI as summarized in B.2.b. in the context of the mental health screening/referral process.

When the recommendations in B.2.b. have been successfully implemented, consideration for submitting a proposal to DOJ for changing the timeframe for completion of routine referrals

would be appropriate.

October 2012 Recommendations for next 6 months:

1. Complete the recommended QI as listed in 2.b.

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

October 2012 Assessment: During the prior April 2012 site visit, the following was noted:

> 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.

Inmates in the B section of the 4th floor no longer have access to the dayroom area due to a broken window, which means they are essentially locked down in their cells 23 hours per day due to reported custody concerns about their behaviors.

Improvement is noted relevant to access to these inmates by mental health clinicians on an individual basis. For example, 4th floor patients are routinely brought by correctional officers to the QMHP crisis, individual, SRA and MHE sessions. Correctional officers have been cooperative with implementing and maintaining an M-TH psychiatrist clinic schedule of inmate movements. Inmates are seen individually with the psychiatrist who is assisted by a QMHS

However, group therapy continues to not occur. The reason cited is lack of correctional officer staffing to conduct movements. This negatively impacts inmates who are housed long term on the mental health unit. It should be noted that groups are being provided on these units for non-mentally inmates for AA and NA purposes via community volunteers. Plans have been discussed to move the entire mental health unit to Z Pod, which is possible to accomplish within the next six months.

Based on information obtained from both custody and mental health staffs, the working relationships between the two staffs has improved but continues to be somewhat strained.

During the morning of October 10, 2012, I observed the mental health rounding process on the fourth floor. One female inmate, who has been waiting for about one month for a state hospital bed to open up, has not showered for at least one month and had smeared feces on her windows three days earlier that had not yet been cleaned up. This inmate was well known to staff and was clearly a dangerous inmate. However, the SORT team had not yet been called re: the above issues.

The mental health treatment being provided to inmates with serious illness, especially on the fourth floor, is inadequate.

October 2012 Recommendations for next 6 months:

1. 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.

2. Expedite the reported plan re: moving of the mental health unit to Z pod. The correctional officers assigned to such a unit should receive special mental health training and be assigned to the unit for at least six months until unless they clearly demonstrate problems working on such a unit. Enhanced mental health staffing will be required in order to provide the necessary psychosocial rehabilitation treatment, which will be predominantly group and activity therapies.

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

October 2012 Assessment: A treatment plan form has been developed as of August 28, 2012 but needs to be revised to be consistent with the recently approved policy and procedure re: treatment planning. The policy and procedure re: treatment plans has not yet been implemented. Training has started on implementation of this policy. QMHPs are focusing upon “crisis stabilization” and “medication management” needs at the present time.

Audits indicated that a very rudimentary treatment plan is being formulated for inmates on suicide precautions.

October 2012 Recommendations for next 6 months:

1. Continue training and implementation of the treatment plan policy and procedure.

a.* 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: PARTIAL COMPLIANCE

October 2012 Assessment: Construction on a new intake screening area is pending- should be completed by December 2012.

Psychiatrist interviews inmates in his office on a regular basis Monday through Thursday each week. A correctional officer (CO) is posted outside the door the entire time.

QMHPs regularly conduct individual sessions in the 4th floor offices. Inmates are escorted by correctional officers (COs). The MHE assessments in booking still involve privacy issues. Unless the referral is an emergent or urgent QMHPs attempt to postpone the MHE until the inmates are placed in general population.

Cell-side assessments are conducted when the potential for harm to staff is evident or when COs will not open the doors to cells. Space for evaluating/treating inmates with adequate sound privacy throughout LCJ remains problematic related to both space issues and correctional officer shortages.

October 2012 Recommendations for next 6 months:

1. Complete the construction of the new intake screening area.
2. Remedy the issues contributing to inadequate assessment/treatment space as described above.

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

October 2012 Assessment:

My April 2012 recommendations included the following: "Increase the psychiatric allocation to 1.0-1.5 FTE psychiatrists."

Although there were 151 inmates receiving psychotropic medications, only 78 of these inmates had been evaluated by the psychiatrist. There was generally a 3-5 week wait for routine referrals

to be seen by the psychiatrist.

It was estimated that approximately 200 inmates were on the mental health caseload at any given time.

Marcus Wigutow, M.D. continues to provide 16 hours per week of psychiatrist coverage. He is at the jail four days a week for 4 hours each day. He averages seeing 8-9 patients per day. A search for NPs with a psychiatric background or certification was conducted by Dr. Harman the mental health director. Two possible candidates have been identified. It was my understanding that a candidate has agreed to the position but there are bureaucratic obstacles delaying her start date.

The psychotropic medication management continues to be very problematic related, in part, the psychiatrist's allocation issue previously referenced.

October 2012 Recommendations for next 6 months:

1. Increase the number of psychiatric hours at the LCJ, which can be partially done via a psychiatric nurse practitioner. The bureaucratic obstacles should be resolved as soon as possible in order to visit to facilitate hiring of this position.

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

October 2012 Assessment:

My April 2012 assessment report included the following:

> 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.

Except for inmates on the fourth floor, the predominant treatment for inmates receiving mental health treatment is medication management and counseling, as needed, in contrast to being seen on a regular basis.

See section 3.b. Very little change is present as compared to the prior site assessment.

Refer to section 3.j. for information relevant to access to inpatient psychiatric care.

October 2012 Recommendations for next 6 months:

Recommendations are essentially unchanged from my April 2012 report which included the following:

> 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 [needs to occur].

An outpatient level of mental health care needs to be more developed and implemented in contrast to the treatment just being seen by the psychiatrist on an untimely basis.

> ***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

October 2012 Assessment:

Recommendations in the April 2012 report included the following:

> 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.

The above recommendations have been incorporated into the "Segregated Inmates" policy and procedure (5/29/12 updated) that was implemented 9/12/12. However, this policy has not yet been completely fully implemented related to the need for training both mental health and custody staff on relevant provisions of the policy and procedure. For example, custody staff is usually not notifying mental health staff of new inmates admitted to the segregation unit.

A brief mental status exam is being utilized to screen and assess the needs of MI and SMI in segregation. MSE and MHEs are conducted outside of the segregation cells in a holding area. This affords adequate privacy from other inmates is problematic due to staff traffic in the immediate area.

During the first 8 months of 2012 there were 35 different trips to segregation for an average of 4 per month. Of the 340 inmates recorded as being placed in segregation, the QMHP found that 87 inmates were in need of mental health services. Thirty-eight (38) of these inmates met criteria for a serious mental illness. 3 inmates were previously on the mental health caseload prior to being placed in segregation. To date a significant number of inmates (13) have been moved off segregation to the 4th floor due to the mental illness. The majority of the inmates with a serious mental illness had a diagnosis of schizophrenia.

The above data was reflective of a backlog in the context of the psychiatrist's evaluations. It is encouraging that inmates in segregation who need to be on the fourth floor are identified and transferred. It is discouraging there were so many of such inmates admitted to the segregation unit because it likely reflects untimely identification of inmates with a mental illness and/or inadequate treatment.

I observed the mental health rounding process in the segregation units during the morning of October 9, 2012, which was done in a competent manner.

October 2012 Recommendations for next 6 months:

1. A quality improvement study needs to be done relevant to timeliness of MHE's being completed following referrals in addition to the nature of the treatment being provided following a positive MHE.

2. The "Segregated Inmates" policy and procedure needs to be implemented, with specific focus on custody staff notifying mental health staff in a timely manner of inmates being admitted to the segregation unit.

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

October 2012 Assessment:

CT issues have been resolved for tracking psychiatrist appointments, medication renewal, medications in MAR.

Dr. Harman reported that LCJ is now capable of maintaining an updated log of inmates receiving mental health services (which shall include both those inmates who receive counseling and those who receive medication), but has not yet produced such a list. Related to both staffing allocation and management information system issues, inmates are not the mental health caseload regular follow-up except on the fourth floor.

In order to mitigate problems associated with not having an outpatient mental health caseload, two QMHPs have been assigned to specific PODS to encourage MH utilization.

Although 2 counseling offices have been identified for individual counseling on the 3rd and 5th floors, inadequate CO coverage prevents using the offices at this time.

October 2012 Recommendations for next 6 months:

1. A current log of inmates receiving mental health services should be readily available. This log should include diagnoses and needed level of mental health care, both of which are necessary for system planning purposes.

   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

October 2012 Assessment: The restraint policy has not yet been finalized. Further input was provided during this site assessment as referenced in the policy and procedure section of this settlement agreement.

October 2012 Recommendations for next 6 months:

1. Finalize and implement the restraint policy.

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

October 2012 Assessment:

Policies and Procedures entitled "Involuntary Commitments" have been implemented to ensure inmates with a serious mental illness who need long term placement are evaluated and placement secured with the cooperation of the court system.

A good working relationship with Regional Mental Health and the court system is in place to provide evaluations for state hospitalization, residential placement in the community as well as follow care for the respective catchment areas of NW, NE and the southern region of Lake County.

Edgewater Systems continues avoid a working relationship with LCJ. The Sheriff and MH staff have developed a working relationship with Gary City Court (Judge Didre Monroe) and the County Court System (Judge Parras) to mandate Edgewater to participate in the process. Edgewater's cooperation for actual placements after the evaluations of patients remains resistant.

In the time between evaluation and placement, the courts have been willing to mandate medication for inmates with a serious mental illness to prevent harm to self and others as an attempt to stabilize the patients before placement. This stabilization/medication measure has proven effective pending placement in a number of cases at LCJ.

The court has appointed an attorney to work with LCJ to access the care needed for inmates with a SMI. 13 inmates with a SMI have been placed within the state system in 2012.

October 2012 Recommendations for next 6 months:

1. Continue to find a remedy to the above described problem with lack of access to an inpatient psychiatric hospitalization for 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

October 2012 Assessment:

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

Staffing allocations for psychiatrists' time remain inadequate as previously discussed.

QI studies relevant to medication management issues were currently lacking. A case conference approach has been used to address medication prescribing practices.

Psychotropic medication utilization has decreased during 2012 related to case discussions, implementation of a formulary and supervision. Review of a small number of healthcare charts indicated poor documentation by the psychiatrist and untimely appointment with the psychiatrist.

Staff described significant continuity of medication issues such as medications not being renewed in a timely manner and medication noncompliance frequently being reported in an untimely fashion by nursing staff.

Discharge medications are not provided to inmates discharged from the jail.

October 2012 Recommendations for next 6 months:

1. QI studies need to be performed re: medication management issues with specific reference to continuity of medications.

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

October 2012 Assessment:

My April 2012 report included the following:

> 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.

Review of current healthcare records demonstrated similar issues.

The psychiatrist's allocation remains at 16 hours per week. A search for NPs with a psychiatric background or certification was conducted by Dr. Harman the mental health director. As previously summarized, bureaucratic obstacles are delaying the hiring of a psychiatric nurse practitioner.

October 2012 Recommendations for next 6 months:

1. At the present time, continue with the case conference format although this type of review should be via QI process in the future.

> ***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

October 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.

October 2012 Recommendations for next 6 months:

1. Develop the relevant policies and procedures and audit implementation.

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

1. <u>Suicide Prevention Policy</u>.

> ***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

October 2012 Assessment: QMHPs and QMHSs have completed in-service training on S.P. policies. Follow up with patients removed from precautions is logged and tracked for compliance at 24 hr, 72 hr. and 7 days.

After the initial 24 hours patients are re-assessed (SRA) for the appropriate return of privileges (paper, reading materials, regular bedding and uniform, etc. Psychiatrist is consistently consulted before orders are rescinded.

QI reports indicates for January 1 through August 31, 2012 - 97 percent of 9965 jail admissions between January and August 2012 were completed. Approximately 70 percent of all admissions were referred for either SRA or MHE (1% for suicide prevention and 68% for non suicide). 91 percent of all SRAs referred were completed, 74% within the 24 hour requirement. Regarding MHE referrals, 76 percent were completed for suicide MHE referrals and 36 percent for non suicide MHE referrals. 74 percent of SRA referrals were completed within 24 hours, 100% referred for 3 hour suicide MHE were completed within 3 hrs; 62 percent for 24 hr referral, and 100% for 72 hr referral.

To be in substantial compliance with this provision of Settlement Agreement, all other provisions relevant to suicide prevention in the SA need to be found in substantial compliance.

October 2012 Recommendations for next 6 months:

1. As per the recommendations in the following sections of this report.

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: SUSTAINED COMPLIANCE

October 2012 Assessment: The mental health staff continues to utilize the procedures outlined in policy. Administrative Coordinator and Clinical Supervisor monitor compliance. Clinical Supervisor is directly involved in treatment of patients on suicide precautions. Log book is kept tracking MHE and follow up sessions.

No change since the previous April 2012 assessment.

*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: SUBSTANTIAL COMPLIANCE

October 2012 Assessment: As of April 2012 the MH Director no longer required to provide coverage for vacant QMHS positions on the midnight shift. A minimum of two QMHS provide coverage 7 days a week for all three shifts. As a result, COs are not required to provide close or constant observations due to unavailability of QMHS.

An audit of healthcare records of 8 inmates placed on suicide precautions was completed by Lindsay Hayes, M.S. Results included the following

> Pursuant to Provision C.1.c of the DOJ Settlement Agreement (which requires safe housing and supervision of inmates on suicide precautions), Observation Sheets that document the required observation of inmates on suicide precautions were randomly reviewed while inmates were on Close Observation status. All were found to be accurate and up-to-date. This is an excellent practice and QMHS/CST staff should be commended for their hard work. (During the previous audit, there were several examples of missed checks due to inadequate QMHS/CST staffing. The program is now at full staffing and this problem has been resolved.)

The audit results were consistent with my observations during the site visit of inmates on precaution on the fourth floor.

*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

October 2012 Assessment: Sustained compliance remains

*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

October 2012 Assessment: Substantial compliance continues.

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: SUBSTANTIAL COMPLIANCE

October 2012 Assessment:

Once suicide precaution orders have been initiated, a colored screen pops up anytime the inmate's EMR is accessed. CT issues have been resolved. Clinical Supervisor monitors CT order for pop up continues.

LCJ has interpreted this provision as follows:

> We believe that this provision is meant to require that when an inmate is readmitted into the jail, that medical and/or mental health staff are aware at intake of any prior suicide attempts within the facility and consider such information during the intake screening process. We have made several changes to CorrecTek and a pop-up screen has been installed that automatically notifies the user (e.g., intake nurses) that the inmate was on suicide precautions during a previous incarceration. The pop-up screen includes the date of suicide precautions. This notification cannot be deleted from CorrectTek. The notification not only includes prior suicide attempts, but more importantly, placement on suicide precautions for a variety of reasons, including suicidal ideation, gestures, mental health status outside normal limits, etc. the most recent QI audit (which should be finalized and to you mid-week) confirms that the pop-up screen appeared on all reviewed records of inmates with prior histories of suicidal behavior in the jail.

The previously referenced audit by Mr. Hayes found that in all the reviewed cases of inmates who were placed on suicide precautions during a previous LCJ confinement and then readmitted into the facility, there was a pop-up screen on CorrecTek that alerted staff of this prior history.

I am in agreement with the above interpretation and findings.

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: SUBSTANTIAL COMPLIANCE

October 2012 Assessment:

Administrative Coordinator reviews all observation logs for compliance and signs and documents date for each observation sheet. SP Policy update replaced EMT language with RN and 10 minute checks changed to 15 minutes.

An audit of healthcare records of 8 inmates placed on suicide precautions was completed by Lindsay Hayes, M.S. Results included the following:

> Pursuant to the DOJ Settlement Agreement (which requires safe housing and supervision of inmates on suicide precautions), Observation Sheets that document the required observation of inmates on suicide precautions were randomly reviewed while inmates were on Close Observation status. All were found to be accurate and up-to-date. During the previous audit, there were several examples of missed checks due to inadequate QMHS /CST staffing. The program is now at full staffing and this problem has been resolved.

The above findings were consistent with my checks during the site assessment.

> ***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

October 2012 Assessment:

Clinical Supervisor has taken an active role in working with QMHPs to re-assess and allow appropriate items.

Allowable items are listed on the top of the observation sheets and documented in patient's CT record with supporting evidence when restrictions apply.

Some resistance remains from COs who state "suicide is suicide risk" and do not want to offer any items. Clinical Supervisor consulted Lindsay Hayes and the Warden sent a directive on 7.23.12 to all LCJ staff that IMs could receive the appropriate items while on precautions, especially toilet paper.

An audit of healthcare records of 8 inmates placed on suicide precautions was completed by Lindsay Hayes, M.S. Results included the following from one of the records reviewed:

> The following day (September 5), a QMHP attempted to assess the inmate in the morning and complete a MHE. A progress note stated that "attempted to complete

> MHE. The inmate could not be pulled for evaluation because of operational conditions in his section. He will not be available for the remainder of the day because visitation for W-Pod will be beginning soon. Follow-up ASAP." Later that evening, a correctional officer called mental health staff after the inmate threatened suicide. He was seen by a QMHS and reported anxiety, depression, and suicidal ideation (without a plan). A progress note indicated that the officer would attempt to relocate the inmate to another housing unit, and the QMHS would refer the inmate to the psychiatrist. Despite expressing suicidal ideation, the inmate was not placed on suicide precautions pending an evaluation by a QMHP.

The above process was not consistent with this provision although the audit results appeared to indicate that this practice was an exception rather than the usual practice.

October 2012 Recommendations for next 6 months:

1. Continue to monitor.

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

October 2012 Assessment:

An audit of healthcare records of 8 inmates placed on suicide precautions was completed by Lindsay Hayes, M.S. Results included the following:

> Pursuant to Provision C.2.c of the DOJ Settlement Agreement (which requires written justification for allowing/prohibiting clothing, property, and utensils when an inmate is on suicide precautions), the current practice of the clinical supervisor is to require removal of clothing/issuance of a safety smock and denial of other privileges such as shower, telephone call, visit etc. in *all* cases for the first 24 hours of suicide precautions. Although this might be viewed as overly cautious, it is not necessarily problematic if it is limited to 24 hours before reassessment. In addition, although most of the reviewed cases in this audit involved inmates who were on suicide precautions for only 24 hours or less, in those cases in which inmates were held on suicide precautions for more than 24 hours, there was no documentation to justify continued prohibition of clothing and privileges, and it would appear that these inmates were denied these items, regardless of level of risk and length of stay on suicide precautions. As previously noted, only one of the reviewed cases involved an inmate on suicide precautions who was reissued

their clothing and permitted a shower, the result of which apparently was confusion amongst mental health staff as to whether the inmate was still on suicide precautions (see **Case T.T.**). Finally, a previous problem of some inmates being denied a mattress and/or toilet paper without justification was resolved with intervention from the LCJ Warden in July 2012.

I am in agreement with the above findings.

October 2012 Recommendations for next 6 months:

1. Train staff re: this provision and re-audit.

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

October 2012 Assessment: QMHPs interact and re-assess patients using SRA daily. In May 2012 QMHP scheduling was changed to include coverage on Saturdays and Sundays to meet this requirement.

The audit by Mr. Hayes included the following findings:

Re: Case JN

In sum, there were several issues noted, including the fact that 2 SRAs were completed within 20 minutes of each other on July 8, and required follow-up assessments post-discharge from suicide precautions were not always provided. The inmate had been refusing his psychotropic medication for almost a month and had not been seen by any mental health staff in almost 2 months. The treatment plan was problematic.

Re: Case DD

In sum, although most follow-up assessments post-discharge from suicide precautions were timely, others were not. Several daily assessments by QMHP staff were not performed while the inmate was on suicide precautions. Multiple MHEs were completed (and only one was necessary). Two SRAs were completed on the same day in close proximity to each other. The treatment plan(s) was problematic. Segregation rounds were timely and the Brief Mental Health Assessment for Segregation was completed as required.

Re: Case DL

In sum, all intake screening, SRAs, and MHE forms were completed on time pursuant to policy. One of the daily QMHP assessments was not performed and only one post-discharge suicide precautions follow-up assessment was done (and it was late). The treatment plan was problematic.

As per the above findings, problems continue re: daily and post discharge follow-up, which was not consistent with log data.

October 2012 Recommendations for next 6 months:

1. Train/supervise staff re: this provision.

2. The Clinical Supervisor should determine why the current Log Book maintained to track inmates on suicide precautions, as well as required post follow-up assessments, is not always accurate based upon the findings from this audit.

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

October 2012 Assessment: I was unable to determine, based on the audit by Mr. Hayes, whether the element of this provision involving consultation with the psychiatrist was followed.

October 2012 Recommendations for next 6 months:

1. Audit all the elements of this 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: SUBSTANTIAL COMPLIANCE

October 2012 Assessment:

QMHPs have received documented training regarding use of SRA. Log utilized to track compliance. QMHP and QMHS assigned to monitor compliance.

The audit by Mr. Hayes indicated that all intake screening, initial SRAs, and MHE forms were completed on time pursuant to policy.

October 2012 Recommendations for next 6 months:

1. Continue to monitor.

   a. 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: SUBSTANTIAL COMPLIANCE

October 2012 Assessment:

As of May 2012 QMHPs utilize SRA for initial assessments and re-assessment when determining continued use of precautions. See SRA in CT.

Except for one case, compliance with this provision was consistent with the audit performed by Mr. Hayes.

October 2012 Recommendations for next 6 months:

1. Continue to monitor

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: SUSTAINED COMPLIANCE

October 2012 Assessment:

Sustained compliance continues.

Based on the Hayes' audit results, LCJ reported the following:

> Pursuant to Provision C .4.b of the DOJ Settlement Agreement (which requires annual suicide prevention training for all LCJ personnel, the current suicide prevention policy (16.07.05: Suicide Prevention, effective July 2011) is being slightly revised to include a protocol for the immediate reassessment of inmates on suicide precautions who are released from custody while still at risk for suicide. Upon completion of the revised policy, the suicide prevention curriculum will be revised to include the new protocol and the annual suicide prevention training will commence (estimated by the end of 2012).

I agree with the above plan.

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: SUSTAINED COMPLIANCE

October 2012 Assessment:

Newly hired medical staff and correctional officers receive the same training and materials originally developed by Lindsay Hayes. Clinical Supervisor conducts the trainings in cooperation with Training Officer. See training records for compliance.

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

Overall Comments: In general, I continue to see improvements in all of these areas : Fire Safety; Sanitation and Environmental Conditions; and Protection From Harm. The most significant issues that need to be addressed in order to achieve substantial compliance in the above 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. Lake County officials have reported that they will authorize an additional 18 correctional officer positions in the 2013 budget which are in addition to the previously added 12 correctional officer positions. This is certainly a step in the right direction. During this tour, DOJ Attorney William Maddox and I toured and inspected the Lake County Work Release Center. The Work Release Center houses both male and female inmates in separate areas of the facility. Overall, we found the Work Release Center to be neat, clean and orderly and properly staffed. The Work Center is self-sustained from the other LCJ Jails with the exception of the medical and mental health program which is administered from the main Jail. The facility has its own Director and staff. The facility has its own food service preparation and feeding area. The facility is equipped with fire extinguishers and AED's as well as other fire and safety features. The only recommendation made to staff was to make available "cut down" tools in strategic areas of the facility.

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 continues to make 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. The full-time Fire Safety Officer for LCJ 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. The fire safety plan will need to be reviewed by the Crown Point Fire Inspector in March 2014 or sooner if any revisions are made to the fire safety plan.

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 staff should continue to maintain the fire safety standards they have achieved.

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. The start and stop time of fire drills are being documented; however, in order to ensure that the fire drill program is comprehensive, additional fire drills must be completed in order to cover all areas of the facility.

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 as well as expanding the fire drills to all areas of the facility in the fire drill schedule.
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 and are being inspected. There were fire extinguishers available in all areas of the jail.

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.

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 continues to serve on a full-time basis and oversees 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 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. 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. Training for staff on the key control system is incorporated into the fire safety training program. The training supervisor reported that they are approximately 37% of LCJ staff have been trained on the fire safety program and policies; however, staff need to ensure that the training program incorporates the current fire safety policies and practices. LCJ staff have developed a "chit" system for maintaining accountability of the facility keys, which is a good correctional practice. However, the number of keys assigned to each key ring still needs to be developed. A master inventory of the facility keys was revised in October 2012 and needs to be maintained and updated as needed.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ staff need to develop a system of identifying emergency keys by touch.
2. The overall key control program needs to be audited on a frequent basis by the Facility Fire Safety Officer and the Fire Safety Compliance Inspector due to the fire safety implications the key control program has in the overall fire safety program.
3. Jail staff need to continue to be trained in the use of emergency keys as part of the pre-service and in-service staff training program and ensure that the current policies and practices are incorporated into the training program.

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 continue to be 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. The fire safety staff have developed a "Manual Unlocking Mechanisms Quarterly Test" schedule which is very helpful in tracking this requirement. It appears that the Fire Safety Officer is the primary staff member who coordinates this effort; however, the evening and night shift security supervisors could also be conducting these types of random audits and report the findings to the Fire Safety Officer as well as generating maintenance work orders on any needed repairs that may be identified. The reports generated by the Fire Safety Officer regarding these types of inspections are good and are starting to identify discrepancies in the system.

RECOMMENDATION FOR THE NEXT 6 MONTHS:

1. LCJ officials should continue to conduct 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 continue to be documented.
2. Security supervisors in the evening and night shifts can help supplement the random audits and report the findings to the Fire Safety Officer and Maintenance Department.

ADDITIONAL INSTRUCTIONS/DOCUMENTS FOR NEXT TOUR:

I would like to continuing reviewing documents that demonstrate the results of the inspections/audits that were conducted for the emergency unlocking system and staff response as well as the follow-up maintenance repairs.

g. LCJ shall implement 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. Staff have started to receive training in fire and emergency procedures. LCJ staff reported that approximately 37% of the required staff were trained in July 2012 and another training class is scheduled for October 2012.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ staff should ensure that competency-based testing for staff regarding fire and emergency procedures continues to be provided.

h. ***LCJ shall ensure that fire safety officers are trained in fire safety and have knowledge in basic housekeeping, emergency preparedness, basic applicable codes, and use of fire extinguishers and other emergency equipment.***

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

LCJ has 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, emergency 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 cleaning of housing, shower, and medical areas. Such policies should include oversight and supervision, including meaningful inspection processes and documentation, as well as establish routine cleaning requirements for toilets, showers, and housing units.***

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

LCJ continues to implement some components of their housekeeping and sanitation plans. LCJ needs to obtain final approval from the Sheriff and Jail Administrator on the overall sanitation plans and policies and procedures, including the sanitation inspection forms. 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 continue to perform 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 continue to be involved in

replacing shower curtains. Housing unit and booking cell vents were much cleaner this tour than in past tours. A professional outside company was hired to clean many of the facility vents that were evident during the tour; however, this is an on-going process that needs to continue to be part of the overall cleaning and sanitation program. Sanitation in the medical area continues to improve generally; however, more emphasis needs to be applied to the patient cells, particularly in the mental health areas and the shower areas. In general, the booking area was neat clean and orderly. LCJ staff have intensified the cleaning and sanitation program in the booking area. However, a cleaning program cannot be sustained 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.
3. LCJ staff need to intensify the cleaning program in the medical area, especially in the patient cells and showers.

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 continues to make strides in refurbishing the physical plant and making needed repairs to the plumbing system, including the shower areas and cell plumbing. During the tour, I did not observe roof leaks. 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 are in the process of developing an automated system for the tracking of facility work orders and expects the program to be functional by early 2013. The automated system will also include a preventative maintenance component.

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. With limited floor officers it is difficult to maintain control over inmate cell vent coverings. 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. LCJ staff also hired an outside contractor to help clean the difficult to reach vents. 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. The facility is doing a good job with the assistance of Johnson Controls in monitoring the airflow and heating and cooling system. Facility staff are able to readily monitor these systems through the use of an automated tracking and reporting system.

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 as part of the on-going and preventative maintenance program.

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 lighting 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 continue 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.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ staff should continue to maintain the lighting and electrical system in a good state of repair. For sustainability purposes, LCJ staff should make the inspection of the lighting system part of their daily housekeeping inspection program and preventative maintenance program.

e. LCJ shall ensure adequate pest control 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 not 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: SUSTAINED 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 continue to observe only 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 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. In my last tour, LCJ received approval from the Lake County Council to hire 12 additional correctional officers and another 18 new correctional officers are projected to be approved in the 2013 budget. These are steps 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. As I have reported in my previous reports, 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. LCJ officials have implemented a twice weekly laundry exchange program for the female population, but not for the male inmates.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

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

> ***b. LCJ shall ensure that inmates are provided adequate clean clothing, underclothing and bedding, consistent with generally accepted 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 continue to be exchanged at least once per month .

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. It remains 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 week, unless inmates are only issued one sheet and one towel, then they should be exchanged 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 implement the revised laundry schedule 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:

As I reported in my previous reports, it appears that a private vendor has continued to provide training to laundry staff. Security staff are provided training on the provisions of the SA as it relates to laundry issues. However, a system has not yet been developed and implemented for educating inmates regarding laundry sanitation policies. 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: SUSTAINED COMPLIANCE

ASSESSMENT:

LCJ staff have developed practices that protects inmates from exposure to communicable diseases. The laundry carts are still being 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 still 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 staff continue to provide laundry exchange twice per week. 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 provision prohibiting inmates from washing and drying laundry outside the formal procedures.
2. Inmates should be issued sufficient quantities of clothing and towels to provide for proper hygiene and laundered as previously recommended in this report.
3. LCJ officials should implement the revised laundry schedule and inmate issue provisions concomitant with an adequate facility staffing deployment plan.

3. <u>Food Service</u>.

a. ***LCJ shall ensure that food service at LCJ is operated in a safe and hygienic manner and that foods are served and maintained 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 continue to make 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 monitor 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 meals continue to be delivered and provided promptly to inmates so that problems are not encountered with food temperatures.

> ***b. LCJ shall ensure that all food service staff, including inmate staff, must be trained in food service operations, safe food handling procedures, and appropriate sanitation.***

OVERALL COMPLIANCE RATING: SUSTAINED COMPLIANCE

ASSESSMENT:

During the inspection I met with food service staff as well as conducting an inspection of the kitchen. Many improvements continue to be made in this area. For example, the dumpsters are still being cleaned on a weekly basis, food service equipment is maintained in good working order, 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: SUSTAINED 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: SUSTAINED 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: SUSTAINED 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 records of these checks.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

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

October 2012 Assessment:

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

October 2012 Recommendations for next 6 months:

1. 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

October 2012 Assessment:

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

The QM/QI activities in the area of the mental health system remain very minimal.

October 2012 Recommendations for next 6 months:

1. 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

October 2012 Assessment:

A QI committee has been established, which has met on a monthly basis since February 2012. Minutes are documented and shared.

October 2012 Recommendations for next 6 months:

1. A mental health subcommittee meeting should be established as part of this QI Committee

2. Begin to implement a more robust QI process re: the mental health services.

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: PARTIAL COMPLIANCE

October 2012 Assessment: Some progress has occurred re: these SA provisions. Performance measures reportedly remain under development in all areas. Utilization of psychotropic medications was studied resulting formulary revisions resulting in reduced costs and maintenance of treatment effectiveness.

An intake MH/SP QM report was developed and implemented to identify compliance with screening completions, referrals, and care indicating that there gaps in assessment compliance. Changes were made to in staff deployment and oversight. The facility undergoes regular inspection to ensure cells are safe for inmates at high risk of self harm.

October 2012 Recommendations for next 6 months:

1. 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, approximately 95% of the 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, with the help of their consultants, is in the process of developing an additional use of force training program for the supervisors. LCJ staff are working diligently on implementing the revised use of force program, but it will take some time to fully 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.
2. LCJ staff need to develop and implement the supervisor use of training program.

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. Monitoring of the use of force reporting is conducted by the Staff Training Division and the Deputy Warden of Security. LCJ staff have developed a use of force tracking system which is still in its infancy stage, but shows signs of effectiveness. When fully implemented, the system should be capable of accounting for each and every use of force, both reported and unreported.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ officials should further refine their process of monitoring this requirement of the SA internally and ensure that all use of force information is entered into the use of force database and that it is accurate and complete. There should be some method to verify that the use of force information is valid and verified.
2. LCJ staff should continue to qualitatively track, review and analyze use of force incidents for conformance with the SA.
3. LCJ staff should also develop a monthly tracking report for all use of force incidents in order to be able to conduct comparative reviews of the program.

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 the 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 injuries 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 ground with the force that was necessary;" and

(8) note whether a use of force was videotaped. If the use of force is not 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. LCJ staff should be conducting qualitative reviews of use of force reports to ensure conformance with the SA and the Use of Force Policy and Procedure.
2. I would also recommend that a new use of force report form be developed and implemented that includes all the elements of this provisions of the SA. A draft report is reportedly under review by the IA Captain of which I will review in my next reporting period.

e. LCJ shall require prompt administrative review of use of force reports. Such reviews shall include case-by-case review of individual incidents of use of force as well as more systemic 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 and 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. As reported earlier in this report, most of the correctional officers have already received training on the new Use of Force policy, but a separate use of force training component is being developed for supervisors that also needs to be fully implemented.

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 as part of the pre-service and in-service training program.
2. It was my recommendation in my previous report that all use of force incidents continue to be reviewed by the Deputy Warden of Security and the Warden. However, I would also be receptive to the idea of LCJ having a multi-disciplinary team reviewing use of force incidents.
3. During my next review I will be reviewing use of force reports and the review process of use of force incidents.

f. LCJ shall ensure that Qualified Medical Staff request that inmates sign arelease of medical records for the limited purpose of administrative and investigative review of any incident involving an inmate injury. Qualified Medical Staff will document the request and the inmate's response. LCJ will ensure that inmates receive adequate 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 revised 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. LCJ staff reported that this task remains under development.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. It is recommended that the medical policies and procedures be developed and finalized and include these provisions of the SA and that both security and medical staff start receiving training on them.

g. LCJ shall ensure that management review of use of force reports and inmate grievances alleging excessive or inappropriate uses of force includes a timely review of medical documentation of inmate injuries as reported by Qualified Medical Staff, including documentation surrounding the initial

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. LCJ staff reported that this task remains under development.

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, considerable 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 as well as developing and implementing the supervisor use of force training. It does not appear that a triggering referral for use of force investigations has been developed and implemented.

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 been developed and is in the initial stage of implementation. RJS Consultants continue 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 continue to be implemented and adjusted as needed.

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 considerable training provided on these provisions to LCJ staff. LCJ staff are in the process of developing and implementing a use of force training program for supervisors who play a critical role in the use of force program. Video recordings of use of force incidents are maintained by the Deputy Warden. During the tour I reviewed several use of force video recording. 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 additional video recordings and photographs taken following use of force incidents.
3. LCJ staff should consider developing separate “use of force package” for each use of force incident that contains all documents and evidence for every use of force incident.

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. The process remains informal at this time.

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. It should be noted that I reviewed a use of force incident that occurred on September 5, 2012 involving the refusal of several inmates to lockdown that was not handled very well in large part due to security staff shortages. The incident occurred in Y-Control at approximately 4:45 pm on September 5, 2012; however, due to staff shortages at the facility and the lack of floor officer to intervene, the SORT team did not respond until approximately 5:55 on the same day upon the second shift reporting for work. The incident involved the use of pepper balls to finally get the inmates into their cells. There was certainly too much lag time in getting the incident under control and could have easily escalated beyond what it did and could have resulted in a more serious incident. Additionally, if there had been sufficient staff to promptly respond to the initial incident, it may not have escalated to a use of force incident.

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. LCJ staff reported that there was one referral made to the IA Unit regarding the inappropriate use of force during this reporting period. However, I was not able to obtain a copy of the investigation because IA staff were unavailable during the inspection.

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.
2. During the next site visit I will be reviewing any IA investigations regarding staff use of force violations as well as personnel records.

> ***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 continues to maintain 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. During this tour and in my previous tour I reviewed use of force incidents. I noted in both of my inspections that in many instances where the Taser was deployed, it was generally used on mentally ill inmates or in the intake area. In my previous report I noted that that the taser was 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. During this inspection I reviewed 2 videos involving male staff that were involved in handling a female mentally ill inmate that was naked and removed from her cell while male inmates cleaned her cell. I believe LCJ staff should carefully review the use of force involving mentally ill inmates and seek better methods for handling them.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The revised Use of Force Policy and Procedures should continue to be implemented.
2. RJS staff should continue working with LCJ staff in addressing the proper use of the Taser and its application on mentally ill inmates as well as other types of force used on the mentally ill. 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. Approximately 95% of the correctional officers have been trained. A separate use of force training program is being developed for the supervisors. In addition to the above use of force training, there is a 4 hour in-service training component on the use of force.

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 continue to 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. LCJ staff reported that this provision is contained in the Inmate Handbook, but it does not appear to be specific to the use of force.

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, regardless 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 continue to work 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 my previous 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. This can be accomplished in a 2 to 3 hour training session.

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 specific instances regarding allegations of staff misconduct for conformance with this provision of the SA.