FIFTH COMPLIANCE REPORT
LAKE COUNTY JAIL
AUGUST 2013

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 has improved its ability to measure performance against the Agreed Order but this has been challenging due to the difficulty in obtaining data from the current electronic record. The program was able to provide data on several items requested on an ongoing basis.

- The length of time from intake screening to provider assessment by acuity status.
  - Because the program has just completed implementation of intake screening utilizing a priority status system the data provided is not yet accurate. The program provided data reporting the percent of patients screened by priority. As of January of 2013 only 34 Priority 1 inmates were reported as receiving provider evaluation based on intake referrals. This is significantly below expectations given that 1135 inmates were incarcerated. On chart review it was clear that patients are not being given accurate priority assignment. In February 97 inmates were reported as evaluated which is also below expectation. The program also reports the number evaluated within 24 hours and those greater than 24 hours. For January of the 34 people evaluated, 31 were reported as evaluated within 24 hours for 91% compliance. For February 91.75% compliance was reported. However, if the priority status is not being assigned correctly, then the numbers reported are not meaningful. So the way the report is structured is acceptable, but the results are not meaningful because the priority system of intake screening needs further modification and training.
- Percent of incarcerated detainees who receive intake screening.
  - The program reported that in January of 2013 there were 1135 admissions and 1037 (91%) intake screenings. In February 2013 there were 906 (83%) intake screenings for 1085 admissions. These are not good numbers and require explanation. The program should separate persons who are pre-booked from booked so that they are not counting in the intake numbers people who after a pre-booking screening are immediately released or sent to a hospital.
- Percent of incarcerated detainees who receive tuberculosis screening.
  - The program reported in their Quality Improvement Committee tuberculosis skin testing data which does not compute. They report data in a table which indicates that for January 2013, 1003 Mantoux skin tests were applied, 491 tests were read, and 451 inmates were released apparently before the test could be read. 491 and

451 does not add up to 1003 tests applied. This may imply that 61 inmates did not have their test read. Did half of the inmates leave before 72 hours of incarceration? As well, the program reported 1135 admissions for January but only reported 1003 Mantoux skin tests applied which is only 88% on inmates screened for tuberculosis. This number should be 100%.

- Number of health care slips picked up daily and triaged within 24 hours.
    - The program reported that 735 health requests slips were placed in January or approximately 24 a day. For February they report 713 requests placed or approximately 25 requests a day. They are reporting that 100% were triaged within 24 hours.
- Number and percent of symptomatic complaints on health care slips which have a face-to-face evaluation within 72 hours.
    - For face to face evaluation, the program reported a study from mid-February to mid-March. Because of the dates chosen, the numbers could not be compared to their monthly reported data. In this sample, they report that of the 799 requests only 303 (37%) involved a symptom. Of the 303 symptomatic complaints reported only 177 received a face-to-face evaluation. This was 58% of symptomatic complaints but only 22% of total complaints.
    - The program also reports 65 inmates refused evaluation which is 21% of symptomatic complaints. This is a high number indicating a potential problem.
- Average time from physician order to administration of medication for prescription medication.
    - The program reported that 98.93% of inmates receive their first dose of medication after a provider order within 1 day. This is tracked utilizing ordering data and data from the medication administration software. This is an acceptable number.
- 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.
    - The program reported data in a study of a portion of scheduled appointments, specifically a no-show study of 14 day history and physical examinations. This was done for February of 2013. Of 930 appointments, only 130 (13.9%) were completed. The study indicated that 65% of appointments didn't occur because the inmate was no longer in the facility. The released inmates should not be included in the study. If this is done, there would be 326 appointments for February of which 130 (40%) took place. This is a very low number. 17% of inmates were said to refuse appointments which is also a very high number of refusals. Further investigation into the cause of refusals should be undertaken.
    - A study of specialty provider appointments for February 2013 was performed. Of 15 appointments, 10 were seen. 2 patients were released.

These form a good basis for quality metrics. However, not all quality improvement metrics have 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. Improve metrics outlined above as part of a Continuous Quality Improvement Program and continue to improve data collection for the existing metrics.

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:

Policies and procedures need to provide concise and simple directions for staff regarding expectations. Too much effort is now being expended on rationales, background, theoretical, and other unnecessary information.

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. I recommend that medication administration and

access to care (sick call) be topics for combined custody and medical inter-agency procedures. The custody procedure should become part of the post orders for officers.

For policies that are written, they would be improved by simplification and by providing clear direction to line staff who will use them. They are still attempts at academic presentation rather than simple directions to line staff, giving guidance in key areas of service.

Under this agreement policies must be developed in multiples areas of service. The policies sent to me did not include policies in the following areas:

- Medical triage and physician review
- Intake screening
- Comprehensive health assessments- chronic illness management
- Emergency response
- Disease prevention

Other policies were provided but many either need revisions or should be re-written. These include:

- The access to care policy is inadequate as it does not address access to the gamut of heath services available to inmates. As well, it does not address access to care through health requests.
- Infection control needs some revisions.
- Intoxification and detoxification need to be re-written.

The following are comments on individual policies.

- The influenza procedure in the Infection Control policy recommends isolation of suspicious cases but does not indicate where patients are to be isolated. Isolation implies negative pressure housing but there are no negative pressure rooms in the jail. The same policy recommends isolation for all detainees in contact with the affected individual. Where are these detainees to be isolated? If the individuals are to be housed alone in single cells, this may be appropriate for influenza but would not be appropriate for diseases such as tuberculosis.
- In the influenza procedure how often are vital signs done for suspicious cases?
- In the tuberculosis policy, it recommends isolation of persons suspicious for active tuberculosis until they are cleared. Since there are no negative pressure rooms at the jail, where are these individual to be housed? These patients should be immediately masked and sent directly to a hospital for evaluation. They should not be housed at the jail. There are several such references like this in the policy.
- The policy recommends isolation for all persons with a positive Mantoux skin test until they receive a chest film. Where are these individuals to be isolated? Prompt x-rays are considered sufficient and Mantoux skin test positivity does not require isolation.
- The tuberculosis policy states that a Mantoux skin test of 5 mm is positive if they are infected with HIV or have an x-ray with abnormal findings. Does this mean that all persons with a 5 mm skin test have an x-ray and HIV test? This should be clarified.
- The policy recommends contact investigation only for suspected or confirmed pleural cavitary disease or positive AFB. Contact investigation should be initiated for all active tuberculosis cases.

- The contact investigation procedure recommends that only contacts with the greatest degree of exposure should have skin testing. All contacts should be skin tested.
- The sexually transmitted disease policy under the HIV section, #1 states that "everyone will have one screen test for HIV in their life who is sexually active". This is not clear. Does this mean that everyone is tested for HIV?
- The STD procedure states that "Positive HIV and RPR tests will be confirmed by specific tests approved by the Medical Director on a case specific basis". This is inappropriate. All positive syphilis and HIV tests should automatically result in confirmatory testing. There should be no need for Medical Director approval. Most laboratories automatically reflex positive screening tests with a confirmatory test so this statement is probably unnecessary to state.
- The STD procedures recommend specific drugs for treatment. Because these drugs change frequently due to antibiotic resistance patterns, it is best to refer to the CDC latest version of STD treatment guidelines instead of trying to give guidance on specific treatment.
- The policy on medication administration training and the policy on pharmaceutical operations states that Corrections Officers administer or deliver medication. Correctional Officers should not administer or deliver medication.
- The pharmaceutical operations policy permits corrections officers access to stored controlled substances. This is inappropriate.
- The continuity of care policy recommends that a SMP reviews discharge instructions after hospitalization, ER visit or off-site consultation. The timeliness is not stated. This should be promptly upon return.
- The continuity of care policy item #4 Periodic Health Assessments doesn't give any direction about what periodic health assessments will be done. It also does not specify which protocols "promulgated by nationally recognized organizations" will be utilized.
- The policy Care of the Pregnant Female states that if an inmate believes she is pregnant the test is done at the 14 day assessment. The test should be done as soon as the inmate states that she might be pregnant.
- The Care of the Pregnant Female policy does not state the laboratory tests which should be done. It also states the HIV testing is offered when indicated. HIV testing is indicated for all pregnant females. Other laboratory testing should follow American College of Obstetrics and Gynecology (ACOG) guidelines.
- Prenatal care should follow ACOG standards.
- The Care of the Pregnant Female policy does not specify who provides prenatal care to the pregnant female. Optimally, this is an obstetrician. If this can not be arranged a Family Practitioner who is trained in prenatal care can be a substitute. Prenatal care should not be provided by clinicians who have not had training and experience in prenatal care.
- The Inmates with Alcohol and Other Drug Problems states that Correctional Officers conduct intake screening. This is inappropriate.
- In general the Alcohol Detoxification procedure should be re-written for clarity and appropriateness. It gives various recommendations which at times seem contradictory (e.g. admission to a hospital for a CIWA of 24 in one section and a CIWA of 15 in another section), confusing or inappropriate directions regarding medication use (use of midazolam for seizures and Phenobarbital for detoxification), unclear directions on how

to use the CIWA scale, and poor directions regarding where patients identified at intake screening in need of detoxification are to be housed. This procedure should be simplified and clarified. Other comments on this policy are listed below.

- The Alcohol Detoxification procedure states that if a patient is unable to walk or almost unconscious the patient should be transferred to a hospital. However, any sign of delirium tremens should prompt evaluation by a physician and transfer to a hospital if a physician is not present. The same procedure states that if an arrestee is uncooperative or unable to be evaluated, the arrestee should be returned to custody and brought for later evaluation. Being uncooperative is characteristic of persons in delirium tremens. Therefore this is poor and potentially dangerous advice.
- Item B in this policy is not clear. It appears to be saying that persons who are detoxifying or withdrawing from alcohol and are uncooperative are managed by custody with vitals every 4-8 hours until cooperative. These individuals should be under medical supervision.
- In the Alcohol Detoxification procedure, Phenobarbital is recommended for use in withdrawal. Phenobarbital is not recommended for alcohol withdrawal.
- The Alcohol Detoxification procedure, item H recommends lorazepam for a CIWA score above 15, but at this score, the patient should probably be hospitalized.
- The medication recommendations in the Alcohol Detoxification procedure are confusing. Use of lorazepam, tegretol and Phenobarbital are all recommended and it is not clear when these are to be used. Phenobarbital is not recommended in withdrawal syndromes.
- How the CIWA scale is to be used is not clear. This scale can be used to determine appropriate housing for the inmate, the status of the withdrawal, and to stage medication dosing. In this procedure it is unclear how to use this instrument.
- The Alcohol Detoxification procedure recommends hospitalization for a CIWA score above 24. Scores above 15 generally require hospitalization or at a minimum, immediate physician evaluation.
- The Alcohol Detoxification procedure states that midazolam (Versed) is the drug of choice for seizures at Lake County Jail. This is dangerous as this medication is not even recommended for routine seizure use and should only be used in a hospital or outpatient surgery center. There is a black box warning for this drug as the risk of respiratory depression or respiratory arrest is present. This drug is recommended for intractable status epilepticus not for withdrawal or typical seizures. It must be used with extreme caution in noncritical care settings.

- The benzodiazepine detoxification /withdrawal procedure needs to be re-written.
  - Item A under the subcategory Dosages in this policy is not understandable. Does this mean that all patients withdrawing from benzodiazepines are treated with Phenobarbital? Phenobarbital is not recommended for use in benzodiazepine withdrawal.
  - The reason for giving a loading dose of Carbamazepine does not appear to have a clinical basis and it is not clear if this drug is to be used on all patients experiencing benzodiazepine withdrawal.

- The medication recommendations in this procedure need to be reviewed for clinical appropriateness.

- For the opiate withdrawal procedure it is not clear where persons with opiate withdrawal are to be housed.
- One major cause of death in patients experiencing opiate withdrawal is inability to consume liquids or food due to vomiting. This should be addressed in the procedure.
- In the Withdrawal from Stimulants procedure, beta-blockers are recommended for tachycardia. This should be reviewed for clinical appropriateness.

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, access to care, and special housing care or infirmary care.

3. Intake Screening and Health Assessments.

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

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

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

c. LCJ shall ensure that the comprehensive assessment performed for each inmate within 14 days of his or her arrival at LCJ shall include a complete medical history, physical examination, mental health history, and current mental status examination. The physical examination shall be conducted by Qualified Medical Staff. Records documenting the assessment and results shall become

part of each inmate's medical record. A re-admitted inmate or an inmate transferred from another facility who has received a documented full health assessment within the previous three months and whose receiving screening shows no change in the inmate's health status need not receive a new full physical health assessment. For such inmates, Qualified Medical Staff shall review prior records and update tests and examinations as needed.

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

e. ***LCJ shall implement a medication continuity system so that incoming inmates' medication for serious medical needs can be obtained in a timely manner, as medically appropriate when medically necessary. Within 24 hours of an inmate's arrival at LCJ, or sooner if medically necessary, Qualified Medical Staff shall decide whether to continue the same or comparable medication for serious medical needs. If the inmate's reported medication is discontinued or changed, a Qualified Medical Professional shall evaluate the inmate face-to-face as soon as medically appropriate and document the reason for the change.***

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

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

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

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

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

3.a.

The policy on reception screening is still incomplete. The procedure should include acuity rankings. I discussed the acuity ranking system with medical leadership. The process of assigning acuity and follow up with a primary care provider should be included in the procedure. This should include timeframes for assessments. Also, the detoxification protocol should be revised and include criteria for who should be included in the protocol. There should be direct provider involvement in starting a detoxification protocol; some of this may need to be telephonic. TB screening should be included in the intake procedures.

Currently, CHI has provided for nurse intake screening 24/7; this is working well and staff are performing well. Construction of an intake medical screening area has been completed and is adequate with a minor exception. The screening area is built with concrete and sound reverberates such that all evaluations can be heard. Some type of soundproofing needs to be added.

3 b. (1-7)

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

3 c.

Based on chart reviews, people with chronic medical illness are not timely evaluated.
The program has established acuity based screening to include 4 priority rankings. These priority rankings do not seem to be useful guidance to staff because many charts reviewed included patients who should have been seen promptly but were given low priority ranking and were seen later.

Based on the intake screening data and on chart reviews, the priority rankings do not appear to be effectively used in identification of the acuity of the chronic illness. Because nurses perform this function, the procedure should be written so that nurses understand how to make these assignments. As well, the intake nurses should be trained on how to perform this evaluation.

In addition, the priority rankings start with a moderate disease classification. It is not clear how patients with severe disease or more acute problems are addressed. This needs to be included in the priority designations.

As a result of ineffective priority assignments by nursing, providers are not timely evaluating patients with serious chronic illness. As well, the quality of the evaluation needs to improve. The first assessment evaluation should be a focused history and physical examination concentrating on the patient's chronic illnesses. There were multiple examples of initial assessments in which providers took no history except to state the patient's disease.

3 d.

Nurses are appropriately and reasonably obtaining medication history from incoming detainees. The nursing staff in intake do take adequate history of prior medication use. As well, they attempt to contact local pharmacies to establish the accurate existing prescriptions for incoming inmates who are on medication. This was verified on chart reviews.

3 e.

For 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.

The program provided data that 98.9% of patients receive their first dose of medication within a day. I reviewed the data used for this and it appears appropriate.

3 f.

Refer to Dr. Metzner's report.

3 g.

The standardized detoxification procedure is not yet complete. The program continues to promote use of Phenobarbital as the primary drug used for alcohol withdrawal. This is not the standard of care. Phenbarbital is acceptable for refractory withdrawal when a benzodiazepine is ineffective. The draft policy on intoxication and detoxification was reviewed with leadership.

LCJ's detoxification procedure should identify a place to house persons undergoing detoxification. There is no data on the numbers of persons who are in need of detoxification. However, these individuals are best housed in a single location because of the number of nursing interventions they will need over the first few days of incarceration. The LCJ compliance progress report indicated that detoxification patients will be housed on the 4th floor after mental health patients move to a different location. This was not yet in place at the time of our visit.

3 h.

The intake screening information is electronically incorporated into the medical record and all records were accessible to me upon inspection. There was no problem locating intake screening records.

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. 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 improve the acuity ranking system so that those with serious medical problems are timely seen after intake screening. Providers should prioritize those detainees with serious medical conditions. This should be codified in a standardized policy and procedure.
2. The intake screening booths should have some sound baffling to ensure sound privacy in screening evaluations.
3. Standardized alcohol and opiate withdrawal procedures should be revised 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.
4. Re-evaluate medication used in the withdrawal procedures.
5. 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.
6. Verbal orders must be signed by providers and signature must be clear in the record.
7. Develop a procedure for alcohol intoxication.
8. Include in the detoxification procedure opiate withdrawal and how it will be handled.

4. <u>Acute care</u>.

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

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

4 a.

The policy on emergency medical response and admission to hospitals is not yet 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.

A comprehensive urgent care log is maintained based on notes extracted from CorrecTek. This note extraction takes a considerable amount of work. I was provided logs for March and April of 2013. This log contains data from the urgent care template present in CorrecTek. There were 195 urgent evaluations in March 2013. This data is now tracked on a monthly basis. The time of urgent care evaluations are also tracked.

The data for this log comes from a template within the electronic record. The template, according to the LCJ Compliance Report includes a disposition or management section. However, this information is not consistently completed. For one patient seen on 4/7/13, the patient complained of repeated vomiting and diarrhea. This patient had a pulse of 105 and a blood pressure of 82/44 which is very low. Based on these vitals the patient could have been extremely dehydrated. There was no treatment provided or the information was not documented. Another patient seen on 4/7/13 was seen urgently for headache and chest pain. The patient had a pulse of 107 and a blood pressure of 168/120. There was no documented treatment or disposition for this patient.

RECOMMENDATIONS FOR NEXT 6 MONTHS:

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

5. <u>Chronic care</u>.

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.

The chronic illness policy and procedure are still incomplete. 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.

A chronic disease roster is available. It is manually derived by the chronic disease nurse. Every day this nurse reviews all intake screenings and enters a disease category based on her interpretation of what the disease is. This list is provided to an advanced practice provider who then reclassifies all patients. The chronic disease roster should be derived from licensed practitioner diagnosed disease not by suggested disease categories of the chronic disease nurse. This system is used because the current electronic record is not capable of providing a listing of patients by disease.

This results in a not very useful disease roster at a significant manpower expense. Because the roster is not useful, practitioners find other ways to manage patients. As an example, the nurse practitioner who tracks and manages diabetics uses her own list for tracking diabetics. She develops her list from the diabetic accucheck list. Also other providers give her names of individuals who have diabetes. Even though the chronic disease nurse spends considerable time developing a tracking list at least one provider spends considerable time to create another more reliable list. The inability to obtain a roster of chronic illness list results in redundant and wasted work.

The chronic disease lists are based on a nurse interpretation of intake screening information and are not accurate. The general medicine chronic disease list, for example lists murmur, blister, alopecia, and dog bite amongst other problems as chronic illnesses. These are not chronic illnesses. As well, the pulmonary list has no disease listed so it is not possible to determine from the list whether patients on the list have asthma, emphysema, sarcoid, or any other pulmonary disease. These diseases are very different illnesses.

The program has developed tracking sheets for diabetes and hypertension in order to track key monitoring values for these diseases. For diabetes the values tracked consist of microalbumin, hemoglobin A1c, lipid values, eye examination and foot examination. Blood pressure and creatinine should be included. This log is maintained manually by the chronic illness nurse with a considerable amount of effort. With a reasonable electronic record, this data could be obtained by a query upon request. Instead this chronic illness nurse spends most of her time maintaining a spreadsheet which could be done by a machine. The nurses time is better spent using a machine to obtain this data and then to spend her time interacting with patients to obtain improved control of their disease.

If the existing electronic record continues to be used, the program will have to develop an alternate way to track patients with chronic illness.

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 much of her time doing the clerical work just tracking patients.

Review of medical records of persons with chronic illness still demonstrate missing diagnoses,and 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.

The management of patients with sickle disease and asthma was reviewed and needs improvement. Patients with sickle disease are not getting sufficient pain medication to control their disease. The medical staff's fear that inmates will misuse pain medication is creating a barrier to appropriate treatment of sickle disease. Patients reviewed had bone fide sickle disease and based on laboratory values were in crisis and were not receiving sufficient pain medication,

In addition, patients with asthma are not receiving rescue inhalers based on standard of care. The standard of care is that all patients with asthma should have a short-acting beta agonist inhaler on their person for use when exacerbations or acute symptoms occur. The existing practice in the LCJ for some patients is to have the nurse provide access to the medication during medication administration. This is inconsistent with standards of care because the patient does not have access when he needs the medication and can only obtain the medication when the nurse arrives for medication administration. Moreover, regular scheduled use of short acting beta agonists is not recommended. All patients with asthma should have a rescue inhaler on their person for use during episodic symptomatic episodes.

The lack of adequate disease management is partly related to lack of adherence to clinical guidelines. The jail can develop their own guidelines but for common illnesses these guidelines should be based on contemporary standards such as:

- American Diabetes Association Clinical Practice Recommendations
- National Heart Lung and Blood Institute (NHLBI) hypertension guidelines (JNC VII)
- NHLBI asthma guidelines: Guidelines for the Diagnosis and Management of Asthma
- NHLBI cholesterol guideline: 3rd Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults
- NHLBI The Management of Sickle Cell Disease

The chronic illness management is not good. The first visit for chronic disease patients is mostly an episodic encounter that doesn't establish an accurate history or physical examination based on the chronic illness of the patient. When guidelines are established the provider staff should receive training on expectations for evaluation and monitoring of patients.

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.

The program still does not have a procedure for handling complex patients. The 4th floor beds are mostly used for mental health patients. Insulin dependent diabetics and all types of chronic illness patients including detoxifying patients are housed randomly throughout the jail. Sicker patients (e.g. patients vomiting, or with heart failure) are sometimes housed on the 4th floor but even these types of patients are housed throughout the jail. Because complex patients require frequent nursing interventions, it is best to house them in the same area to save nursing labor in

managing these patients. As well, it is best for these patients to be near a nursing station so that nurses can respond quickly when an emergency occurs. Groups of patients that should be housed together include complex medical patients, patients with acute infections that need monitoring, insulin requiring diabetics (because they require nurse administered insulin injections), disabled persons, persons who are detoxifying, and pregnant women. The health program should work with the Sheriff to identify housing where these patients can be housed together.

Wheelchair patients are housed on the 4th floor where there are ADA accessible showers. People who are not well controlled have to be housed in general population except for brief periods of time.

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. The providers must use a standardized method of recording problems in the electronic record which permits maintaining a roster of persons with chronic illness.
4. Physicians must manage chronic illness by seeing patients at appropriate intervals, renewing medication, and performing thorough evaluations pertinent to the chronic disease being managed.
5. Lab and other testing (EKGs) should be performed as indicated by appropriate guidelines at indicated intervals. This information should be interfaced with the EMR.
6. 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. Tracking of TB skin test data is still a work in progress. The policy is to perform a Mantoux skin test on all incoming inmates. However, the

data presented for TB skin testing does not reflect that all inmates were tested. There is currently no way for the IC nurse to identify persons who have not had their TB skin test not read. We discussed data which needs to be kept in order to obtain this data. Despite the fact that the data is not completely accurate, the surveillance data is significantly improved from the previous visit and this item is nearing substantial compliance.

The Infection Control nurse provides patient education for HIV, Hep A, B and C. The content of the education is good; brochures are used which can be given to patients. The very positive program can be expanded to include MRSA and hygiene steps inmates may take to reduce infection.

6.b.

The infection control policy and procedure was presented for review. Multiple suggestions were given to bring this procedure into compliance.

6.c.

All inmates coming into the jail now receive a Mantoux skin test to screen for tuberculosis. While there are problems maintaining surveillance statistics, the program has made considerable progress in this area. Because there are no negative pressure cells in the jail, there can be no respiratory isolation and reference to this in policy should be removed. Any patient suspicious for contagious tuberculosis should be masked and immediately transported to a hospital for evaluation. Existing tuberculosis policy should refer to the Centers for Disease Control and Prevention document Prevention and Control of Tuberculosis in Correctional and Detention Facilities, 2006.

6.d.

There is no negative pressure ventilation system at the jail. Nevertheless, current policy still references placement in respiratory isolation at the jail which is not possible under existing conditions. All patients suspicious for contagious tuberculosis should be masked and immediately transported to a hospital for evaluation.

6.e.

Surveillance data for methicillin resistant staph aureus (MRSA) is obtained by the infection control nurse from culture data and by reviewing the urgent care log to determine who might have been treated for MRSA. The providers are not reporting MRSA treatments which means that MRSA is most likely under reported. The procedure on MRSA and actual practice should provide a method to capture all cases of treatment for MRSA both presumed and culture positive.

Treatment guidelines should reference local board of health recommendations based on local sensitivity patterns.

6.f.

A nurse is assigned to infection control. Surveillance data for MRSA is obtained from culture data and from treatment records in the urgent care log. Also, MRSA is not reported by housing units. This is important if the surveillance data is to be used to prevent infections from spreading by improving sanitation of cells. For tuberculosis screening, data is extracted, at considerable manpower expense, from the electronic record. The program has demonstrated ability to do this but needs to clean up the data so that inmates who are discharged before having skin tests read and previously positive skin tests patients are recorded. Data for STDs is obtained from culture results (chlamydia, gonorrhea, syphilia). HIV, hepatitis is both lab data and self-report.

Data is now reported to the QI Committee. This is an appendix of monthly QI Committee meetings. Data reported to QI should include the number of positive skin tests and any suspicious or positive TB disease. Rates of skin test positivity should be derived and reported to QI. The program does not work with the local department of health in developing a surveillance plan.

RECOMMENDATIONS FOR NEXT 6 MONTHS:

1. Revise the Infection Control procedures considering comments in the policy section of this report. 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. <u>Access to Health Care</u>.

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

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

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

(4) opportunity for all inmates, irrespective of primary language, to access medical and mental health care.

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

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

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

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

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

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

OVERALL COMPLIANCE RATING: Substantial Compliance

ASSESSMENT:

7.a-b

Progress continues on this item and it is just barely substantially compliant. The policy and procedure on this item are not yet complete. The slips are now available in English and Spanish. For languages other than Spanish or English, the program utilizes a telephonic interpretative service that can offer translator services in any language. Patients with cognitive impairment are seen 3 times a week by a nurse who asks if the patient has a problem. The program is working on ways to improve access for illiterate inmates.

7.c-d

The program does log and track sick call requests. The program has created a "sick call log" which is a defined template in the electronic record. Information on hand written slips is entered into a template called "sick call log" which includes the complaint type, the complaint, the date collected, triage date (face to face), the triage type, symptoms, the triaged acuity level, the response, and date scheduled for a provider, and whether the patient was seen in primary care by date. The log was reviewed and is adequate.

Sick call requests are evaluated M-F with paper triage on weekends. Documentation of nurse FTF evaluations is a SOAP note documented on a blank form in the electronic record.

The log can be used to monitor quality of nurse evaluation. The number of slips for the month of March is listed below in a table. As can be seen, the mental health requests are nearly equivalent to medical requests.

	Medical	Dental	Mental Health
# in March	360	92	304
% in March	48%	12%	40%

The data provided is that 100% of slips are triaged within 24 hours. I did find in earlier time periods, on chart review, where some slips were not triaged timely. Follow up of this item will be performed, but clearly this is an improvement over prior visits.

7.e.

All face-to-face evaluations are done in a clinic setting. In addition to the clinic examination rooms in the 4th floor clinic area there are several rooms in housing units where nurses can conduct sick call evaluations. I inspected one of these rooms. It was properly sized and equipped but was cluttered and not sanitized properly.

There is a single sick call nurse who picks up all slips in the morning, triages all slips and then gives a list to custody so that by noon they bring patients to one of the designated examination rooms for evaluation.

On chart reviews, ten episodes of sick call requests were evaluated. The sick call nurse performed very well on her evaluations. The weekend nurse needs to improve documentation and there were other problems identified on these reviews.

Four of the ten were appropriately evaluated. In five of the ten requests, the inmate refused to be seen after placing the request. This is one of the highest rates of refusal that I am familiar with. This is consistent with comments by medical staff that there are high rates of refusal for medical services. In one of these, the officer reported that the inmate didn't need to be seen. Officers should not be involved in judgments regarding whether an inmate needs to be seen or not.

The high rate of refusals is extraordinary. I interviewed one of the inmates regarding his refusal. He indicated that the reason he refused was because he didn't want to wait in the waiting room on the 4th floor clinic area. This room is a small room approximately 10 by 10 feet. I walked into the room and the smell was overpowering. It appeared to have no ventilation. Additionally, I witnessed this room when well over a dozen people were in this room making inmates stand very close one to another. They may have to wait in excess of an hour in these conditions. Clearly, this is a barrier to access to care. In any case the program should investigate why there is such a high rate of refusal and attempt to remedy this barrier to access.

In one of the four nurse evaluations, the evaluation occurred on the week end. The documentation was poor. As a result of the nurse evaluation, an antibiotic was started, but there was no physician order and the nurse documentation did not describe a physician order or the indication for the clindamycin. It appears from documentation that the nurse prescribed the medication.

In another chart reviewed, the nurse did an appropriate evaluation and referred the patient to a provider to evaluate for the need for an asthma inhaler. The scheduled appointment with the provider occurred but the provider did not address the complaint. It is not even clear that the provider knew why the patient was scheduled for the appointment.

7.f.

There are no perceived problems related to officers moving detainees for clinic evaluations. This is a significant improvement over previous visits. Although the refusal problem exists, the availability of officer transport is significantly improved.

7. g.

Nurses make segregation rounds in the jail 3 times a week. They utilize a segregation list that they obtain from custody. However these rounds are not logged on the units. Segregation rounds are documented in the electronic record for each individual who is in segregation. Segregation rounds should be documented on the units where inmates are housed.

7. h.

The co-pay practice has been modified so that sick call request charges are only for sleep medication, ear wax treatment, and $3 for a prescription medication.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. Sick call policy and procedure must be completed.
2. 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.
3. Nurse protocols for evaluations should be developed. These must be approved by the Medical Director.

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. In practice, it appears that it is clear where patients return, but the policy should state this.

Inmates returning from offsite visits, in practice, are returning to intake and are seeing a nurse. This appears to occur for all patients. The nurse does not always document understanding of why the patient had been off site, particularly for hospitalizations. On chart review, the physician review sometimes did not include a review of what had transpired at the hospital or specialty clinic. Also, it did not appear that the physician updated the patient on what had occurred during the off-site event. The provider follow up piece is still deficient in this process.

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.

The emergency care policy is not yet complete. Once completed, if satisfactory, this item should move to compliance.

The training syllabus is complete and is satisfactory. I was unable to verify the numbers of officers trained. This will need to be provided in aggregate as a number of officers trained divided by the number of officers.

9.b.

I randomly checked a control station on one of the tiers. The control room had a first aid kit, including mask and gloves. An oxygen tank was also present on the unit. The supplies were marked, secured and orderly.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. Complete the emergency response policy.

10. Record Keeping.

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

b. LCJ shall develop and implement policies, procedures, and practices to ensure timely responses to orders for medications and laboratory tests. Such policies, procedures, and practices shall be periodically evaluated to ensure timely implementation of clinician orders.

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

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

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

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

10.a.

Some improvements to the electronic medical record have been made. The integration with the pharmacy has been completed. A sick call template is in use which permits tracking of health request data. However, staff continue to find the product very difficult to use. Requirements of

this agreement include production of data which has not been possible to obtain directly from the electronic record such as a chronic illness roster and infection control surveillance data. Much effort has been made both on the part of the Sheriff's staff and the medical contractor staff to obtain the necessary data. In addition, both the Infection Control nurse and the Sick Call nurse spend almost all their time performing clerical work to obtain data that typically would be provided by an electronic record. The work that these individuals should be performing to obtain compliance under this agreement is thus diverted to a clerical function made necessary by a product unable to provide information as needed.

The electronic record still appears to permit more than one staff to document on the same note. The electronic record does not lock the user to a single user. Staff were inconsistent in their response as to whether locking records to a single user was possible or not. If this is possible, then training is an issue. If it is not possible to lock records, there is a major problem with the electronic record. The program needs to resolve this issue.

It is extraordinary the extent to which staff have created work-a-rounds in order to make the existing electronic record useable.

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 downtime procedure needs some revisions. It does not provide direction for when paper records are to be used, where the paper records are to be obtained and who gives approval to start using paper records when the electronic record is not functioning. This procedure should be revised.

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. On chart reviews, it is still evident that when physicians see patients return from the hospital or from offsite consultation they either do not have the consultant or hospital record or are not documenting that they have reviewed this information.

10 e.

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

RECOMENDATIONS FOR THE NEXT 6 MONTHS:

1. 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 s ystem 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. Medication Administration.

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: Substantial Compliance

ASSESSMENT:

11.a.

The program is able to track prescription order times and compare them to first dose delivery time. Approximately 99% of the time this time occurs within 24 hours. On chart review, I did not identify any patient who did not receive medication within 24 hours for the first dose.

11.b.

The medication policies were reviewed and discussed with leadership. Under this policy officers are permitted to administer and deliver medication. As well, officers are allowed access to stored narcotic medication. Neither of these procedures should be permitted. Officers should not be involved in administration or delivery of medication and should not be permitted access to stored narcotic medication. In reality, I believe that this does not happen, but the policy should be corrected.

Also, the procedure for medication renewal may be prone to problems. This was discussed with the leadership. Currently, a report of all medication that is expiring within 14 days is given to a scheduling nurse who schedules the patient to the provider clinic. If the patient refuses clinic twice, the renewal is dependent on the chronic clinic nurse to identify that the medication is expiring. Given the very high refusal rate, it is possible that medication expires because inmates are not seen. It would be better if notice of expiring medication were given to providers so that they could review the record, decide if a patient needed to be evaluated and to renew medication if indicated.

The procedure for medication administration did not include specific steps the medication assistant follows in administration of medication.

11.c.

Documentation of administration of medication is recorded at the time medication is administered. I was told that participation of officers in medication administration has improved significantly since the Deputy Warden of Security issued a memo to correctional staff clarifying their responsibilities during medication administration. T his could be improved further by development of an interagency procedure resulting in post orders. During the medication administration I observed, however, there was no officer present to assist the nurse because there was no available cross watch officer. W hile we were waiting for a replacement officer, a custodian officer offered to assist. Medication was administered with the three inmate workers standing nearby. T he monitoring of inmate's swallowing medication was less than optimal; it would not be surprising to find that inmate's are hoarding medication as swallowing of medication was not ensured.

The 5 rights of medication administration were acceptably followed. The medication packet the nurse administers from is labeled by the pharmacy. T he inmate name is verified from a wristband or by an identification card that the officer holds. The nurse verifies the inmate name, returns to the eMAR to verify medication information and correct patient and then verifies that the labeled medication packet is correct. T he medication assistant could improve hygiene by periodically sanitizing her hands. I did not notice the nurse directly handling medication, but sanitizing hands before beginning work on a unit would be appropriate.

11.d.

Medication administration is performed by medical assistants. T hese 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 t ake 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. Data provided to me shows that 78 verbal order prescriptions from April 29th to May 3 were not as yet co-signed by a physician. I could not find evidence of physician co-signing of verbal orders in the record.

11.e.

LCJ states that it provides 7 days of medication to inmates who are discharged. This is performed for planned discharges. Because the health program seldom knows when an inmate is being discharged, few if any inmates receive discharge medication.

11.f.

There is a pharmacy and therapeutic committee meeting with minutes. They have minutes for these meetings. It occurs separate from the CQI meeting. These minutes were in the CD ROM. A formulary is in place but has some restrictions. Peridex, for example, is a typical antibacterial used for persons with gingivitis but is not permitted. Mostly, barriers to medication are not via formulary restrictions but practice decisions. For example, asthmatics are systematically denied access to keep-on-person beta agonist rescue inhalers. Use of pain medication for sickle disease

is severely restricted. Both of these practice decisions result in barriers to standard of care practice.

11.g.

The new medication policy is adequate regarding medication refusals. I did not observe medication refusal on chart reviews. The custody memo from the Deputy Warden directs that all refusals are to be made directly face to face to the nurse.

11.h.

Significant improvement has been made in regards storage of medication and cleanliness of the medication room.

RECOMMENDATION FOR NEXT 6 MONTHS:

1. 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.
2. Medication administration must be standardized and facility specific.
3. Storage of medication carts should be in a secured area, away from civilians and inmates.
4. 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.

Significant renovation has taken place and this item is near substantial compliance. The intake area was renovated to now include 3 interview booths. The purpose of these booths was to ensure privacy. The construction occurred in a room with concrete or block walls. A conversation in these booths echoes throughout the room so that there is no verbal privacy. Because everything else about the room is adequate, I suggest the program install sound baffling to muffle the sound. The examination room in this area is adequate.

On the 4th floor the dental unit has been renovated and is adequate. Similarly, the compressor was placed in a closet but the sound of the compressor is quite loud. Sound baffling should be placed on the door and walls of the closet to reduce sound transmission. The air vent opening must, however, not be covered so that the machine functions properly.

There is still no identified location to perform detoxification and to house medically complex patients. I was told that once mental health abandons the 4th floor, the 4th floor will be used for this purpose.

The clinic rooms in the 4th floor are acceptably remodeled to permit private examinations. Staff must utilize the ability for privacy to actually conduct examinations in private.

Showers on the 4th floor have been modified so as to provide ADA acceptable showers.

12.b.

The clinics were cleaner. However, some rooms were cluttered and not sanitized. The dental operatory floor was soiled and had trash in the can. The last use of this clinic had been a week previous so this indicates lack of sanitation. One of the nursing sick call examination rooms on the 3rd floor was also cluttered and not sanitized. Since the clinics are newly renovated, I would suggest that the health program work with the Sheriff to develop a sanitation schedule appropriate for health care units and ensure that this is done. Weekly inspections of the areas should be done to ensure that sanitation is being performed.

12.c.

I did not inspect biohazard containers this visit.

12.d.

Privacy of care is now possible, but I did notice staff not taking advantage of privacy and conducting examinations in the presence of officers or other staff. This is a training issue.

RECOMMEDNATIONS FOR THE NEXT 6 MONTHS:

1. The intake medical screening booths should have some type of sound baffling to ensure sound privacy.
2. Develop a plan for medical and mental health higher acuity care housing.
3. Determine a single location for detoxification and insulin requiring patients which is near to the nursing station.
4. Standardize sanitation schedules and include monitoring of sanitation as part of QI.
5. Make adjustments to the waiting room on the 4th floor so it is not a barrier to access.

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 is now a nephrologist and no trouble with dialysis appointments. There is a consultant cardiologist. There aren't requests for dermatology but there is no available dermatologist. There have been problems with the obstetrician and the program is in the process of obtaining another obstetrician. There have been several cancellations of obstetrical appointments. There are no current backlogs in any specialty.

Verification of timeliness of specialty appointments is not possible with the existing tracking system. The spreadsheet does not capture the date a specialty appointment was first ordered but only the latest date of order. For example, if an appointment was ordered 1/14/13 and cancelled on 2/4/13 and then re-ordered 2/6/13, the spreadsheet will indicate that the appointment was ordered 2/6/3. Thus, appointments can be repeatedly cancelled and it will appear on the tracking sheet that they are timely. I discussed with the IT person for the medical program how this could be corrected so that specialty appointments can be verified as being timely. This is a major barrier to substantial compliance along with a stable obstetrical consultant.

13.c.

The log does now track cancelled appointments. The appointment order date is still not on the log. The appointment rescheduled date is also not on the log. For January there were 25 appoiutments; 18 were seen, 4 were released, 1 inmate refused and 1 was cancelled. The 1 appointment cancelled was rescheduled but the patient was discharged before he could be seen. For January through March there were 3 cancellations. 2 were seen and 1 was discharged before being seen. There were 4 cancellations of obstetrical appointments over this time period.

13.d.

There have been problems with the obstetrician and the leadership is negotiating with a new obstetrician. Policies still need to be modified so that the proper list of laboratory tests required is in the procedure. Testing should follow American College of Obstetrics and Gynecology standards (ACOG).

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The program should finalize arrangements for obstetrical consultations.
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. 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.
4. 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.
5. Information from the obstetrician should be exchanged with the medical staff at the jail and scanned into the medical record.
6. 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. <u>Staffing, Training and Supervision</u>.

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

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

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

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

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

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

g. LCJ shall ensure that correctional officers receive initial and periodic training on basic mental health information (e.g., recognizing mental illness, specific problematic behaviors, additional areas of concern); recognition of signs and symptoms evidencing a response to trauma; appropriately responding to mental illness; proper supervision of inmates suffering from mental illness; and the appropriate use of force for inmates who suffer from mental illness. Such training shall be conducted by a Qualified Mental Health Professional, registered psychiatric nurse, or other appropriately trained and qualified individual.

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

14.a.

CHI has a good leadership team and lines of authority are clear and understood by all. The program would benefit by structured performance reviews of providers. The review of providers does not include clinical performance review. Reviews of chronic illness history and physical examination should be done as this is the area of greatest deficiency.

14.b.

A staffing plan was reviewed. There are 46 full time equivalent staff which seems reasonable. It appears adequate with a couple of exceptions. There appears to be insufficient dental hours.

Additionally, the withdrawal procedures and infirmary care management have not yet been started and it is not certain therefore that there are sufficient staff to do this.

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. This folder is well maintained.

14.d.

The physician assistant has to have 100% of charts reviewed for the first year, 50% the 2nd year, and 25% the 3rd year, and 25% thereafter for the purpose of licensure. This review was behind schedule year to date. Nurse practitioners are required to have 5% of charts reviewed which are also behind year to date. The reviews are of random charts. The review consists of looking at the Subjective, Objective, Assessment and Plan for each chart reviewed. Comments are made on each review. All comments to the providers are made verbally. There is no documentation to the provider. The Medical Director keeps a log of charts reviewed. There should be a documented report of these reviews. There is no physician performance evaluation which should occur.

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. Leadership tracks credentials, blood borne pathogen training, suicide prevention training. An on-line blood borne pathogen training course is utilized for all staff. Certificates are in the tracking log. All credentials were checked and are up to date. Physician National Practitioner Data Bank information was unable to be obtained for this visit due to enrollment issues.

14.f.

The medical program developed a training program for officers on how to recognize medical emergencies. I was told that 97 % of officers have had training on recognition of medical emergencies but did not verify this data.

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. 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. Summary statistics of aggregate numbers of officers trained and not yet trained should be provided.

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

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

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

OVERALL COMPLIANCE RATING: Partial Compliance

ASSESSMENT:

15.a-b

The dental unit has been renovated and is adquate. It still appears that there are insufficient dental hours. There are 8 hours of dental time. For the month of April there were 81 dental requests. Yet, in April the dentist saw 54 patients or approximately 13.5 patients a week. There is no tracking of dental requests and it was difficult to determine adequacy of staffing in this area but it appears from the need that insufficient numbers of patients are seen. The timeliness of dental requests were not evaluated. The many dental refusals seem unusual and should be examined. The dentist does not prioritize dental requests. Dental requests that include pain are now evaluated by a nurse. Medication is provided pending the dental appointment.

RECOMMENDATIONS:

1. Dental requests should be prioritized by the dentist.
2. Patients with dental pain should not exceed a week in waiting.

16. <u>Mortality Reviews</u>.

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.

There were two deaths in the calendar year. For each death there was an autopsy.

The deaths were February 8th 2013 and the second was March 4th 2013. The mortality reviews were not yet available at the time of our visit. I sat in on a mortality review meeting on 5/8/13. All key personnel attended this review including custody staff. The custody reports should be incorporated into the timeline of events leading up to the death. The discussion was good. It remains to be seen whether problems identified in the discussion are described in the report and if appropriate corrective action results.

RECOMMENDATIONS FOR NEXT 6 MONTHS:

1. The mortality review should result in a document that gives recommendations for improving aspects of care that were deficient as identified in the mortality review.
2. The mortality review policy and procedure should be completed.

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

May 2013 Assessment: As of May 6, 2013 the 19.2 FTE QMHP FTE allocated positions were allocated as follows:

1.0 FTE PNP Psychiatric Nurse Practitioner, MSN, RNC, CNS
2.0 FTE QMHP Mental Health Director, Ph.D., LMHC, LMFT, LCAC
3.0 FTE QMHP Clinical Supervisor, MS, LMHC, LCAC
1.0 FTE QMHS Mental health Team Leader, B.A. (MSW in progress)
2.0 FTE QMHPs LCSW, LMHC, LCAC
5.0 FTE QMHP-C (Candidates for LMHC and LCSW)
8.2 FTE QMHS, Crisis Stabilization/Suicide Counselors, B.S. (4 graduate May M.S.)

The above represents a decrease of a 0.2 FTE QMHP-C.

My October 2012 report included the following:

> 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.

My opinion re: the above is unchanged.

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

Mr. Ray and Terry Harman, LMHC indicated that a staffing analysis will be performed once the new mental health unit is opened.

May 2013 Recommendations for next 6 months:

Perform the staffing analysis re: the number of FTE mental health positions necessary to comply with the various provisions of this Settlement Agreement (SA).

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

May 2013 Assessment: Mental health policies completed by Lindsay Hayes and signed by the Sheriff, Dr. Forgey and Dr. Harman since October 2012 included the following:

16.01 Governance 10.22.12
16.01.02 Access to Care 3.20.13
16.01.06 Policies & Procedure 3.20.13
16.02 Safety 10.22.12
16.03 Personnel & Training 10.22.12
16.04 Healthcare & Support 10.22.12
16.05 Inmate Care & Treatment 10.22.12
16.06 Health Promotion 10.22.12
16.09.01 Clinically Ordered Restraint 10.18.12 revised 3.22.13
16.09.02 Emergency Psychotropic Medication 3.20.13

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

1. Mission and goal
2. Administrative structure
3. Staffing (i.e., job descriptions, credentials, and privileging) and 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

May 2013 Recommendations for next 6 months:

The recommended draft policies and procedures need to be completed.

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

May 2013 Assessment: The CorrecTek (CT) issues preventing the data collection for the MH Intake Process reported in the October 2012 report have been resolved.

The 3.22.13 audit by Lindsay Hayes includes the following comment relevant to the booking process:

> The Mental Health/Suicide Risk Intake Screening Form has been revised (based upon consultation with the DOJ monitor) to better assist intake nurses with the mental health referral process. As a result, almost all of the 17 intake questions will provide guidance for an immediate, 24-hour, or 72-hour referral requirement to mental health staff. In addition, the "Observation of Mental Status" section of the form was slightly revised. The revised form was sent to CorrecTek for inclusion into the electronic medical record. The revised form should be available for use in April 2013.

Early in 2012 the referral rate of inmates to the mental health department reached 82%. The above measures brought the rate down to 66% in December 2012 for an overall 2012 rate of 64%. The first three months of 2013 indicate an average referral rate of approximately 52% (see below).

	JAN	FEB	MAR	APR	YTD	AVG
SRA REFERRALS	14	17	10	9	50	12.5
MHE REFERRALS	609	573	553	567	2302	575.5

The referral rate of inmates to the mental health department from intake has decreased but still remains very high. The recent refinement of the screening instrument and further training of the intake nurses should help further reduce the referral rate.

In the first three months of 2013 the percentage of IMs completing the MH Intake screening dropped to from 96% overall in 2012 to 85%. This change was brought to the attention of the joint medical and mental health QI committee. It was determined that change in compliance was due to the RNs increasing the number of "Pre-screenings" during high volume periods in booking. Many of the IMs who were "pre-screened" were booked and released before the RN could complete the full MH Intake.

Audits relevant to meeting timeframes for emergent, urgent, and referrals for MHEs were reviewed. Problems were identified relevant to meeting the specified timeframes. Dr. Harman indicated the issues with completing timely urgent and routine referrals included the following:

> The untimely follow up of urgent (24 hour) and routine (72 hour) referrals are primarily due to court, lockdowns, visitation, commissary and before new CO's were hired lack of movement [in addition to administrative staffing issues].

Since the hiring of new CO's and implementation of video visitation the non-completions have been reduced on urgent and routine referrals.

May 2013 Recommendations for next 6 months:

1. Continue to audit responses to referrals from a timeframe perspective.

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 (9/11)

May 2013 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

May 2013 Assessment: Refer to SA provision B.2.b. re: timeliness issues following a mental health referral. (95% of SRAs are completed by a QMHP with 86% being completed within the 24 hour requirement. 75% of urgent referrals completed within 24 hour requirement. 72% of routine referrals completed within 72 hour requirement).

The mental health evaluation form (MHE) in CT is utilized by QMHPs on a regular basis. A "stand alone" treatment plan is completed on every patient, which includes a standard five-Axis diagnosis from DSM-IV-TR, and entered into CT.

Line mental health staff reported that they do no routinely attempt to obtain mental health records from community providers. However, nursing staff in the intake area routinely attempt to verify medications reportedly prescribed to newly admitted inmates.

May 2013 Recommendations for next 6 months:

1. Improve compliance with completing referrals within the specified timeframes
2. Implement a process for mental health staff to routinely attempt to obtain mental health records from community providers.
3. Develop a plan for training mental health staff re: DSM V and implement the plan.

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

May 2013 Assessment: My October 2012 report included the following:

> [Re: the mental health unit on the fourth floor] group therapy continues to not occur. The reason cited is lack of correctional officer staffing to conduct movements… . 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.
>
> [Recommendations]: 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.

April 2013 update: 7 Group Therapy and Medication Education groups are being conducted Monday through Friday by the Psychiatric Nurse Practitioner, Clinical Supervisor and MHTs.

The increase in the new correctional officers has eliminated the movement issues related to the daily mental health clinic, individual and group sessions.

Cooperation between custody and the mental health department has reportedly improved due to a series of joint meetings with mental health, custody supervisors, DW Hogan and AW Ivetic.

The mental health treatment being provided to inmates with serious illness, especially on the fourth floor, is improved but remains inadequate related to mental health and correctional staffing allocations and physical plan problems.

May 2013 Recommendations for next 6 months:

1. Implement the reported plan re: moving of the mental health unit to Y (originally planned for Z Pod) pod.
2. Perform the mental health staffing plan as previously referenced.

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

May 2013 Assessment: MH Staff received in-service trainings on the policy focusing upon MHE and Treatment Plans since the last site assessment. The Clinical Supervisor has established a weekly review of treatment plans and these are discussed in weekly supervision of QMHPs by the Clinical Supervisor.

A "stand alone" treatment plan is completed on every patient and entered into CT. Carl Alaimo, Psy.D. has met with the mental health department to coordinate focused training on treatment planning for SRAs and treatment plans resulting from MHEs.

I reviewed the draft comprehensive treatment plan form and made recommendations re: revisions in terms of goals, interventions and measurable outcomes.

May 2013 Recommendations for next 6 months:

1. Finalize the treatment plan form.
2. Training re: treatment plan implementation via Dr. Alaimo.

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

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

May 2013 Assessment: Construction of new intake area is complete. The improvements are very beneficial.

"Privacy issues" have been addressed in the new booking area although some form of sound batt insulation is needed in the interview rooms due to significant sound proofing issues that currently exist.

Mental health staff has been provided a specific area to interview inmates in booking with complete access to CT.

A full-time Psychiatric Nurse Practitioner (PNP) was hired in November of 2012. The PNP conducts evaluations in private office with correctional officer posted outside the door.

May 2013 Recommendations for next 6 months:

Remedy the sound proofing issue.

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

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

May 2013 Assessment: There were 183 inmates on the mental health caseload receiving psychotropic medications during May 6, 2013.

My April 2012 recommendations included the following: "Increase the psychiatric allocation to 1.0-1.5 FTE psychiatrists." Since the October 2012 site assessment, the psychiatric allocation was increased from 16 hours of service by the psychiatrist by hiring a 40 hour per week psychiatric nurse practitioner. This alleviated the back log of inmates waiting to be evaluated. Initial psychiatric appointments are generally scheduled within 17 days of referral, which is a significant improvement from prior site assessments. However, the current PNP allocation does not permit follow-ups visits to be routinely scheduled and routine mental health sick call requests have a backlog of ~ 17 days.

The CT productivity report reveals PNP averages approximately 300 psychiatric encounters per month. Prior to hiring the PNP psychiatric encounters averaged 70-80 per month. Despite this improvement in productivity, the PNP/psychiatrist allocation is clearly not adequate.
Due to budget constraints the psychiatrist's hours were reduced from 16 per week to 3 hours of supervision per week. In early November 2012 the psychiatrist resigned. A psychiatrist is needed at the LCJ for several reasons that include the legal requirement that the PNP has a collaborative agreement with a psychiatrist. Unfortunately, another psychiatrist has not yet been hired. Feedback from some psychiatrists indicate the problem with securing psychiatric services

may be due to the compensation package (3 hours per week @ $195 per hour) in the context of the risk of liability within LCJ.

May 2013 Recommendations for next 6 months:

1. A psychiatrist needs to be hired for supervision purposes of the PNP.
2. Increase the number of psychiatric hours at the LCJ. It is likely that 2.0 FTEs will be needed, especially after the special mental health unit is opened.

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

May 2013 Assessment: See section B.3.b. Very little change is present as compared to the prior site assessment.

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

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. 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.

Mental Health patients housed in B dayroom and G dayroom were reported to continue to have access outside the cell a minimum of 4 hours per day.

May 2013 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 [22-23] 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

May 2013 Assessment: I observed the mental health rounding process in the segregation units during the morning of May 8, 2013, which was done in a competent manner.

A brief mental status exam is being utilized to screen and assess the needs of inmates with a mental illness in segregation although it is usually not completed within a timely basis as specified in this provision of this Settlement Agreement. Brief mental health assessments and MHEs are conducted outside of the segregation cells in a holding area. This affords some privacy from other inmates but is problematic due to staff traffic in the immediate area. The QMHP regularly uses the brief mental health assessment as part of the evaluation process.

The Clinical Supervisor assigned QMHP met with Sgt. Leto as well as other custody staff to improve working relationships and relevant discussions regarding the need for privacy, policy requirements and the necessity of transferring some segregated inmates to the 4th floor.
When it is determined by the QMHP that an inmate's disciplinary sanction might be mitigated by their mental illness a transfer is made to the 4th floor if appropriate. QI data indicates transfers to the 4th floor have happened without impediment from custody. However, not all inmates with a serious mental illness in segregation are receiving mental health assessments for potential mitigation purposes.

Audits indicate an average of 2 inmates per month require transfer from segregation to the 4th floor. The highest number was 5 in one month with some months zero transfers were required. Since January of 2012 no segregated inmates required a transfer to a psychiatric hospital to meet their needs. The majority of the transfers to the 4th floor were for medication and stabilization needs.
Information was obtained from Sgt. Leto and Deputy Warden Gore re: the disciplinary hearing process. Although it was clear that a process exists for obtaining mental health input into the disciplinary, it was not a formal process and was not consistent with the above provision of the SA.

QI studies indicate the average daily population for segregation is 24 inmates daily. During any given month the number of different inmates admitted to segregation housing averages 49 inmates. Of these 49 inmates an average of 7 have a diagnosis of mental illness and another 8 inmates have a diagnosis of a serious mental illness (SMI). The primary SMI diagnosis remains schizophrenia.

Weekly rounds are provided by the QMHP with an average of 40 monthly encounters. Of the 40 encounters 17 are those inmates with a diagnosis of mental illness and 23 inmates with a diagnosis of SMI.

Since May 2012 the same QMHP has been assigned to conduct weekly MH rounds in segregations.

May 2013 Recommendations for next 6 months:

A formal process needs to be developed and implemented concerning providing mental health input into the disciplinary process consistent with the above provision of the SA.

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

May 2013 Assessment: CT does not have the capacity to produce all of the elements of the above referenced log.

May 2013 Recommendations for next 6 months:

Develop other mechanisms for producing the above log information in a reasonable time efficient manner.

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.

May 2013 Assessment: The restraint chair policy has been finalized.

Correctional and medical staffs have reportedly been trained on the appropriate use of restraints.

From April through December 2012, there were 7 incidents of the use of the restraint chair with mental health caseload inmates. Audits have not been performed re: compliance with the restraint chair policy and procedure.

Review of the healthcare records of two inmates who required the use of clinical restraints indicated that the policy and procedure was not being followed with specific reference to the initial four hour face to face assessment. Other aspects of the policy and procedure also need to be audited on a concurrent basis or very shortly after the restraint episode is ended.

May 2013 Recommendations for next 6 months:

1. Re-train staff re: the restraint policy and procedure.
2. Train and privilege the RNs in the context of the policy, with a focus on the face to face assessment.
3. Audit implementation of this 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

May 2013 Assessment: LCJ has improved relationship with many community agencies. Cooperative efforts between LCJ, Regional Mental health, Edgewater Systems for Balanced Living, Gary City Court and county courts have resulted in increased access to outside psychiatric services for inmates.

LCJ continues a cooperative working relationship with the services of Methodist Hospitals in Gary and Merrillville.

Regional Mental Health continues to serve LCJ by providing timely "gate keeper" functions for inmates requiring state hospitalizations. In addition, Regional Mental Health continues to provide 24/7 emergency services for inmates being released from LCJ who still need continued MH services.
In 2012 a total of 17 involuntary commitments were made to the state hospital system. Much of this occurred the first 9 months of the year. In 2013 there have been 4 transfers to the psychiatric hospitals. Five inmates have transfers pending to psychiatric hospitals. Court orders for involuntary psychotropic medications were pending for five inmates.

Various local courts, especially Gary City Court with Judge Deidre Monroe, have been instrumental in inmates receiving the medications necessary to stabilize their condition. The courts have been more open to "mandated medications" which has resulted in a reduction of the number of inmates requiring a transfer to inpatient psychiatric services. There were significant differences in the due process available to inmates in the context of nonemergency involuntary medications administration which depended on the court of jurisdiction (i.e., city vs. county).

Due to the continued efforts of the Clinical Supervisor, Robert Nagan, a cooperative relationship has been developed with Edgewater Systems for Balanced Living. In 2013 Edgewater agreed to transfer 2 LCJ inmates to two of their residential programs.

Since the last DOJ review LCJ has developed a working relationship with St. Margaret Mercy Hospital system.

May 2013 Recommendations for next 6 months:

1. Continue to foster the relationships with community mental health providers.
2. Finalize the policy and procedure for administration of involuntary medications on a nonemergency basis.

4. Psychotherapeutic Medication Administration

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

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

May 2013 Assessment: A QI study addressed issues related to refusal of medications, which subsequently resulted in a significant decrease of refusals related to educational efforts by the PNP. QMHPs and MHTs routinely follow up in an attempt to increase medication compliance.

Audit results indicated that inmates are receiving prescribed medications within 24 hours of the medication being prescribed. Issues remain in the context of medication continuity when inmates are transferred from one housing unit to another.

Other QI audits need to address medication management issues such as continuity of medication issue, untimely expiration of prescriptions and discharge medications.

May 2013 Recommendations for next 6 months:

Continue to audit medication management issues.

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

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

May 2013 Assessment: Psychiatric services increased from 16 hours to 40 hours per week with the hiring of the PNP. An average of 300 encounters per month has been recorded in the EMR.

QI report entitled "Faith Ornelas Caseload" tracks follow ups after initial psychiatric evaluations. Previously there was a large back log of inmates waiting for the initial psychiatric evaluation. All back logs have been caught up.

Information obtained from the PNP indicated that timely follow-up of inmates who are newly prescribed medications does not routinely occur unless they are housed on the 4th floor.

May 2013 Recommendations for next 6 months:

1. A psychiatrist needs to be hired for collaboration/supervision purposes.
2. The current allocation for a PNP/psychiatrist is not adequate to provide the needed psychiatric services to inmates with a mental illness at the LCJ. It is likely that 2.0 FTE positions will be needed.

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

May 2013 Assessment: Protocols are in the early phase of being developed re: laboratory testing and psychotropic medications. The PNP is not receiving the lab results in a timely manner related, apparently, due to MIS issues.

May 2013 Recommendations for next 6 months:

1. Correct the MIS issues so that the PNP is notified directly re: lab studies ordered by her.
2. Finalize the above protocols, implement it and perform QI studies re: the implementation.

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

1. Suicide Prevention Policy.

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

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

May 2013 Assessment: Suicide Prevention Policy updated 2.25.13 by Lindsay Hayes to change EMTs to RNs and 10 minute S.P. rounds to 15 minute checks.

New section in the policy entitled: "Release from Custody While on Suicide Precautions" addresses safety concerns for patients released from custody who are still in need of mental health services due to active suicidal ideation.

All other areas of policy and procedures remain the same.

100% of Mental Health Department completed the 2 hour suicide prevention annual in-service on 4.3.13.

See the findings of other section of this provision in the context of establishing a s uicide prevention program in accordance with generally accepted correctional standards of care.

May 2013 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 (4/11)

May 2013 Assessment: The suicide prevention policy includes all of the above provisions.

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: SUSTAINED COMPLIANCE (10/12)

May 2013 Assessment: A recent audit demonstrated continued compliance with this provision in the context of supervision by the mental health staff.

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 (4/11)

May 2013 Assessment: Sustained compliance remains based on audit results.

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

May 2013 Assessment: Five cells in Section 4C were being retrofitted for suicide prevention during the latter part of the site visit. They had previously been used for suicide watch purposes.

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: SUSTAINED COMPLIANCE (10/12)

May 2013 Assessment: No change. The red pop up screen continues to work as designed.

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: SUSTAINED COMPLIANCE (10/12)

May 2013 Assessment: No change .

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

May 2013 Assessment: A March 22, 2013 QI assessment by Lindsay Hayes found issues with the quality of some of the SRAs performed.

May 2013 Recommendations for next 6 months:

Provide additional training and supervision re: the suicide risk assessments.

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

May 2013 Assessment: Little change from the previous site assessment in terms of decreasing property restrictions after the first 24 hours of suicide watch. Documentation re: reasons for continued restrictions need to be improved.

May 2013 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: SUBSTANTIAL COMPLIANCE (5/13)

May 2013 Assessment: The 3.22.13 audit by Lindsay Hayes demonstrated compliance with this provision.

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

May 2013 Assessment: QI studies show compliance with the follow-up assessments.

Issues remain with the quality of the treatment plans.

May 2013 Recommendations for next 6 months:

1. Provide training re: treatment planning.
2. 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: PARTIAL COMPLIANCE

May 2013 Assessment: The audit by Mr. Hayes indicated that problems remain with the quality of the initial SRAs and, at times, the lack of an initial SRA.

May 2013 Recommendations for next 6 months:

1. Continue to train and monitor.

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

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

OVERALL COMPLIANCE RATING: SUSTAINED COMPLIANCE (10/12)

May 2013 Assessment:

No change.

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 s uicide attempt; and
x. the proper use of emergency equipment, including suicide cut-down tools.

OVERALL COMPLIANCE RATING: SUSTAINED COMPLIANCE (9/11)

May 2013 Assessment: No change. Sustained compliance achieved.

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 for initial training. (9/11); SUBSTANTIAL COMPLIANCE for annual training (5/13)

May 2013 Assessment:

The 2 hour annual Jail Suicide Prevention training was developed by Lindsay Hayes. Terry Harman, Mental Health Director trained 100% of the Mental Health Department on 4.3.13. The Director will conduct the annual trainings for other Jail staff according to the training department schedule. Eight hour initial suicide prevention training was conducted for new correctional officers 10.25.12, 11.8.12, 12.20.12, 1.11.13, 3.7.13. Two hour annual suicide prevention training was conducted for mental health department 100% 4.3.13

May 2013 Recommendations for next 6 months:

Continue to monitor compliance with annual training requirements.

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

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: SUSTAINED 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 continue to 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. The Crown Point Fire Captain participated in the December 2012 fire drill that also included the key inspection process which is also commendable.
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: SUBSTANTIAL 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. Records reflect that LCJ staff are conducting fire drills on all shifts and a Quality Assurance reporting system was developed for monitoring fire drills. LCJ staff are also monitoring the start to finish times of the fire drills as well as evacuation time frames. In April 2012 a full-time Fire Safety Officer was appointed and continues to oversee the implementation of the fire safety program for LCJ. The Fire Safety Officer is charged with the responsibility for ensuring that the fire drill schedule is fully implemented.

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 and to analyze the evacuation time frames and data to make sure inmates are promptly evacuated from their housing units in case of a fire or smoke situation.
2. During the next compliance visit I will be reviewing fire drill monitoring reports and evacuation procedures.

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: SUSTAINED 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. A Quality Assurance tracking system has been developed for ensuring this provision of the SA continues to be maintained.

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: SUSTAINED 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 on a monthly basis 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. For the purposes of sustainability LCJ staff have developed a Quality Assurance monitoring system with performance measures.

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 and implemented. LCJ staff reported that the Crown Point Fire Inspector determined that facility conditions do not warrant key-identification by touch; however, this requirement is specifically addressed in the SA and in the Life Safety Code Handbook and cannot be minimized. (See Life Safety Code Handbook 2009 Chapter 23.7.5) During the inspection I discussed several options with LCJ staff for coming into compliance with this provision of the SA. LCJ staff have developed and implemented a Key Control policy and a key inspection program. A baseline audit was conducted in 2012 and additional keys were purchased. LCJ staff developed an audit process for the key control program and it appears to be working well. LCJ staff also developed a "chit system" for the control and accountability of facility keys and it also appears to be working well. Staff are knowledgeable of the emergency key process as my inspection revealed. Facility staff are being trained in the use of the emergency keys and has been incorporated into the fire safety training program.

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 continue 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.

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: SUBSTANTIAL 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 continue conducting proficiency audits of floor officers in conjunction with fire safety drills and the process has been formalized and audits are being conducted on all shifts. 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 helpful in identifying discrepancies in the system. Whenever a maintenance related discrepancy is identified, it is reported to the Maintenance Department via a work order.

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: SUBSTANTIAL 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 96% of the required staff have been trained on this requirement. There were training sessions conducted in July 2012 and October 2012 and has become part of the pre-service and in-service staff training program.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ staff should ensure to provide competency-based testing for staff regarding fire and emergency procedures.

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: SUSTAINED 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. The Fire Safety Officer continues to interact with the local fire department and the DOJSA in seeking assistance and guidance for the facility fire safety program.

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. *Sanitation and Maintenance of Facilities.*

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 their housekeeping and sanitation plans. Monthly inspection forms were developed and they are in the process of automating the inspection process. Additional equipment and supplies are being distributed to the housing units. Three more staff members were added to the sanitation program as well as increasing the inmate manpower. A sanitation work crew of staff and inmates has been assigned to the booking area and sanitation continues to improve. At this point, staff need to more closely supervise and properly train inmate workers on the proper cleaning and sanitizing of the booking cells and plumbing fixtures. The booking area has undergone significant upgrades to the floor, shower areas ventilation system which is commendable. Sanitation staff have also continued to be involved in replacing shower curtains. Housing unit and booking cell vents continue to improve in terms of keeping them free of blockage by inmates, but more work needs to continue in this area. The showers and general areas of the medical department were much cleaner than on previous inspections. The showers in the medical area were refurbished and they are much improved.

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 and instructed on the proper cleaning and sanitizing procedures.
3. LCJ staff need to continue to provide additional emphasis to the overall housekeeping program in the housing units, medical area and booking.

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. However, there are still many plumbing problems to overcome. LCJ staff reported that a major plumbing project for refurbishing the plumbing system in the housing units will commence in June 2013. 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. LCJ staff developed an automated system for the tracking of facility work orders and it appears to be working well. The automated system also includes a preventative maintenance component. LCJ staff are in the process of developing an inventory of spare parts.

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 continue to implement their written preventative maintenance plan including the schedules for preventative maintenance inspections and repairs, staff assignments that are responsible for inspection and repairs and develop an inventory of regularly needed spare parts and plumbing fixtures.
3. The above requirements should continue be addressed in a facility policy and procedure and should be revised as programs are implemented to the system.

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 the acquisition of the new floor officers it is expected that this area will continue to improve due to more officer presence in the housing units. 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 and they are being better maintained. LCJ staff also hired an outside contractor to help clean the difficult to reach vents and internally address the vents that can be reached without additional equipment. In order to maintain the ventilation system clean, it requires the continued and intense cleaning and staff supervision over the inmate crews that are performing these types of tasks. The facility continues to do 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 with 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 also 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 continue to 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 providing enhanced 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: SUSTAINED 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.

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.

There were, however inmate complaints of ant infestation in some of the housing units in the Old Jail that were valid. The issue was brought up to LCJ staff and the records reflect that extermination services continue to be provided, but there are occasions when the exterminator services need to be directed to a specific problem.

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 bi ohazardous area are properly trained in universal precautions, are outfitted with protective materials, and receive proper supervision when cleaning a biohazardous area.

OVERALL COMPLIANCE RATING: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

LCJ staff continue to revise their policies and procedures to address this area of operation. 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 and the containers were properly covered with the lids. LCJ staff provide supervision of inmates when they are cleaning up biohazard spills.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ should continue to maintain biohazard program.

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. I also observed numerous new mattresses that are scheduled to replace old ones or those are not usable.

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:

During my previous inspection LCJ had two full-time and one part-time sanitation officers; however, during this inspection, LCJ staff have increased the sanitation work force to six staff members. 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 on a daily basis. I found that sanitation in the housing units has improved from previous tour, but not significantly; however, the new sanitation officers have only recently been assigned. 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 continue to observe 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. 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 deployment practicesand 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 in increasing correctional officer presence in the housing units.

2. <u>Sanitary Laundry Procedures</u>.

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: SUBSTANTIAL 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; however, the issue has been addressed by LCJ by adding two more laundry officers to help perform laundry requirements. LCJ officials have implemented a twice weekly laundry exchange program for both the female population and male population which is commendable. During the tour I observed laundry officers performing this additional duties. I also reviewed the updated laundry schedule and interviewed inmates who further confirmed these positive changes.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ should ensure that they continue to implement their 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: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

Based upon my observations, LCJ officials continue to maintain a substantial amount of inmate clothing, bedding and towels in order to satisfy this requirement of the SA. Two additional officers were added to the laundry operation to ensure that the provisions of this paragraph are being met. LCJ officials revised their laundry schedule in order to allow both male and female inmates are provided adequate clean clothing, underclothing and bedding at least twice per week.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ should continue to maintain this level of staff assigned to laundry services in order to continue to implement the revised laundry schedule.

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.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. 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. I did not conduct a visit to the laundry during this tour, but staff reported that there have been no changes to the operation with the exceptions of adding two more laundry staff members and implementing the revised laundry schedule.

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. LCJ staff continue to provide laundry exchange twice per week for the female population and have now also included the male population.

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.

3. Food Service.

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

OVERALL COMPLIANCE RATING: SUSTAINED 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.

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 and the dietician 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 the 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 r egular 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 continue to maintain 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

May 2013 Assessment:

Policy and Procedure completed via work group consisting of Corrections and Medical-Mental Health staff working under the directive of the Sheriff's March 2010 procedure for policy development

Recommendations for next 6 months: Continue to increase the number and scope of the QI studies with particular reference to relevant Settlement Agreement provisions. Please send me an electronic version of Policy 16.01.07 (Continuous Quality Improvement Program).

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

May 2013 Assessment:

LCJ has begun performing QA studies as a component of the evolving QI process.

Recommendations for next 6 months: Continue to increase the number and scope of the QI studies with particular reference to relevant Settlement Agreement provisions.

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

May 2013 Assessment:

The Mental Health Department had established separate Mental Health Quality reports which are submitted monthly to Ken Ray and to the Medical-Mental Health Quality Improvement Committee. MH has monthly QI meeting that began 10/14/12.

The mental health QI results are evaluated by the consultant Ken Ray monthly and by the Medical Mental Health Committee Monthly. Dr Alaimo has been hired to work as a mental health consultant for QI purposes

MH developed the following QI reports 1) Segregation 2) Suicide Precautions MHE referrals from booking 3) S.P. Compliance (all referral sources) 4) SRA MHE completion compliance 5) CT report PNP encounters in development

Recommendations for next 6 months: Continue to increase the number and scope of the QI studies with particular reference to relevant Settlement Agreement provisions. Begin some QI studies in contrast to QA audits.

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

May 2013 Assessment:

As previously referenced, a QI policy has been developed and QI activities initiated.

Recommendations for next 6 months: Continue to use the QI process to address the above performance measures.

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: SUSTAINED 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. The Use of Force policy continues to be updated as changes to the operation occur.

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. Approximately 97% 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. Training for supervisors was schedule for June 2013 in collaboration with the FBI; however, due to budget constraints the training has not occurred.

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 fully 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 (data tracker) which 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. Sampling is on-going and is starting to provide useful and meaningful data. Also, a use of force review board has been developed and implemented which also contributes positively to this requirement.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. LCJ officials should continue to 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. LCJ staff should continue 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 continue to implement tracking system 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. The Use of Force tracking system includes these requirements of the SA. However, the revised Use of Force report is still under development.

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.

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. A Use of Force Team was developed and implemented for reviewing use of force incidents primarily involving mentally ill inmates and it is showing signs of effectiveness.

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. Continue to further develop the Use of Force Review Team and consider expanding it to review all significant uses of force.
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. A s 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. LCJ staff with the guidance of the DOJSA Coordinator have developed a Use of Force Tracker that management staff use to identify trigger criteria for review and follow-up of investigations. The Deputy Warden can also make referrals to the investigations unit for reviewing questionable uses of force. The Sheriff is also actively involved in the process by obtaining the services of a third party to review questionable uses of force and has shown signs of effectiveness. D uring the inspection I also observed a Use of Force Review Team and was very impressed by their sincere commitment to the process.

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. LCJ staff should continue to implement the positive changes that were made to the use of force program as described above.

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: SUBSTANTIAL 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 implemented requirements of this paragraph of the SA. RJS Consultants should 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 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: SUBSTANTIAL 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. Supervisors are required to obtain photographs of reported injuries sustained by inmates during a use of force incident. The Deputy of Security developed and implemented a "use of force package" for each use of force incident

which was impressive. The use of force package also includes video recordings of the use of force incidents.

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 continue to implement 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. A ppropriate LCJ leadership, supervisors, and investigative staff shall have access to this information and monitor the occurrences.

OVERALL COMPLIANCE RATING: SUBSTANTIAL 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. An early warning system has been developed and implemented.

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 continue to implement the early warning system described in the revised Use of Force Policy and Procedure.

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

OVERALL COMPLIANCE RATING: SUBSTANTIAL 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, signed and implemented. I reviewed planned uses of force and they consistently complied with this provision of the SA. S upervisors are deployed to planned uses of force events.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. The revised Use of Force Policy and Procedure should continue to be implemented.
2. During the next tour I will be reviewing planned uses of force for continued 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. L CJ 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: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

The revised Use of Force Policy and Procedure contains the provisions of this paragraph of the SA. T he revised Use of Force Policies and Procedures have been approved, signed and implemented. LCJ staff make referrals for investigation when warranted and disciplinary action is taken.

RECOMMENDATIONS FOR THE NEXT 6 MONTHS:

1. It is recommended that the revised Use of Force Policy and Procedure continue to be implemented.
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. T he 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 my inspections that in many instances where the Taser was deployed, it was generally used on mentally ill inmates or in the intake area. Data collected by LCJ staff and RJS suggests that this pattern continues. Data provided suggests that there continues to be an over representation of uses of force involving mentally ill inmates. The implementation of the Use of Force Review Team was a positive step in helping identify this phenomena. T he DOJSA recommends that LCJ adopt a policy requiring the on-site verbal approval of Taser use against mentally ill inmates by a shift commander or higher rank, except under exigent circumstances to prevent imminent harm to the inmate and/or others. I concur with this recommendation as a component of the overall intervention process that needs to occur in helping reduce the inordinate use of the taser on mentally ill inmates.

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 and to implement the recommendation made by the DOJSA as articulated above.
3. 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.
4. LCJ staff should continue to review all uses of force involving mentally ill inmates with the Use of Force Review Team.
5. LCJ staff should continue to explore strategies for reducing uses of force incidents involving mentally ill inmates.

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: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

The staff training provisions for the requirements of this paragraph of the SA have been developed and implemented. Additional use of force instructors have been identified. A 40 hour training course on the use of force for officers and supervisors has been developed and implemented. Approximately 97% of the correctional officers have been trained. An additional 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. The supervisor training program has not yet been implemented due to budget constraints with the agency, but this provision applies only to correctional officers and not supervisors.

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 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.

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

(1) take all appropriate steps to preserve evidence of the injury (e.g., photograph the injury and any other physical evidence);

(2) report the suspected abuse to the appropriate LCJ administrator;

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

(4) complete an incident report.

OVERALL COMPLIANCE RATING: PARTIAL COMPLIANCE

ASSESSMENT:

These provisions of this paragraph of the SA are addressed in the revised Use of Force Policy and Procedure. The revised Use of Force Policy and Procedures has been approved signed and partially implemented. LCJ staff 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 tours 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 the investigative guideline manual for use by the specialized use of force investigators remains in draft form for allowing time to test currently used investigation processes. Once the processes have been found to be valid and reliable, the manual will be formally implemented.

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 finalize and implement their investigative guideline manual for the use of force investigative process once it is determined to be valid and reliable.
3. I also recommend that the specialized use of force investigators receive formal training on t he 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: SUBSTANTIAL COMPLIANCE

ASSESSMENT:

The revised Use of Force Policies and Procedures address the provisions of this paragraph of the SA. T he revised use of Force Policies and Procedures have been approved, signed and implemented. Supervisory staff and the inmate grievance supervisor 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.