



**SECOND SEMI-ANNUAL REPORT OF THE
INDEPENDENT MONITOR OF THE MEMORANDUM
OF AGREEMENT BETWEEN THE UNITED STATES
DEPARTMENT OF JUSTICE AND THE STATE OF
DELAWARE REGARDING THE DELORES J. BAYLOR
WOMEN'S CORRECTIONAL INSTITUTION, THE
DELAWARE CORRECTIONAL CENTER, THE
HOWARD R. YOUNG CORRECTIONAL INSTITUTION
AND THE SUSSEX CORRECTIONAL INSTITUTION**

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EXECUTIVE SUMMARY

This is the second report submitted pursuant to the MOA² and the Monitoring Agreement,³ covering the period from July 30, 2007 through December 31, 2007. During this monitoring period, the Monitoring Team⁴ has visited each of the Facilities⁵ on multiple occasions in order to provide technical assistance and conduct monitoring. In addition to the technical assistance provided with regard to the provision of medical and mental health care during the visits to the Facilities, the Monitoring Team was able to provide technical assistance with regard to the drafting of the State's new policies, and provide suggestions to the parties regarding the appropriate definitions of substantial compliance for each provision of the MOA.

During this monitoring period, the Monitoring Team conducted interviews of leadership and staff of Delaware Department of Correction ("DOC") and Correctional Medical Services ("CMS"),⁶ and inmates housed in the Facilities.⁷ In addition, the Monitoring Team has reviewed between 100 to 200 medical records at each facility, except at Baylor, where approximately 50 to 100 files were reviewed due to the smaller size of this facility. All of these materials, in

² The "MOA" refers to the Memorandum of Agreement between the United States Department of Justice ("DOJ") and the State of Delaware (the "State") regarding the Delores J. Baylor Women's Correctional Institution, the Delaware Correctional Center, the Howard R. Young Correctional Institution, and the Sussex Correctional Institution, which was entered into on December 29, 2006. The MOA is attached to this report as Appendix I, and is available at http://www.deprisonmonitor.org/pdf/delaware_prisons_moa_12-29-06.pdf.

³ The "Monitor Agreement" refers to the Agreement between Joshua W. Martin III (the "Monitor") Individually and on Behalf of Potter Anderson & Corroon LLP and the State of Delaware, which was entered into on May 14, 2007 (the "Monitor Agreement").

⁴ The Monitor has retained a team of medical and mental health experts. The Monitor, together with the medical and mental health experts and other attorneys, are hereinafter referred to as the "Monitoring Team."

⁵ The term "Facilities" refers to the Delores J. Baylor Women's Correctional Institution ("Baylor"), the Delaware Correctional Center ("DCC"), the Howard R. Young Correctional Institution ("HRYCI"), and the Sussex Correctional Institution ("SCI").

⁶ CMS is a private contractor that has been providing medical and mental health care services at the Facilities since it took over the prior vendor's contract on July 1, 2005. The CMS website is available at <http://www.cmsstl.com>.

⁷ The Monitoring Team also has received unsolicited information from inmates, their families, advocates, community groups and other external sources, which has been taken into consideration.

connection with the observations that the Monitoring Team made while on site at the Facilities, form the basis of the compliance assessments⁸ contained in this Report.

The compliance assessments made in this report regarding the State's compliance with the provisions of the MOA are made by consensus of the Monitoring Team, which means that the Monitoring Team reviews the evidence and determines whether the evidence shows substantial, partial or no compliance with a provision of the MOA. The State and the DOJ continue to discuss the approach to be used in the future with regard to measuring the State's compliance with the provisions of the MOA. Specifically, the parties are attempting to identify with greater precision the relevant universe of documents to be reviewed, and, to the extent feasible, objective indicators of compliance. The Monitor is hopeful that that approach will be in place for the next report, which is due on or about June 29, 2008.

Summary of Findings

In the first report, the Monitor focused on describing problems with clinic space and equipment available at each of the Facilities, the staffing of leadership positions, and documenting and maintaining appropriate data so that both the Monitoring Team and the State can measure the State's performance. After the first report, the DOC created a Corrective Action Plan to ameliorate the sanitation issues highlighted in the first report. The Monitoring Team notes that the DOC has been more successful in maintaining sanitary infirmaries. Additionally, the DOC has been fairly responsive to the Monitoring Team's suggestions regarding the use of certain spaces within the Facilities to ameliorate the budgetary and structural constraints of those Facilities, resulting in some improvement in that regard. Clinic space and equipment, especially as it relates to how lack of privacy can limit the adequacy of medical and mental health services provided to inmates, is an issue that has arisen since the first report.

The lack of stable and effective leadership at the vendor-level remains a concern. Without stable and effective leadership, the State will be significantly hampered in its attempts to become compliant with the MOA. As will be seen throughout this report, while CMS has had some success in filling leadership positions, there has continued to be turnover, and those individuals filling the leadership positions have not yet had enough time in those positions for their influence to be seen in results of this report. Moreover, there has been consistent turnover at staff-level positions, and, at HRYCI in particular, there is a problem with staff insubordination that needs to be addressed because it affects inmate medical and mental health services negatively.

The Monitoring Team has also faced difficulty in receiving consistent and accurate information from CMS. On a number of occasions, well-meaning individuals have given the Monitoring Team information about a practice or procedure that they believe is being followed. Upon further investigation by the Monitoring Team, it often turns out that such practice or

⁸ For those provisions of the MOA for which the Monitoring Team made an assessment, there are three different compliance assessments possible: substantial compliance, partial compliance, and non-compliance. These compliance assessments will be explained at greater length in the introduction to the report.

procedure is not, in fact, being followed in spite of the belief of the individual providing information. This is symptomatic of a lack of supervision of staff, and poor or non-existent self-monitoring. The Monitoring Team recommends that CMS begin to self-monitor for compliance with DOC policies as soon as possible so as to be able to assess its own compliance, and provide the Monitoring Team with reliable information.

Additionally, the Monitoring Team has noted that in many medical records that have been reviewed, both nursing and physician documentation of care is poor. Poor documentation can be symptomatic of an overburdened staff without the time to keep up with filing,⁹ or of care not being provided at all. In some cases, staff could be providing adequate care for an inmate but is too busy to document that care. In that case, the Monitoring Team will be unable to make the determination that there is adequate care because it is not properly documented in the inmate's medical record. On the other hand, the fact that there is inadequate documentation of the care provided to an inmate can also indicate that, in fact, inadequate care is being provided to an inmate. The Monitoring Team has found examples of both of these scenarios. In either case, the lack of documentation creates difficulty in providing adequate medical care in future circumstances because it will be more time consuming for staff to determine the inmates history.

Summary of State's Compliance

The MOA contains fifty-five provisions which apply to Baylor, and fifty-four provisions which apply to each of the other three facilities. The Monitoring Team's assessments of the Facilities are as follows:¹⁰

- The Monitoring Team found Baylor in substantial compliance with nine of the fifty-five provisions; in partial compliance with twenty-four of the provisions; and in non-compliance with five provisions. The Monitoring Team did not assess Baylor with respect to seventeen of the provisions.¹¹

⁹ Medical records filing and maintenance is better left to individuals who are trained in that specialty. The Monitoring Team has recommended that CMS hire appropriately qualified individuals to supervise medical record-keeping on a statewide and facility level to ensure more adequate medical record-keeping as well as alleviate an unnecessary burden on nursing staff. CMS advertised for a central office position, but the Monitoring Team has not received information regarding CMS' continued efforts and success regarding recruiting for that position.

¹⁰ Certain provisions of the MOA contain separate assessments for medical and mental health services. Thus, there are a greater number of specific assessments in the text of this report than are discussed in the above summary. In order to count each provision of the MOA only once for the purpose of the above summary, the Monitoring Team combined the medical and mental health assessments.

¹¹ Certain provisions were not assessed at each of the facilities for one of two general reasons. First, some provisions were not monitored because of time constraints which prevented the Monitoring Team from assessing all of the provisions. Second, certain provisions were not assessed because the Monitoring Team deferred assessment at this time.

- The Monitoring Team found that DCC was in substantial compliance with seven of the fifty-four provisions; in partial compliance with thirty-four of the provisions; and in non-compliance with two provisions. The Monitoring Team did not assess DCC with respect to eleven of the provisions.
- The Monitoring Team found that HRYCI was in substantial compliance with six of the fifty-four provisions; in partial compliance with thirty-four of the provisions; and in non-compliance with five provisions. The Monitoring Team did not assess HRYCI with respect to nine of the provisions.
- The Monitoring Team found that SCI was in substantial compliance with nine of the fifty-four provisions; in partial compliance with twenty-six of the provisions; and in non-compliance with five provisions. The Monitoring Team did not assess SCI with respect to fourteen of the provisions.

While the State needs to continue improving, the Monitoring Team notes that during the time period between the first report and this report, the State has completed a number of tasks which are relevant to its obligations under the MOA, including the following:

- Released the first of its semi-annual Compliance Reports on July 30, 2007;¹²
- Drafted new and/or revised policies after consulting with the Monitoring Team, and submitted those policies to the DOJ;
- Received approval of all new and/or revised policies submitted to DOJ to date;¹³
- Posted the DOC policies, Compliance Report, and Action Plan on the DOC website;¹⁴
- Implemented an updated version of the Delaware Automated Correctional System (“DACS”) computer program and trained DOC and CMS personnel on that program;
- Recruited and hired a Compliance Coordinator, who performs a number of important tasks to assist the State in achieving compliance with the MOA;

¹² The State is required to report its progress toward implementing its Action Plan, which was issued on April 5, 2007. *See* MOA ¶¶ 65, 66. The State’s next semi-annual Compliance Report is scheduled to be issued on January 31, 2008. The first Compliance Report can be found at: <http://www.doc.delaware.gov/information/Prison%20health%20Care.shtml>.

¹³ The DOC medical unit policies can be found at: http://www.doc.delaware.gov/information/DOC_Policy_Manual6.shtml.

¹⁴ The Action Plan is attached as Appendix II to this report, and is available at: <http://doc.delaware.gov/information/Prison%20Health%20Care.shtml>.

- Trained 2,247 DOC staff on suicide prevention issues, as required under ¶ 43 of the MOA;
- Contracted with CMS for increased staffing at the Facilities based on recommendations previously obtained from members of the Monitoring Team;
- Conducted a campaign encouraging DOC inmates and personnel to be vaccinated against the influenza virus, in accordance with recommendations issued by the Centers for Disease Control (“CDC”); and
- Has received approval for some plans to ameliorate the privacy and clinic space concerns highlighted in the report.

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INTRODUCTION

The First Semi-annual Report of the Independent Monitor for the State of Delaware Department of Correction was published on June 29, 2007, and represented a preliminary overview of the Monitor's duties, and summaries of the Monitor's first observations regarding the State's compliance with the MOA.¹⁵

This second report represents the Monitoring Team's first opportunity to conduct and report on monitoring of the facilities. The organization of the report is a review of each MOA provision, any findings made by the Monitoring Team regarding that MOA provision, an assessment of the State's compliance with that provision of the MOA, and recommendations, if any, to assist the State in reaching substantial compliance with a given provision of the MOA.

Between the publication of the first report and this second report, the Monitoring Team visited the Facilities on a number of occasions to offer technical assistance and perform monitoring, spending a great deal more time at the Facilities during October and November 2007. Also, during this time period, the State completed its new policies, and submitted those policies to the DOJ for approval. The DOJ approved the policies. The State continues to develop and revise the policies as needed. Further, the State is now in the process of developing and implementing procedures at the facility level.

Additionally, the DOC and the DOJ continue to work cooperatively to identify with greater precision the relevant universe of documents to be reviewed, and, to the extent feasible, objective indicators of compliance. The Monitor is hopeful that that approach will be in place for the next Report, which is due on or about June 29, 2008. For purposes of this report, the Monitoring Team used a consensus approach to determine the State's level of compliance with a given MOA provision. This approach might change in future reports depending upon the parties' agreement regarding the proper substantial compliance metrics.

Definition of Assessment Ratings

Pursuant to paragraphs 71 and 72 of the MOA, the Monitor is required to review and report on the State's implementation of, and assist with the State's compliance with, the MOA. The Monitor must determine whether the State has successfully complied with each requirement contained in the MOA at each of the Facilities. In order to make that determination, the parties must agree upon appropriate measurements and standards against which the State's performance will be compared. The parties are discussing what will constitute substantial compliance for each requirement of the MOA. The following are the assessment ratings used by the Monitoring Team:

¹⁵ The first report can be found on the Monitor's website, at the following address: www.deprisonmonitor.org. The website contains an overview of the Monitor's role, and links to press releases and reports. All future reports will be posted on the website.

- The term “substantial compliance” shall mean that the State has satisfied the requirements of all components of the assessed MOA provision. If the State has sustained substantial compliance with all provisions of the MOA for a period of one year, then the State may submit a written request to the DOJ for early termination of the MOA. *See* MOA ¶ 60. The DOJ will determine whether the State has, in fact, maintained substantial compliance for the one year period. *Id.* Otherwise, the MOA is designed to terminate after three years from December 29, 2006. *See* MOA ¶¶ 59 and 60. Non-compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance will not constitute failure to maintain substantial compliance. *See* MOA ¶ 60. At the same time, temporary compliance during a period of sustained non-compliance shall not constitute substantial compliance. *Id.*

- The term “partial compliance” shall mean that the State has achieved less than substantial compliance with all of the components of a rated provision of the MOA, but has made some progress toward substantial compliance on most of the key components of the rated provision. A partial compliance rating encompasses a wide range of performance by the State. Specifically, a partial compliance rating can signify that that the State is nearly in substantial compliance, or it can mean that the State is only slightly above a non-compliance rating.

- The term “non-compliance” shall mean that the State has made negligible or no progress toward compliance with all of the components of the MOA provisions being assessed.

Also, the Monitoring Team deferred assessing some provisions of the MOA while the finalized policies were pending because the Monitoring Team believed that it would be appropriate to allow for the implementation of required policies prior to conducting formal monitoring, and to use the State’s compliance with its policies as the basis for the assessment of the State’s compliance with the MOA. The State and the DOJ have informed the Monitoring Team that this approach was not what the parties had contemplated, and that the Monitoring Team should assess the State’s compliance against the generally accepted professional standards that formed the basis of many of the State’s policies and procedures. The assessments that the Monitoring Team made in this report are based upon those generally accepted professional standards. For the purposes of future reports, whether a policy or procedure is pending or not will not have any bearing on whether the Monitoring Team monitors and assesses a given provision. In addition, the Monitoring Team deferred assessing some provisions of the MOA because of time constraints. Finally, in some cases, the Monitoring Team was unable to assess the State’s compliance with a provision because there were no relevant cases to review.

For the purposes of this second report, the Monitoring Team has reviewed the information available to it, and assessed the level of the State’s compliance with each MOA provision at each of the Facilities based upon a consensus approach. This means that for each provision, the Monitoring Team reviews the evidence and determines whether the evidence shows substantial, partial or no compliance with a provision of the MOA.

Overview of second report

This report acts as a baseline against which the State’s future improvement will be compared. The State still has a great deal more to accomplish to come into substantial

compliance with the MOA, but now the State has information to use to assist with coming into substantial compliance with the MOA.

The second report generally follows the format of the MOA. The MOA is organized into three distinct substantive areas: (1) Medical and Mental Health; (2) Suicide Prevention; and (3) Quality Assurance.¹⁶ The second report mirrors that format and contains individual sections devoted to each of these three areas. Each MOA substantive provision is listed by MOA paragraph number and is followed by some or all of the following:

- a summary of the particular MOA requirements;
- discussion, as appropriate, of any applicable generally accepted professional standards which relate to the MOA provision;¹⁷
- key findings made by the Monitoring Team;
- an assessment of the State's compliance with the relevant provision;
- recommendations, if any, to assist the State in achieving substantial compliance with the provision.¹⁸

¹⁶ See MOA ¶ 65 (defining Sections III through V as the “Substantive Provisions” of the MOA).

¹⁷ In this report, the monitor has cited to both NCCHC standards (or other appropriate standards).

¹⁸ Recommendations included in this Report are in the nature of technical assistance and do not represent an obligation of the DOC pursuant to the MOA.

MEDICAL AND MENTAL HEALTH CARE

1. Standard

A. Relevant MOA Provision

Paragraph 1 of the MOA provides: “The State shall ensure that services to address the serious medical and mental health needs of all inmates meet generally accepted professional standards.”¹⁹ This provision of the MOA requires that the State provide services in all of the areas set forth in the MOA according to generally accepted professional standards, including but not limited to, the standards promulgated by the National Commission on Correctional Health Care (“NCCHC”) for prisons and for jails. The Facilities are all used both as jails²⁰ and as prisons.²¹ For the most part, the NCCHC standards for jails and prisons are the same; however, there are some notable differences based upon the different functions served by a jail versus a prison, especially with regard to intake procedures. *See e.g., discussion of provision*

¹⁹ According to section II.C. of the MOA, “generally accepted professional standards” means:

[T]hose industry standards accepted by a significant majority of professionals in the relevant field, and reflected in the standards of care such as those published by the National Commission on Correctional Health Care (NCCHC). DOJ acknowledges that NCCHC has established different standards for jail and prison populations, and that the relevant standard that applies under this Agreement may differ for pretrial and sentenced inmates. As used in [the MOA], the terms “adequate,” “appropriate,” and “sufficient” refer to standards established by clinical guidelines in the relevant field. The Parties shall consider clinical guidelines promulgated by professional organizations in assessing whether generally accepted professional standards have been met.

²⁰ A “jail” is, “a detention facility where accused persons are detained until their alleged crime is adjudicated before a jury or judge.” Joseph E. Paris, Ph.D., M.D., CCHP, FSCP, *Interaction Between Correctional Staff and Health Care Providers in the Delivery of Medical Care, in Clinical Practice in Correctional Medicine* (Michael Puisis, D.O. ed., 2006). Thus, “[f]or the most part, persons in jails are not yet convicted of a crime, although some jails also house those serving misdemeanor terms (1 year or less) as well as those serving county jail time as condition of felony probation.” *Id.*

²¹ A “prison” is a “facilit[y] where persons are incarcerated as punishment for crimes for which they have been convicted.” Joseph E. Paris, Ph.D., M.D., CCHP, FSCP, *Interaction Between Correctional Staff and Health Care Providers in the Delivery of Medical Care, in Clinical Practice in Correctional Medicine* (Michael Puisis, D.O. ed., 2006).

10 of the MOA, *infra*. As the DOJ has acknowledged in the MOA, the NCCHC has adopted separate standards for prisons and for jails.²²

B. Assessment

As will be discussed at length below, the State has a great deal more to accomplish to bring each of the Facilities into substantial compliance with all provisions of the MOA. Overall, the Monitor found that the State is in partial compliance with this provision of the MOA because the State has made some progress toward reaching substantial compliance with it.

2. Policies and Procedures

A. Relevant MOA Provision

Paragraph 2 of the MOA provides:

The State shall develop and revise its policies and procedures including those involving intake, communicable disease screening, sick call, chronic disease management, acute care, infection control, infirmary care, and dental care to ensure that staff provide adequate ongoing care to inmates determined to need such care. Medical and mental health policies and procedures shall be readily available to relevant staff.

This provision of the MOA requires that the State have policies²³ and procedures²⁴ in place to address vital procedural steps in providing appropriate medical and mental health care for inmates, and is meant to ensure that these policies and procedures are readily available to relevant staff. According to NCCHC standards, policies and procedures should be facility-specific. J-A-05; P-A-05.

B. Findings

The State submitted its draft policies to the DOJ on July 5, 2007. As provided in paragraph 61 of the MOA, any policies to which the DOJ did not object in writing were deemed

²² Unless otherwise noted, all references in the format of “J-__-__” shall refer to standards from the *Standards for Health Services in Jails*, National Commission on Correctional Health Care (2003). Likewise, unless otherwise noted, all references in the format of “P-__-__” shall refer to standards from the *Standards for Health Services in Prisons*, National Commission on Correctional Health Care (2003).

²³ A “policy” is defined by the NCCHC as “a facility’s official position on a particular issue related to an organization’s operations.” J-A-05; P-A-05.

²⁴ A “procedure” is defined by the NCCHC as “describ[ing] in detail, sometimes in sequence, how a policy is to be carried out.” J-A-05; P-A-05.

approved on September 3, 2007 (60 days after the State's submission to the DOJ). The DOJ supplied comments regarding the State's draft policies on August 30, 2007. The State submitted its revised draft policies to the DOJ on October 18, 2007. The DOJ approved those policies on November 6, 2007. The State has several more policies regarding mental health that it is in the process of drafting. In addition, the State now must promulgate procedures for each facility to assist with the implementation of the policies.

In addition to the provision of the MOA requiring policies and procedures regarding intake, communicable disease screening, sick call, chronic disease management, acute care, infection control, infirmary care, and dental care, various other provisions of the MOA contain specific requirements for policies and procedures. Specifically, the following paragraphs contain a requirement for policies and procedures: 4 (medication and laboratory orders); 15 (drug and alcohol withdrawal); 16 (pregnant inmates); 19 (access to medical and mental health services); 21 (grievances), 23 (immunizations); 24 (medication administration); 31 (administration of mental health medications); 33 (mental health screening); 34 (mental health assessment and referral); 39 (procedures for mentally ill inmates in isolation or observation status); 44 (mental health intake screening/assessment); 48 (communication); 50 (observation); 52 (intervention); 53 (mortality and morbidity review); 54 (policies and procedures for quality assurance); and 55 (corrective action plans). This report will address those requirements for policies in occasion in the text of the report.

C. Assessment

The State has made significant progress with regard to this provision of the MOA, and therefore, the Monitoring Team found that the State is in partial compliance with this provision.

3. Record-Keeping

A. Relevant MOA Provision

Paragraph 3 of the MOA provides:

The State shall develop and implement a unitary record-keeping system to ensure adequate and timely documentation of assessments and treatment and adequate and timely access by medical and mental health care staff to documents that are relevant to the care and treatment of inmates. A unitary record-keeping system consists of a system in which all clinically appropriate documents for the inmate's treatment are readily available to each clinician. The State shall maintain a unified medical and mental health file for each inmate and all medical records, including laboratory reports, shall be timely filed in the medical file. The medical records unit shall be adequately staffed to prevent significant lags in filing records in an inmate's medical record. The State shall maintain the medical records such that persons providing medical or mental health treatment may gain access to the record as needed. The medical record should be complete,

and should include information from prior incarcerations. The State shall implement an adequate system for medical records management.

This provision of the MOA contains several key elements. First, the State must develop and implement a unitary record-keeping system. According to the MOA, a unitary record-keeping system consists of a system in which all clinically appropriate documents for an inmate's treatment are readily available to each clinician, and should include information from prior incarcerations. Although the amount and type of documentation that should be in an inmate's health record is determined by the individual inmate's medical history and condition, an inmate's health record normally should contain the following categories of documents:

- identifying information (*e.g.*, name, identification number, date of birth, gender);
- problem list containing medical and mental health diagnoses and treatment as well as known allergies;
- receiving screening and health assessment forms (*see discussion of provisions 10 and 12 of the MOA, infra*);
- progress notes of all significant findings, diagnoses, treatments, and dispositions;
- provider orders for prescribed medication;
- medication administration records ("MARs");
- reports of laboratory, x-ray, and diagnostic studies;
- flow sheets;
- consent and refusal forms;
- release of information forms;
- results of specialty consultations and off-site referrals;
- discharge summaries of hospitalizations and other inpatient stays;
- special needs treatment plan, if applicable;
- immunization records, if applicable;
- place, date, and time of each clinical encounter; and

- signature and title of each documenter.

J-H-01; P-H-01. A health record of this magnitude will not always be established for every inmate; however, any health intervention after the receiving screening will require the initiation of a record containing some or all of the foregoing documents. *Id.*

The MOA also requires that the State ensure that adequate staffing is maintained to support medical records filing. Specifically, the State should maintain sufficient staffing so that appropriate medical records are filed properly, and quickly enough so that staff can access relevant information as needed. One requirement implicit in this provision of the MOA is that the staff performing medical record-keeping functions be adequately trained to do so.

The DOC uses a paper medical records system, rather than electronic medical records. However, some information generated for the paper record is initially recorded in the DACS. DACS contains multiple “modules,” and is used by the DOC for many non-medical tasks. Although DACS contains a medical module, the DOC reports that it was not designed to be (and has not been) used as an electronic medical record. Until recently, the DACS medical module was used mostly for certain intake and scheduling tasks.

The State began working with the DACS software vendor in April 2006 to improve 178 medical module functions. *See* DOC Action Plan, Section II.3a. The DOC implemented these upgrades on October 8, 2007, and reports that training on the upgrades is ongoing. The Monitoring Team concluded that the DACS upgrades have the potential to assist the state in obtaining more complete health information for inmates’ medical records; however, the State should ensure that information collected and maintained in DACS is printed and incorporated in the paper medical record promptly and properly.

There are several observations that apply to all of the Facilities:

- The Facilities maintain separate infirmary and outpatient records. This practice is not inconsistent with generally accepted professional standards, however, the Monitoring Team observed that patients’ infirmary and outpatient charts are not being maintained properly. Records regarding a patient’s stay in the infirmary should be maintained in the infirmary record, and once the patient’s stay in the infirmary is finished, that infirmary record should be filed in the patient’s outpatient record. The Monitoring Team found that filing of records at the Facilities is not consistent with that practice.
- The Facilities are failing to maintain inmate files in an organized fashion. For example, the Monitoring Team found that some records are filed in the incorrect portion of inmates’ health records, which means that unless a clinician searches the entire health record, he or she will not be aware of a patient’s entire history.

- As will be discussed below in reference to HRYCI, the DOC has problems with medical records being maintained properly in light of intrasystem transfers.²⁵ The Monitoring Team recommends that the DOC conspicuously note in the front of, or in some other prominent place in, the chart every transfer from one facility to another so that the dates of stay at each location are clear. J-H-01; P-H-01. In addition, the inmate's entire health record needs to be transferred to the new facility so that the health care providers at that facility can have complete information regarding the inmate.
- Improper or nonexistent filing of MARs is a consistent problem. The Monitoring Team found that all of the Facilities had difficulty in ensuring that these documents are filed properly and in a timely fashion.

The Facility-specific assessments are as follow:

B. Baylor

1. Findings

The Monitoring Team's findings at Baylor are consistent with the global findings mentioned above. The Monitoring Team found that documentation for patients in the infirmary sometimes occurred in the patient's outpatient record instead of in the patient's infirmary binder. As a result, a clinician seeking information pertinent to a patient's infirmary care would not find all of the relevant information in the patient's infirmary binder. Also, the Monitoring Team noted that documentation of patients being treated by nurses pursuant to detoxification protocols is kept in a separate book.

The Monitoring Team further found that notes are frequently filed out of sequence, and that some records are filed under incorrect tabs within a patient's health record. As mentioned above, this problem makes it difficult for health care providers to access (or be aware of) important medical information in a consistent and efficient manner.

The Monitoring Team found that some charts were missing MARs, and, upon inspection, the Monitoring Team found some MARs in loose filing at the facility. Finally, at the time of the Monitoring Team's visit to Baylor to monitor this provision, the Monitoring Team found that there was a backlog of filing extending back to May 2007. The Health Services Administrator at Baylor informed the Monitoring Team that additional staff had been allocated to alleviate the backlog.

2. Assessment

²⁵ An "intrasystem transfer" occurs when an inmate is transferred from one DOC correctional facility to another.

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA because a unified health record system is in place, but the implementation of that system still needs improvement.

C. DCC

1. Findings

The Monitoring Team's findings at DCC are consistent with the global findings mentioned above. The Monitoring Team found that the manner in which documents are not filed in an inmate's health record was not consistent, and depended upon the opinion of the individual who was filing the records rather than a uniform process. In addition, the Monitoring Team found that there were not as many infirmary records as there were patients in the infirmary, and that it was not immediately apparent (*i.e.*, without opening a file) which file was an infirmary record, and which file as an outpatient record. As a result, the Monitoring Team found that an inmate's infirmary records are sometimes filed in an inmate's outpatient record.

The Monitoring Team found that, overall, there was some confusion about where certain records should be filed, as evidenced by nurses' sometimes ad hoc filing methods as described in the preceding paragraph, and information the Monitoring Team learned through discussions with mental health and nursing staff. Specifically, a mental health clinician believed that mental health records were supposed to be filed in a patient's outpatient record under all circumstances, and the nursing staff stated that many times mental health records are kept in hardback binders.

In addition to those problems discussed above, the Monitoring Team found that staffing at DCC is not adequate to prevent significant lags in filing records in an inmate's health care record. Nurses are given the responsibility of managing the medical record-keeping in the DCC infirmary. This type of arrangement is not necessarily inappropriate, but given that the levels of nurse staffing in the DCC infirmary are inadequate to take on this type of responsibility, this arrangement is not appropriate at DCC. The nursing staff at DCC is not able to adequately maintain medical records and carry out their nursing duties. In light of the fact that CMS is having difficulty hiring enough nurses to adequately provide medical and mental health care to inmates, one solution to both the medical record-keeping problem and the overall nurse staffing problem is to hire appropriately trained medical records staff to ensure proper medical record-keeping and alleviate this additional clerical burden on the nurses at DCC.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA because a unified health record system is in place, but the implementation needs improvement.

D. HRYCI

1. Findings

HRYCI has significant problems with medical record-keeping. During their October 2007 visit, the Monitoring Team found that hundreds of intake records²⁶ had not been incorporated into inmates' health records after those inmates were transferred to the other Facilities from HRYCI. The transferred records therefore did not contain the intake sheets and other relevant documents. After the discovery of this problem, staff at HRYCI began culling through thousands of records in an attempt to correct the problem.

The Monitoring Team also found that many medical record documents are not getting filed in the medical record and clinicians cannot rely on the medical record representing the complete number of medical record documents. The Monitoring Team discovered this problem after multiple record reviews and discussions with clinicians. During the October 2007 visit, the Monitoring Team found random, loose laboratory reports, health care requests, consultation requests and other documents scattered within boxes of archive records, and even in the medical records room.

The Monitoring Team returned to HRYCI on November 12, 2007. At that time, the Monitoring Team found that most of the medical record problems caused by not sending newly created charts on to permanent institutions had been resolved. A policy had been in place for over a month to send all new charts to the permanent institution for that respective inmate. As a result of this transfer of a number files, the Monitoring Team was informed that some backlog had been created at the other Facilities. Under such circumstances, a backlog is to be expected.

During the November 2007 visit, the Monitoring Team found remaining about 150 boxes of old medical records that still needed to be reviewed to determine whether the patients are still in the system. If the inmates are still in the system, then those remaining boxes will be sent to the appropriate facility. Those inmates that are not found to be in the system and have not been since 2004 will have their records sent to the archive area. The Monitoring Team also found 2 to 3 boxes of loose documents that had not yet been reviewed, and therefore, there was not yet any information regarding their contents or what needed to be done with those contents.

At the time of the November 2007 visit, the archive room at HRYCI contained the files of inmates no longer found in the computerized system that tracks those individuals that are currently under the jurisdiction of the DOC who have been in the system at some time since 2004. There were three boxes of documents in the archive room that were to be filed with medical records. A computer search was conducted, and revealed that those documents belonged to patients no longer in the system.

²⁶ "Intake records" are those records that are created at the time an inmate is brought into one of the Facilities, and a brief medical history is taken prior to the inmate being scheduled for a full health assessment. Intake records are of special importance at HRYCI because of the high level of intake conducted at that facility versus the other Facilities. Many inmates that go through the intake process at HRYCI are transferred to other Facilities upon sentencing.

The Monitoring Team also learned that other DOC facilities not covered by the MOA are sending unmarked documents to HRYCI, for staff at HRYCI to review and forward to the appropriate facilities. This practice should be stopped, as it creates an additional burden for HRYCI staff. The Monitoring Team recommends that other DOC programs determine where the documents should be sent, and send them directly to the correct facility.

The Monitoring Team has been informed that CMS brought in some temporary staff to go through the backlog of filing issues at HRYCI, but the temporary workers were released without the task having been completed. The archive room also contains records that have been alphabetized only through the letter "I." The room contains records of people no longer on the locator, but who have been in the system between 2004 and the current date.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team's findings at SCI are consistent with the global findings mentioned above. Specifically, the Monitoring Team found records where the active volume did not contain necessary information, such as the reception information. They also found numerous records in which materials were filed in the wrong section and were sometimes chronologically inconsistent. These inconsistencies make it difficult for a clinician to have all the necessary information available in order to make an appropriate clinical decision for the patient. Additionally, infirmary records and orders are scattered throughout the record and MARs are frequently not filed in the charts, sometimes for periods as long as four months.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendations

The Monitoring Team makes the following recommendations for each of the Facilities with regard to medical record-keeping: (i) hire a professional medical records staff to provide leadership, supervision, and standardization to medical records policies and procedures; (ii) hire medical records staff dedicated only to that task in order to relieve the nursing staff from that clerical function; (iii) provide standardized inpatient binders sufficient for each bed in the infirmary; (iv) ensure timely, consistent and standardized filing of all documents; (v) ensure that the creation of additional binder volumes for a given inmate results in all necessary documents being moved to the active file; and (vi) self-monitor for timeliness and standardization of filing.

In addition to the global recommendations, the Monitoring Team has the following additional recommendations for HRYCI: (i) Medical Records staff needs to develop a system to track the daily change log and move the appropriate records, MARs and medications to newly assigned clinic areas, and (ii) staff at HRYCI must complete the process of bringing HRYCI records up to date.

4. Medication and Laboratory Orders

A. Relevant MOA Provision

Paragraph 4 of the MOA provides:

The State shall develop and implement policies, procedures, and practices consistent with generally accepted professional standards to ensure timely responses to orders for medications and laboratory tests. Such policies, procedures, and practices shall be periodically evaluated to ensure that delays in inmates' timely receipt of medications and laboratory tests are prevented.

The MOA requires that the State develop policies, procedures, and practices consistent with generally accepted professional standards to ensure timely responses to orders for medications and laboratory tests. The State has adopted policies consistent with this requirement of the MOA. *See* State Policy D-02 and D-04. The State has not yet completed its facility-specific procedures. The implementation of this policy should ensure that inmates do not experience unnecessary delays and interruptions to care due to physician orders for medications and laboratory tests not being timely performed. *See* J-E-12; P-E-12. Finally, the MOA requires that the policies, procedures, and practices be periodically evaluated to ensure that delays in inmates' timely receipt of medications and laboratory tests are prevented. The Monitoring Team recommends that the State include this periodic review as a part of the Continuous Quality Improvement Program. *See discussion of provision 54 of the MOA, infra.*

In general, when assessing this provision of the MOA, the Monitoring Team reviewed five to ten records at each facility for each chronic disease being assessed in conjunction with other provisions of the MOA. By doing so, the Monitoring Team was able to review whether orders for medications and laboratory tests were being responded to in a timely fashion.

B. Baylor

1. Findings

From a review of patients' charts, the Monitoring Team found that laboratory studies were not always performed prior to inmates' chronic care visits. A timely laboratory study would take place prior to a chronic care visit. In addition, health records and interviews with staff demonstrated that medication and laboratory orders are not consistently transcribed and implemented. Finally, the Monitoring Team found that patients being prescribed certain psychotropic medications are not receiving timely follow-up laboratory studies.

The Monitoring Team noted several cases where the physician ordered various studies or tests which were not completed, in one case as long a period as eight weeks elapsed after the order. Furthermore, there were some cases where the tests were completed, but the results were never obtained or noted.²⁷ This finding is based on both a review of a limited number of files (~5) and information consistent with this review provided by staff.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that physician orders for laboratory tests are not consistently obtained at all, let alone in a timely manner. Specifically a review of health records revealed that laboratory tests are not consistently obtained in a timely fashion, and sometimes are not obtained at all. Interviews with staff revealed that emergency testing is sent to Kent General Hospital, but results are not returned in a timely fashion. The Monitoring Team also found that health records reflected that critical laboratory results were followed up several days after the report. Such reports should be followed up the same day.

The Monitoring Team found that routine laboratory studies are generally performed in a timely manner. However, it appears that laboratory studies that must be performed on an empty stomach are delayed by about one to two weeks. In addition, the Monitoring Team noted that there has been difficulty in obtaining laboratory samples from inmates housed in maximum security.

A review of an internal audit performed by CMS revealed that there had been four apparent failures to perform an ordered laboratory study. Specifically, the orders for the laboratory studies were transcribed but there was no corresponding progress note in the inmates' health records indicating that the laboratory study was done.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

²⁷ At various points during this report, the Monitoring Team will refrain from providing further detail regarding a specific inmate due to confidentiality concerns.

The Monitoring Team found that, similar to DCC, physician orders for laboratory tests are not consistently obtained at all, let alone in a timely manner. HRYCI lacks a system to track laboratory testing, which results in laboratory testing not being adequately monitored or supervised.

Regarding mental health tests and orders, lab results were reported to be in the chart, but a significant number were ordered but never drawn, based on the December 6, 2007 audit. The Monitoring Team found that, according to staff, approximately one-third of the ordered lab studies were refused by the inmate, but there was no information why the other two-thirds were missing.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that laboratory tests are rarely ordered, and those that are consist primary of psychiatric medication level testing. Once the results of those laboratory tests are reported, the Monitoring Team found that appropriate follow-up does not occur.

The Monitoring Team noted several cases where the physician ordered various studies or tests which were not completed, in one case as long a period as eight weeks elapsed after the order. Furthermore, there were some cases where the tests were completed, but the results were never obtained or noted.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendations

The Monitoring Team recommends that the State: (i) draft and implement procedures to ensure timely receipt, review, and response to all laboratory orders; (ii) draft and implement procedures to ensure timely response to emergency orders and “critical” values; and (iii) self-monitor these procedures to ensure timeliness and appropriateness of medication and laboratory orders.

STAFFING AND TRAINING

5. Job Descriptions and Licensure

A. Relevant MOA Provision

Paragraph 5 of the MOA provides:

The State 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. The State shall establish a credentialing program that meets generally accepted professional standards, such as those required for accreditation by the National Committee for Quality Assurance.

The first component of this provision of the MOA requires that all persons providing medical or mental health services meet applicable state licensure and/or certification requirements and practice only within the scope of their training and licensure. In addition, the MOA requires that the State establish a credentialing program such as those required for accreditation by the National Committee for Quality Assurance.

B. Baylor

1. Findings

The Monitoring Team found that appropriately trained and credentialed staff are providing medical and mental health services.

2. Assessment

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that not all of the physicians at DCC are practicing within an appropriate scope of their training. Specifically, one physician is a pathologist, but practices general medicine; another physician has completed only an internship, but has been managing patients with both complicated and uncomplicated chronic illnesses. The Monitoring Team believes that this is not an appropriate arrangement although it meets the standard set forth in the MOA. It is the Monitoring Team's experience from monitoring in other jurisdictions that a disproportionate amount of bad outcomes have been found with physicians practicing primary care medicine who have not successfully completed a primary care residency.

The Monitoring Team found that only two non-psychiatrist mental health clinicians are appropriately licensed. As a result, although they have, for the most part, achieved the required educational training, the remaining mental health clinicians must be supervised in order to become licensed.²⁸

The clinical supervision consists of weekly meetings, a weekly case review, and informal daily interaction. This clinical supervision reportedly meets the criteria for supervised practice under supervision to meet licensure criteria. Some of the mental health staff has shown discomfort with this necessary level of scrutiny.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA with regard to medical health staff licensure, and not in compliance with this provision of the MOA with regard to mental health staff licensure.

D. HRYCI

1. Findings

The mental health clinical staffing is not adequate, as will be discussed below. With respect to licensing, the Monitoring Team found that the mental health counselors at HRYCI are not appropriately licensed. The mental health counselors have, for the most part, completed the educational requirements; however, these counselors require approximately two years of supervised practice, depending upon the specific license that the counselor intends to obtain.

It was reported to the Monitoring Team by the mental health director that she provides supervision for the unlicensed staff. The supervision was supposed to consist of individual meetings of one hour per week, and one three-hour group meeting per month. Upon investigation, the Monitoring Team found that these meetings may not be occurring as they were reported.

2. Assessment

The Monitoring Team did not assess HRYCI's compliance with this provision of the MOA with respect to the health services staff due to high staff turnover. While the Monitoring Team did examine this issue when it visited HRYCI, given the high rate of turnover it would be inappropriate to give an assessment rating at this time. The MOA requires that all

²⁸ The State plans to ensure that all mental health clinicians are appropriately licensed by December 2008. CMS is providing tuition reimbursement, and plans to retain unlicensed staff members until December 2008 as long as the staff member is showing progress toward licensure. The Monitoring Team found that because some staff will have to obtain an additional master's degree to qualify to licensure, their future employability might have become an issue.

medical and mental health staff be appropriately licensed. Given the rate of turnover of staff at HRYCI, the Monitoring Team is unable to assess the State's compliance.

With respect to mental health services staff, the Monitoring Team found that HRYCI is not in compliance with this provision of the MOA.

E. SCI

The Monitoring Team did not assess SCI's compliance with this provision of the MOA.

F. Recommendations

The Monitoring Team recommends the following with respect to all facilities in order to address situations involving turnover of staff. The State should forward to the Monitoring Team copies of relevant licensing materials for all newly hired medical and mental health staff. By doing so, the Monitoring Team will be able to give an assessment of a facility even if there is a high turnover of staff after the Monitoring Team's visit.

The Monitoring Team offers additional recommendations regarding this provision of the MOA for DCC and HRYCI. At DCC, the Monitoring Team recommends that the State ensure that all primary care providers have completed a primary care residency. Also, the Monitoring Team recommends that the State create a plan to ensure that all positions are staffed with appropriately credentialed professionals.

At HRYCI, the Monitoring Team recommends that the State: (i) create a plan that ensures ongoing, direct supervision of service provided by unlicensed staff; and (ii) ensure that all staff members who require licenses obtain them in a timely fashion.

6. Staffing

A. Relevant MOA Provision

Paragraph 6 of the MOA provides:

The State shall maintain sufficient staffing levels of qualified medical staff and mental health professionals to provide care for inmates' serious medical and mental health needs that meets generally accepted professional standards.

One way to evaluate the adequacy and effectiveness of a Facility's staffing plan is the Facility's ability to meet the health needs of the inmate population. J-C-07; P-C-07. Various factors can be examined to determine the number and type of health care professionals required at a facility, such as the: (i) size of the facility; (ii) types and scope of health services delivered; (iii) needs of the inmate population at the particular facility, and (iv) organizational structure of the facility. *Id.* In addition, two other factors of significance in evaluating the sufficiency of

staffing levels are whether a prescribing provider²⁹ is available for a sufficient amount of time so as to avoid any unreasonable delay in patients receiving necessary care, and if physician time³⁰ is sufficient to meet both clinical³¹ and administrative responsibilities.³² *Id.*

B. Baylor

1. Findings

The Monitoring Team found that both physician and nursing staff time is inadequate given the missions and size of Baylor.³³ The Monitoring Team found problems at Baylor that are symptomatic of a nursing shortage. Specifically, physician orders were not being performed and laboratory tests were not prepared in a timely fashion for clinician appointments. Another example of inadequate nursing assistance is that the nurse practitioner does not have a nurse assigned to assist her during appointments with pregnant women. These staffing shortages create systemic problems that have the potential to result in providers being impeded in rendering adequate health care to patients.

The Monitoring Team found that the physician and primary nurse practitioners are very conscientious. It is only through their extra efforts that patients at Baylor usually are receiving the care that they need.

With respect to mental health staffing, the Monitoring Team observed that the staffing was adequate to assess new intakes to Baylor, see crisis patients, and complete isolation

²⁹ A “prescribing provider” is defined as “a licensed individual, such as an medical doctor, doctor of osteopathy, nurse practitioner, or physician’s assistant, authorized to write prescriptions. J-C-07; P-C-07.

³⁰ Typically, 3.5 hours of physician time per 100 inmates housed at a facility is regarded as the minimum acceptable physician time. J-C-07; P-C-07. Nurse practitioners or physician’s assistants may substitute for a portion of the physician’s time seeing patients, but must do so under the supervision of a physician. *Id.*; *see generally*, 24 *Del. C.* § 1772.

³¹ Clinical responsibilities include conducting physical examinations, evaluating and managing parties in clinics, monitoring other providers by reviewing and co-signing charts, reviewing laboratory and other diagnostic test results, and developing individual treatment plans. J-C-07; P-C-07.

³² Administrative responsibilities include reviewing and approving policies, procedures, protocols, and guidelines, participating in staff meetings, conducting in-service training program, and participating in quality improvement and infection control programs. J-C-07; P-C-07.

³³ Nursing shortages are being experienced throughout the United States, including Delaware. Thus, it is difficult for the State to recruit nurses to work in correctional facilities. The State believes that it is especially difficult to recruit qualified nurses for HRYCI due to the large number of employers aggressively recruiting for those same nurses.

rounds and suicide observation. Beyond this basic level of services, however, very limited mental health services are being offered at Baylor. Given the number of monthly contacts per counselor, it is not possible for that much psychotherapy to be delivered. The mental health staff at Baylor was very new at the time of the Monitoring Team's visit regarding this provision of the MOA. Specifically, new staff had been hired between the Monitoring Team's visits in July and October, the temporary mental health supervisor had left, and the new director was to begin the same week of the Monitoring Team's October 2007 visit to Baylor. As a result of these changes around the time of the Monitoring Team's visit, the Monitoring Team found that it is premature to judge their level of efficiency.

CMS has reallocated a Director of Nurses position, three LPN's and a clerical position to Baylor, which provides support to the partial compliance assessment.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

1. Findings

With respect to physician staffing, the Monitoring team found that the physician to inmate ratio (1:650) generally would be sufficient; however, given needs of the inmate population at DCC, physician staffing is not adequate. Specifically, DCC houses the sickest inmates within the State's correctional system in its infirmary, and has a special needs unit with a large number of inmates with disabilities, chronic illnesses, or other issues that cause them to need more attention from health care staff.

With respect to nurse staffing, the Monitoring Team found that the number of nurses allocated to medication administration and the level of nurse staffing in the infirmary is inadequate. Specifically, in the infirmary, there are two nurses and one medical assistant assigned to an infirmary unit with a capacity of 44 inmates, which is often at or near capacity. Patients in this infirmary are either ones that would require a nursing home if they were in the community, or ones that have some acute problem that requires careful attention. Several of the patients in the infirmary are either partially or totally dependent on nurses because they are unable to care for themselves. The infirmary also houses a few patients who are incontinent, one of whom is very large and requires multiple staff to move him so that he and his bed can be cleaned.

The two nurses and one medical assistant assigned to the infirmary must administer medication, perform physician order assignments, perform health assessments, perform admissions and discharges, make rounds, document progress notes and other items in patients' charts, perform patient cleaning and hygiene assistance for all of these patients. The fact that staffing of this infirmary is insufficient is evident by the lack of nurse documentation in

patient charts. The burden on these employees could be lessened somewhat if they were relieved of their medical record-keeping and cleaning duties.

The Monitoring Team found that mental health staffing is not adequate due to licensure, supervision, and vacancy issues. Specifically, ten of the clinicians are unlicensed. One Special Housing Unit (“SHU”) counselor position is vacant due to a suspension in December 2007, and another clinician is on leave, resulting in that position being functionally vacant. While the psychiatrist nurse position is filled, the person holding that position is also on leave, resulting in this position being as well functionally vacant.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA with regard to medical staffing, and not in compliance with regard to mental health staffing.

D. HRYCI

1. Findings

One significant problem that the Monitoring Team found at HRYCI relates to maintaining adequate numbers of qualified nursing staff to provide health care to the inmate population. Additionally, there is a significant problem with staff not coming to work as scheduled, and staff insubordination. The Health Services Administrator and the Director of Nursing are attempting to alleviate these problems.

If staff is not showing up for work or performing adequately, although a sufficient number of positions might be filled, the State’s ability to come into compliance with this provision of the MOA might be impaired because the adequacy of care could continue to be hampered in spite of sufficient staffing levels. These issues compound the overall difficulty with nurse recruiting due to nurse shortages.

With respect to mental health staffing, the Monitoring Team found that the staffing is inadequate to provide the depth of services necessary.³⁴ In general, the mental health services that the staff is able to provide amounts to welfare checks.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

³⁴ Recently, the mental health supervisor resigned, and one of the psychiatrist’s contracts was terminated for cause.

1. Findings

The Monitoring Team found that physician and nursing staffing is inadequate. The Monitoring Team found that one of the doctors at SCI is also assigned to act as the statewide HIV doctor, which causes him to have less time to spend at SCI. The physician is not providing leadership and supervision to all of the clinical staff. Also, the Monitoring Team found that the number of available nurses was not adequate to cover necessary duties at SCI, and there is no chronic disease nurse, which would be helpful given the characteristics of SCI. The lead nurse and the Health Services Administrator provide coverage for general nursing duties that would otherwise be carried out by others.

The Monitoring Team found that most of the mental health positions have been filled, which has allowed for SCI to begin providing more services above and beyond the bare minimum. SCI offers clinical mental health services between 8:30 a.m. and 8:00 p.m. during the workweek. The clinical mental health services consist of individual encounters and some group programming, although lack of space presents an obstacle to the mental health staff's ability to provide such services.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

At DCC, the Monitoring Team recommends that the State ensure that all primary care providers have completed a primary care residency. In addition, the Monitoring Team recommends that the State perform a staffing analysis regarding numbers of staff by discipline needed per shift to adequately meet the nursing needs of a full infirmary and perform medication administration. Finally, the Monitoring Team recommends that the State conduct a staffing analysis for mental health professionals with descriptions of the duties by discipline and shift.

At HRYCI, the Monitoring Team recommends that the leadership should continue to hold staff accountable for performance issues. The addition of nursing supervisory staff should assist with this issue. In addition, the Monitoring Team recommends that the State create a plan to fill all mental health positions at HRYCI and the Central Office within a reasonable timeframe. Currently there are 1.5 full time equivalent ("FTE") mental health clinical staff allocations which are vacant.

At Baylor and SCI, the Monitoring Team recommends performing staffing analyses that address the issues raised in findings, and ensures timely provision of services and compliance with policies and procedures.

7. Medical and Mental Health Staff Management

A. Relevant MOA Provision

Paragraph 7 of the MOA provides:

The State shall ensure that a full-time medical director is responsible for the management of the medical program. The State shall also provide a director of nursing and adequate administrative medical and mental health management. In addition, the State shall ensure that a designated clinical director shall supervise inmates' mental health treatment at the Facilities. These positions may be filled either by State employees, by independent contractors retained by the State, or pursuant to the State's contract with a correctional health care vendor.

According to NCCHC Standards for both jails and prisons, each of the Facilities should have a designated health authority responsible for health care services and, as provided in the MOA, each of the Facilities should have another responsible health authority for mental health services. J-A-02; P-A-02. According to the State's Action Plan, positions that State plans to fill in order to meet this requirement are a statewide full-time medical director, statewide director of nursing, a statewide full-time mental health director as well as additional administrative management staff to assist the foregoing state-level positions. *See* Section 7 of the State's Action Plan. In addition, there is a position at each of the Facilities for a clinical director of mental health, a Health Services Administrator, medical director and director of nursing. For a Facility to be in substantial compliance with this provision of the MOA, the Monitoring Team needs to find that there has been stable and quality leadership at the Facility. Thus, simply filling a position will not be adequate.

B. Baylor

1. Findings

While the position is filled for the on-site medical director, documentation was not received by the Monitoring Team to describe the site responsibilities of the medical director. Thus, the Monitoring Team was unable to evaluate whether the medical director would meet the applicable standard. Also, the administrative support for medical and mental health management clinicians has not been adequate, as evidenced by the clinicians creating their own backup systems to ensure that care is timely. By "backup system" the Monitoring Team is referring to the physician keeping her own notebook containing scheduling for offsite appointments. While this practice shows the conscientiousness of this particular physician, the Monitoring Team believes the physician should not be doing this sort of clerical work and it demonstrates the inadequacy of the support infrastructure at Baylor.

The Monitoring Team found that there has been high turnover in the mental health director position at Baylor. The mental health director who had been at Baylor for a long time resigned in 2007. A new mental health director was moved from a position at DCC to Baylor in August 2007, but resigned effective October 31, 2007. A new mental health director is in place at Baylor who previously worked at HRYCI. Based on interviews with the new mental health director and staff, as well as a review of the overall organization with health care services delivery systems at Baylor indicated to the Monitoring Team that the new mental health director

can be an effective leader and administrator, but the Monitoring Team believed it was premature to make that determination.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that, at the time of the visit to DCC to assess this provision of the MOA, DCC did not have a single medical director. Instead, CMS had assigned the title of medical director to two physicians. This arrangement is not working because the staff do not uniformly recognize who the medical director is and as a result there is confusion and a lack of direction. A single person should be designated as a medical director. This assignment should be clear to all staff and should result in that person having clinical leadership of the program.

The Monitoring Team found that DCC had a designated mental health director who administratively supervises inmates' mental health treatment. The mental health director was new at the time of the Monitoring Team's visit to monitor this provision of the MOA. Thus, it is premature to make an assessment as to the adequacy of the new mental health director. Based upon interviews with the mental health director, staff, and a review of the overall organization of mental health services delivery systems, the Monitoring Team believes that the present mental health director will be an effective leader.

2. Assessment

The Monitoring Team found that DCC is not in compliance with this provision of the MOA with respect to medical healthcare management, and that DCC is in partial compliance with respect to mental healthcare management.

D. HRYCI

1. Findings

The Monitoring Team found that turnover among leadership positions has been much higher than a good organization can tolerate. The Health Services Administrator that is in place has been at HRYCI for approximately five months, and the director of nursing for a shorter period of time. Before these individuals were hired, turnover in these positions was a serious problem. All of the inconsistency in medical health services management has led to inhibited growth of program development, and a lack of adequate supervision and leadership has appeared in the performance of medical staff. The Monitoring Team is hopeful that the current Health Services Administrator and director of nursing will stay and continue to provide HRYCI with

stability and leadership. The on site medical director position was not filled at the time the Monitoring Team monitored this provision of the MOA.³⁵ Finally, there was a lack of adequate nurse supervisors.

A mental health director is in place at HRYCI, and has been a stable presence at HRYCI. This mental health director administratively supervises inmates' mental health treatment.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

While the primary physician and psychiatrist are in place, the Monitoring Team found that neither provides very strong leadership or meaningful peer review.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendations

The Monitoring Team recommends that the State take the following actions at Baylor: (i) implement systems to ensure that support results in timely services consistent with the policies and procedures; and (ii) provide psychiatric peer review regarding clinical performance and documentation.

The Monitoring Team recommends that the State take the following actions at DCC: (i) delineate Medical Director responsibilities and, if necessary, Assistant Medical Director duties; and (ii) ensure that the staffing plan allows for both direct clinical service hours and hours for administrative and supervisory functions.

The Monitoring Team recommends that the State take the following actions at HRYCI: (i) CMS should establish and fill nursing supervisor positions to provide 24-7 nursing supervisory coverage; and (ii) CMS should hire an on-site medical director, thus allowing the State Medical Director to resume his other duties.

³⁵ In fact, at that time, the lead physician had just been terminated for performance deficiencies.

The Monitoring Team recommends that the State take the following actions at SCI: (i) create a plan to improve clinical leadership over the Medical program; and (ii) create a plan that addresses concerns raised in the Findings.

8. Medical and Mental Health Staff Training

A. Relevant MOA Provision

Paragraph 8 of the MOA provides:

The State shall continue to ensure that all medical staff and mental health professionals are adequately trained to meet the serious medical and mental health needs of inmates. All such staff shall continue to receive documented orientation and in-service training in accordance with their job classifications, and training topics shall include suicide prevention and the identification and care of inmates with mental disorders.

Adequate training for medical and mental health staff includes an immediate basic orientation³⁶ and all full-time staff must complete a formal in-depth orientation³⁷ to the health services program at a facility. J-C-09; P-C-09.

B. Baylor

³⁶ A “basic orientation” is one that “is provided on the first day of employment, includes information necessary for the health staff member (e.g., full-time, part-time, consultant, per diem) to function safely in the institution.” J-C-09-; P-C-09. At a minimum, the basic orientation should include relevant security and health services policies and procedures, response to facility emergency situations, the staff member’s functional position description, and inmate-staff relationships. *Id.*

³⁷ An “in-depth orientation” should occur within 90 days of employment, and includes “a full familiarization with the health services delivery system at the facility, and focuses on the similarities as well as the differences between providing health care in the in community and in a correctional setting.” J-C-09-; P-C-09. Specifically, at a minimum, the curriculum of the in-depth orientation should include all health services policies and procedures not addressed in the basic orientation, health and age-specific needs of the inmate population, infection control including use of standard precautions, and confidentiality of records and health information. *Id.* In addition to these essential topics, a formal orientation program could include the following topics: (i) security, including classification of inmates; (ii) health care needs of the inmate population; (iii) the inmate social system; (iv) the organization of health services at the facility; and (v) infection control. *Id.* For nursing staff, topics could also include: (i) assessment and sick-call triage; (ii) emergency triage and management; (iii) resource utilization outside the facility; (iv) procedures for release of information; (v) expected documentation practices; (vi) isolation procedures; and (vii) professional boundaries. *Id.*

The Monitoring Team did not assess Baylor’s compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that staff training consists of an orientation, basic life support and cardiopulmonary resuscitation (“CPR”), an eight-hour presentation on suicide prevention sponsored by the State, and a four-hour presentation on suicide prevention sponsored by CMS. In addition, staff receives a 16-hour presentation course in emergency preparedness. The Monitoring Team found that all of the staff have completed the required training, with the exception of a psychiatrist who was hired in November 2007.

2. Assessment

The Monitoring Team did not assess DCC’s compliance with this provision of the MOA with respect to the medical staff. The Monitoring Team found that DCC is in substantial compliance with this provision of the MOA with respect to mental health staff.

D. HRYCI

1. Findings

The Monitoring Team found that staff training consists of an orientation, basic life support and cardiopulmonary resuscitation (“CPR”), an eight-hour presentation on suicide prevention sponsored by the State, and a four-hour presentation on suicide prevention sponsored by CMS. In addition, staff receives a 16-hour presentation course in emergency preparedness.

2. Assessment

The Monitoring Team did not assess HRYCI’s compliance with this provision of the MOA with respect to the medical staff. The Monitoring Team found that HRYCI is in substantial compliance with this provision of the MOA with respect to mental health staff.

E. SCI

The Monitoring Team did not assess SCI’s compliance with this provision of the MOA.

9. Security Staff Training

A. Relevant MOA Provision

Paragraph 9 of the MOA provides:

The State shall ensure that security staff are adequately trained in the identification, timely referral, and proper supervision of inmates with serious medical or mental health needs. The State shall ensure that security staff assigned to mental health units receive additional training related to the proper supervision of inmates suffering from mental illness.

Adequate training for security staff should occur at least every two years, and include, at a minimum, the following topics: (i) the administration of first aid; (ii) recognizing the need for emergency care and intervention in life-threatening situations (e.g. a heart attack); (iii) recognizing acute manifestations of certain chronic illnesses, intoxication and withdrawal, and adverse reactions to medications; (iv) recognizing signs and symptoms of mental illness; (v) procedures for suicide prevention; (vi) procedures for appropriate referral of inmates with health complaints to health staff; (vii) precautions and procedures with respect to infectious and communicable diseases; and (viii) CPR. J-C-04; P-C-04. At any given time, at least 75% of the security staff present should be current with their health-related training. *Id.* The Facilities should maintain a certificate or other evidence of security staff's training, and an outline of the course content and the length of the course for the Monitoring Team's review to assess the appropriateness of the health-related training. *Id.*

B. Baylor

1. Findings

The Monitoring Team found that every new member of the security staff attends a three-hour general overview regarding mental illness as a cadet in the academy, and these hours are tracked on a statewide basis. Also, each new member of the security staff attends an eight-hour course regarding suicide prevention training, and then that training is repeated at the facility-level. The Statewide training completion date regarding suicide prevention training for all personnel occurred on September 30, 2007. The training officer at the facility-level tracks these hours. The most current count available to the Monitoring Team at the time of their visit was that 99% of security staff had completed the training. Finally, the State is working on a refresher requirement that DOC is working on with their Employee Development Center. *See* State Policy C-04.

2. Assessment

The Monitoring Team did not assess Baylor's compliance with this provision of the MOA with respect to training security staff regarding non-mental health medical topics. The Monitoring Team found Baylor to be in substantial compliance with this provision of the MOA with respect to training security staff regarding mental health topics.

C. DCC

1. Findings

The Monitoring Team found that every new member of the security staff attends a three-hour general overview regarding mental illness as a cadet in the academy, and these hours are tracked on a statewide basis. Also, each new member of the security staff attends an eight-hour course regarding suicide prevention training, and then that training is repeated at the facility-level. The Statewide training completion date regarding suicide prevention training for all personnel occurred on September 30, 2007. The training officer at the facility-level tracks these hours. The most current count available to the Monitoring Team at the time of their visit was that 99% of security staff had completed the training. Finally, the State is working on a refresher requirement that DOC is working on with their Employee Development Center. *See* State Policy C-04.

2. Assessment

The Monitoring Team did not assess DCC's compliance with this provision of the MOA with respect to training security staff regarding non-mental health medical topics. The Monitoring Team found DCC to be in substantial compliance with this provision of the MOA with respect to training security staff regarding mental health topics.

D. HRYCI

1. Findings

The Monitoring Team found that every new member of the security staff attends a three-hour general overview regarding mental illness as a cadet in the academy, and these hours are tracked on a statewide basis. Also, each new member of the security staff attends an eight-hour course regarding suicide prevention training, and then that training is repeated at the facility-level. The Statewide training completion date regarding suicide prevention training for all personnel occurred on September 30, 2007. The training officer at the facility-level tracks these hours. The most current count available to the Monitoring Team at the time of their visit was that 99% of security staff had completed the training. Finally, the State is working on a refresher requirement that DOC is working on with their Employee Development Center.³⁸ *See* State Policy C 04.

2. Assessment

The Monitoring Team did not assess HRYCI's compliance with this provision of the MOA with respect to training security staff regarding non-mental health medical topics. The Monitoring Team found HRYCI to be in substantial compliance with this provision of the MOA with respect to training security staff regarding mental health topics for the same reasons cited above with regard to DCC.

E. SCI

³⁸ The Employee Development Center provides training to DOC correctional staff. Thus, if the Employment Development Center causes topics or courses to become part of its required curriculum, correctional staff should receive the training at adequate rates.

1. Findings

The Monitoring Team found that every new member of the security staff attends a three-hour general overview regarding mental illness as a cadet in the academy, and these hours are tracked on a statewide basis. Also, each new member of the security staff attends an eight-hour course regarding suicide prevention training, and then that training is repeated at the facility-level. The Statewide training completion date regarding suicide prevention training for all personnel occurred on September 30, 2007. The training officer at the facility-level tracks these hours. The most current count available to the Monitoring Team at the time of their visit was that 99% of security staff had completed the training. Finally, the State is working on a refresher requirement that DOC is working on with their Employee Development Center.³⁹ See State Policy C 04.

2. Assessment

The Monitoring Team did not assess SCI's compliance with this provision of the MOA with respect to training security staff regarding non-mental health medical topics. The Monitoring Team found SCI to be in substantial compliance with this provision of the MOA with respect to training security staff regarding mental health topics for the same reasons cited above with regard to DCC.

³⁹ The Employee Development Center provides training to DOC correctional staff. Thus, if the Employment Development Center causes topics or courses to become part of its required curriculum, correctional staff should receive the training at adequate rates.

SCREENING AND TREATMENT

10. Medical Screening

A. Relevant MOA Provision

Paragraph 10 of the MOA provides:

The State shall ensure that all inmates receive an appropriate and timely medical screening by a medical staff member upon arrival at a facility. The State shall ensure that such screening enables staff to identify individuals with serious medical or mental health conditions, including acute medical needs, infectious diseases, chronic conditions, physical disabilities, mental illness, suicide risk, and drug and/or alcohol withdrawal. Separate mental health screening shall be provided as described in Paragraph 34 [of the MOA].

According to NCCHC standards, timely receiving screening⁴⁰ means that the screening performed on inmates immediately⁴¹ upon arrival at the respective intake facility, and is performed by a qualified health care professional or a health-trained person. J-E-02; P-E-02. The policies adopted by the State provide that such receiving screening will be initiated within two hours of arrival into a facility and will be the responsibility of the nursing healthcare staff. *See* State Policy E-02. This policy is adequate. If a receiving screening is completed within three to four hours of arrival to a Facility, the Monitoring Team believes that is reasonable.

The MOA requires that the State ensure that the receiving screening, “enables staff to identify individuals with serious medical or mental health conditions, including acute medical needs, infectious diseases, chronic conditions, physical disabilities, mental illness, suicide risk, and drug and/or alcohol withdrawal.” In order to comply with this requirement, the State should ensure that receiving personnel are making consistent and complete inquiries and

⁴⁰ A “receiving screening” is

[A] process of structured inquiry and observation designed to prevent newly arrived inmates who pose a threat to their own or others’ health or safety from being admitted to the facility’s generally population, and to get them rapid medical care. It is intended to identify potential emergency situations among new arrivals to the facility, and also to ensure that those patients with known illnesses and currently on medications are identified for further assessment and continued treatment.

J-E-02; P-E-02. In sum, the purpose of a receiving screening is to (i) identify and meet any urgent health needs of those admitted; (ii) identify and meet any known or easily identifiable health needs that require medical intervention before the health assessment (*see infra*); and (iii) identify and isolate inmates who appear potentially contagious. *Id.*

⁴¹ NCCHC standards do not clarify what is meant by “immediately.” The Monitoring Team believes that 3 to 4 hours is reasonable.

observations. Reception personnel should use a checklist to ensure that they inquire about the following important information:

- current and past illnesses, health conditions, or special health requirements (e.g. dietary needs);
- past serious infectious disease(s);
- recent communicable illness symptoms (e. g. chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever, night sweats);
- past or current mental illness, including hospitalizations;
- history of or current suicidal ideation;
- dental problems;
- allergies;
- legal an illegal drug use (including the last time of use);
- drug withdrawal symptoms;
- current or recent pregnancy; and
- other health problems that the State should decide to include on its form.

J-E-02; P-E-02. In addition, reception personnel should note on the receiving screening form observations:

- appearance (e.g. sweating, tremors, anxious, disheveled);
- behavior (e.g., disorderly, appropriate, insensible);
- state of consciousness (e.g., alert, responsive, lethargic);⁴²
- ease of movement (e.g. body deformities, gait);

⁴² Persons who are unconscious, semi-conscious, bleeding, mentally unstable, or otherwise urgently in need of medical attention upon arriving at a Facility should be referred immediately for care. J-E-02; P-E-02. Such an immediate referral upon arrival at a Facility should be noted on the receiving screening form. *Id.* In addition, if the inmate is referred to a community hospital for care of the emergency condition and are returned the Facility should require a written medical clearance from the community hospital. *Id.*

- breathing (e.g. persistent cough, hyperventilation); and
- skin (e.g. lesions, jaundice, rashes, infestations, bruises, scars, tattoos, and needle marks or other indications of drug abuse).

Id. The disposition of the inmate (*i.e.*, if the inmate was immediately referred for medical care, or placed in general population, etc.) should be indicated on the receiving screening form. *Id.* Once the receiving screening form has been completed, it should include the date and time of completion, and the signature and title of the person completing the form. *Id.* Finally, the receiving screening should allow for all immediate health needs to be identified and addressed, and potentially infectious inmates to be isolated. *Id.*

As noted above, the State has created a policy stating that a receiving screening will be initiated within two hours of arrival to a Facility. *See* State Policy E-02. This policy further provides that inmates will be screened in a manner consistent with the NCCHC standards cited above. *Id.* Also, the State will record the findings of the screenings in DACS, and that the screenings will include a history and observations based on a health screening form. *Id.* The screening form supplied by the State is adequate, but will require some progress notes to be attached and cross-referenced in the case of positive answers to questions that require follow-up.

B. Baylor

1. Findings

As a preliminary matter, the Monitoring Team was unable in some instances to measure the timeliness of the receiving screening because the correctional officers did not consistently document the date and time of the inmate's arrival at Baylor. At Baylor, for each medical reception chart the Monitoring Team reviewed, there was a handwritten booking form completed by the correctional officer. The Monitoring Team found that these forms did not consistently document the date and time of the inmate's arrival. The State has informed the Monitoring Team that this information is documented elsewhere. The Monitoring Team will follow up on this item in future reports.

In those records that the Monitoring Team reviewed where timeliness was measurable, the Monitoring Team found that 3 out of 10 records reflected that the nurses did not complete the Intake Screening Report within the four-hour time frame.

With respect to the appropriateness of the receiving screening, progress notes, if written, often were not referred to on the screening report form, which meant that such notes would not be helpful. The Monitoring Team also observed that when inmates arrived who were already on medication, the nurses were not consistently documenting the medication dosages.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that in nine out of ten records reviewed reflected that the receiving screenings took place within four hours of the inmate arriving at DCC. With regard to the adequacy of the receiving screenings, more than half of the receiving screenings reviewed by the Monitoring Team either were incomplete or not adequately performed. The most common problem that the Monitoring Team found was that the person conducting the receiving screening did not include sufficient follow-up details when an inmate answered “yes” to questions that require further information from the inmate.

With regard to intrasystem transfers, the Monitoring Team found that five out of ten of the records reviewed demonstrated some deficiencies concerning the follow-up or continuity of care afforded to the inmate.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team selected 20 records for review. These records represented a sample of those inmates who had entered HRYCI within the previous three weeks.

The Monitoring Team found that 55% of the records reviewed demonstrated that the inmate had a tuberculosis (“TB”) test planted and read within the first four days of arrival at HRYCI. The Monitoring Team found that, in almost all cases the TB test was planted. There were instances in which there was no documentation of the TB test in the chart, but those instances were the exception.

With regard to the adequacy of the receiving screenings at HRYCI, the Monitoring Team found that, similar to the findings at DCC, most of the receiving screenings records reviewed did not include sufficient follow-up details when an inmate answered “yes” to questions that require further information from the inmate.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team selected 20 charts to review at SCI for this provision of the MOA. Although the Monitoring Team noted that screening had been completed, the Monitoring Team was unable to assess the timeliness of the receiving screenings at SCI because of a lack of documentation of the inmate's time of arrival at the Facility. With regard to the adequacy of the receiving screenings at SCI, the Monitoring Team found that, like DCC and HRYCI, a number of the receiving screening records reviewed did not include sufficient follow-up details when an inmate answered "yes" to questions that require further information from the inmate.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

The Monitoring Team recognizes that the implementation of the new DACS might have a considerable positive impact on the State's compliance with the provisions of the MOA. The Monitoring Team recommends that the State take the following actions at Baylor and SCI: (i) draft and implement procedures that ensure that all screening is performed timely and completely; and (ii) begin self-monitoring of implementation.

11. Privacy

A. Relevant MOA Provision

Paragraph 11 of the MOA provides:

The State shall make reasonable efforts to ensure inmate privacy when conducting medical and mental health screening, assessments, and treatment. However, maintaining inmate privacy shall be subject to legitimate security concerns and emergency situations.

The MOA requires that the State make "reasonable efforts" to ensure inmate privacy when conducting medical and mental health screening, assessments, and treatment, subject to legitimate security concerns and emergency situations. This provision of the MOA differs somewhat from the NCCHC standards, which provide for clinical encounters⁴³ to be conducted in private, without being observed or overheard by security personnel unless the

⁴³ "Clinical encounters" are defined as "interactions between inmates and health care providers that involve a treatment and/or an exchange of confidential information." J-A-09; P-A-09.

patient poses a probable risk to the safety of the health care provider or others. J-A-09; P-A-09.⁴⁴ The MOA does not require an individual correctional officer to make an independent assessment of the security risk of an individual inmate. Rather, the State can set the procedures for correctional officers to follow to ensure that privacy is afforded in accordance with this provision of the MOA.

The policies adopted by the State call for healthcare to be provided with consideration of inmate dignity and feelings. *See* State Policy A-09. Further, healthcare encounters are to be carried out in a manner and location that promotes confidentiality within the dictates of security and safety. *Id.* The State's policy calls for security staff or interpreters who may be present during healthcare encounters to be informed and educated regarding the need for confidentiality. *Id.* Finally, the State's policy provides for a female escort to be provided for encounters with a female inmate by a male healthcare provider. *Id.*

B. Baylor

1. Findings

Due to the lack of sufficient clinic examination rooms, the nurses conduct sick call in the infirmary hallway where there is no auditory or visual privacy. In addition, because there is no correctional officer posted in the infirmary, inmates are free to wander about the clinic and overhear conversations or view confidential health documents laying on desks in the hallway. The Monitoring Team learned that Baylor has formed a plan to use the infirmary space in a more efficient manner, which promotes greater patient privacy.

The Monitoring Team also found that, with respect to the provision of mental health services, there is no office designated for private contacts by mental health staff for women on close observation. The mental health staff interviews women in the dental office if it is not in use. Otherwise, there is no private area to assess the inmate. Also, women who are on suicide precautions should be allowed a privacy curtain to use the toilet, if it is clinically appropriate (*see infra.*) for such a curtain to be in the observation room.

2. Assessment

The Monitoring Team found that Baylor is not in compliance with this provision of the MOA. At the time of the Monitoring Team's visit, it appeared that the State was not

⁴⁴ Further, NCCHC standards provide that, in cases in which it is necessary for security personnel to overhear clinical encounters, security personnel should be instructed regarding the maintenance of confidentiality of health information. *Id.* Such privacy is not feasible under all circumstances, such as instances in which health staff is dealing with an inmate's health concern at the inmate's cell, or in Facilities in which space issues do not allow for privacy as described above. Under such circumstances, if safety is a concern and full visual privacy cannot be afforded, the NCCHC recommends that alternative strategies for partial privacy, such as a privacy screen, be used. *Id.*

making reasonable efforts to ensure patient privacy. The State has informed the Monitoring Team that there are concrete plans to improve patient privacy issues. These efforts will be the subject of future reports.

C. DCC

1. Findings

The Monitoring Team observed that the infirmary unit does not have an examination room. As a result, examinations are performed in the patient rooms, even when those rooms are occupied by multiple inmates in a dormitory style. In some of the patient rooms, the beds are so close together that it is not possible to obtain visual or aural privacy. If DCC is unable to create a space for an infirmary examination room to afford inmate's greater privacy, the State should, at the very least, provide for some means of dividing inmate rooms so that at least visual privacy can be maintained for examinations.

With regard to the privacy of mental health services, the Monitoring Team found that there is one office available for every tier (four per 100 inmates), and one group space. This office space is adequate to afford reasonable privacy. The Monitoring Team found one problem regarding the privacy afforded by the office space, which is that mental health professionals do not have the option to close the doors during interviews with inmates because the office doors lock automatically upon closing.

Space within the infirmary for the provision of mental health services is not adequate. The State is making reasonable efforts, however, to remedy this situation

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that all clinical encounters are conducted with doors open and correctional officers standing in the doorway, regardless of the need to do so.⁴⁵

The Monitoring Team also observed that the room used for chronic clinics is typically so hot that the door is left open. The problem with that situation is that the chronic

⁴⁵ By way of example, during a visit by the Monitoring Team, one of the medical experts requested to meet in private with an inmate. The correctional officer refused the expert's request, stating, "This is a prison. There is no privacy in a prison." The State has informed the Monitoring Team that the correctional officer's conduct is not representative of the State's approach to inmate privacy, and that the correctional officer has been disciplined.

clinic room is adjacent to the waiting room, and therefore, inmates and correctional officers are immediately outside of the door and can overhear the clinical encounters taking place.

The Monitoring Team also observed a nursing station that is being shared with security personnel. This shared space jeopardizes the confidentiality of inmate medical records.

2. Assessment

The Monitoring Team found that HRYCI is not in compliance with this provision of the MOA with regard to the privacy afforded to inmates receiving medical services, and is in partial compliance with regard to the privacy afforded to inmates receiving mental health services.

E. SCI

1. Findings

The Monitoring Team found that some of the housing units provide no private or confidential space for clinical encounters, and most clinical encounters occur in public. This is a serious concern with regard to the ability of staff to adequately assess an inmate's suicide risk.

2. Assessment

The Monitoring Team found that SCI is not in compliance with this provision of the MOA. At the time of the Monitoring Team's visit, it appeared that the State was not making reasonable efforts to ensure patient privacy. The State has informed the Monitoring Team that there are concrete plans to improve patient privacy issues. These efforts will be the subject of future reports.

F. Recommendation

The Monitoring Team recommends that the State create a plan that ensures professional and adequate assessment space while also ensuring security at Baylor.

The Monitoring Team recommends that the State develop and implement procedures that ensure professionally appropriate assessment space at DCC.

The Monitoring Team recommends that the State create a plan that provides for confidential assessment space in both the clinic and inpatient areas at HRYCI.

The Monitoring Team recommends that the State create a plan to the Monitor that ensures a professionally appropriate environment for all encounters at SCI.

12. Health Assessments

A. Relevant MOA Provision

Paragraph 12 of the MOA provides:

The State shall ensure that all inmates receive timely medical and mental health assessments. Upon intake, the State shall ensure that a medical professional identifies those persons who have chronic illness. Those persons with chronic illness shall receive a full health assessment between one (1) and seven (7) days of intake, depending on their physical condition. Persons without chronic illness should receive full health assessment within fourteen (14) days of intake. The State will ensure that inmates with chronic illnesses will be tracked in a standardized fashion. A readmitted inmate or an inmate transferred from another facility who has received a documented full health assessment within the previous twelve (12) months, and whose receiving screening shows no change in health status, need not receive a new full medical and mental health assessment. For such inmates, medical staff and mental health professionals shall review prior records and update tests and examinations as needed.

The MOA provides for timely and adequate medical and mental health assessments⁴⁶ to occur. NCCHC standards differ with respect to timeliness of a health assessment (*compare* J-E-04 and P-E-04 (stating that health assessments in jails take place “[a]s soon as possible, but no later than 14 days...” and in prisons, “[a]s soon as possible, but no later than 7 days...”)), but the MOA requires that the State adhere to the standard for jails, which is 14 days.⁴⁷ An adequate health assessment should include at least:

- a review of receiving screening results;
- the collection of additional data to complete the medical, dental, and mental health histories;
- a recording of vital signs;
- a physical examination (an objective, hands-on evaluation of an individual, involving the inspection, palpation, auscultation, and percussion of a patient’s body to determine the presence or absence of physical signs of disease);
- laboratory and/or diagnostic tests for communicable diseases including sexually transmitted diseases;

⁴⁶ A “health assessment” is defined as “the process whereby the health status of an individual is evaluated, including questioning the patient regarding symptoms.” J-E-04; P-E-04.

⁴⁷ The State’s policy adopts the 7-day standard applicable to prisons for timeliness of health assessments. *See* State Policy E-04.

- a test for TB; and
- initiation of therapy and immunizations when appropriate.

Id. The hands-on portion of the health assessment should be performed by a physician, physician assistant, or nurse practitioner, and the health history and vital signs should be collected by a qualified health care professional.⁴⁸ *Id.* When significant findings are present as the result of the hands-on portion of the health assessment, and it is done by a health professional other than a physician, the physician should document his or her review of the health professional's health assessment in the inmate's medical record.

B. Baylor

1. Findings

After a review of medical records, the Monitoring Team found that inmates are not consistently receiving physical examinations within the required time frames, and as discussed in reference to paragraph 10 of the MOA, in two cases discovered by the Monitoring Team, health assessments did not occur when warranted (*e.g.*, when newly arrived inmates are demonstrating symptoms of sexually transmitted diseases, which would warrant a health assessment prior to the expiration of fourteen days). Furthermore, in three of ten records reviewed, TB tests were not consistently documented.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team reviewed ten charts, and found that in some, the physical examination was not completed. The Monitoring Team did not find a complete initial problem list or plan in many of the records reviewed.

With respect to the mental health assessments, the Monitoring Team found that mental health staff was not reviewing the files of inmates transferred to DCC from other Facilities.

⁴⁸ The hands-on portion of the health assessment may be performed by a registered nurse when (i) the nurse completes appropriate training, approved or provided by the responsible physician; and (ii) the responsible physician documents his or her review of all health assessments. J-E-04; P-E-04.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that half of the records reviewed did not reflect a timely health assessment, and several records indicated that no health assessment had been completed. The Monitoring Team found that, of those records that reflected completed health assessments, appropriate referrals to chronic care program were made.

With respect to the mental health assessments, the Monitoring Team found that mental health staff was not reviewing the files of inmates transferred to HRYCI from other Facilities.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that health assessments were completed in most of the records reviewed; however, the health assessments were completed within the MOA's 14-day requirement.

The Monitoring Team found that mental health assessments are occurring in a timely fashion. The Monitoring Team found that mental health assessments generally are complete and appropriately refer individuals identified with mental health problems for further review. The only exception found by the Monitoring Team was that one newly hired mental health professional was completing the incorrect form for the health assessment, but that problem has been remedied.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA with regard to the medical health assessments performed on inmates, and in substantial compliance with regard to the mental health assessments performed on inmates.

F. Recommendation

The Monitoring Team recommends that the State: (i) draft and implement procedures to ensure the timely and appropriate health assessments are completed within seven days of entry; (ii) ensure that the assessments include an initial comprehensive problem list with relevant diagnostic and therapeutic plans; and (iii) begin self-monitoring of timeliness, appropriateness and completeness of health assessments.

13. Referrals for Specialty Care

A. Relevant MOA Provision

Paragraph 13 of the MOA provides:

The State shall ensure that: a) inmates whose serious medical or mental health needs exceed the services available at their facility shall be referred in a timely manner to appropriate medical or mental health care professionals; b) the findings and recommendations of such professionals are tracked and documented in inmates' medical files; and c) treatment recommendations are followed as clinically indicated.

The MOA requires that the State ensure that inmates whose medical or mental health needs exceed the services available at the Facility shall be referred in a timely manner to appropriate medical and mental health care professionals. For routine referrals, generally accepted professional standards would permit a timely referral to be defined as being seen by a specialist within 40 days, unless that inmate is seen by the primary care physician at the Facility every 30 days until the specialist appointment occurs. In any event, the appointment with the specialist should not occur more than 100 days after the initial request. For urgent consultations, the process should occur within 14 days. In addition, the MOA requires that once an inmate has seen the appropriate medical or mental health professional, the findings and recommendations are tracked and documented in inmates' files, and the patients are seen in follow-up by their primary care physician at the Facility.

B. Baylor

1. Findings

The Monitoring Team reviewed several charts of patients for whom consultations had been ordered. The Monitoring Team found that most of the medical consults are occurring on a timely basis, but that there is a lack of consistency in reports being available on a timely basis, follow-up visits occurring after an appointment, and documentation in the inmate's medical record regarding the reasons for the initial referral.

The problems identified by the Monitoring Team with Baylor's compliance with this provision of the MOA relate mainly to a lack of adequate administrative staff and resources for the clinicians. The consult scheduler does not have a phone or computer at his/her desk. The Health Services Administrator at Baylor has brought in her own laptop to assist with this process. Tracking is done on paper, which is then later entered into the computer tracking system. The physician maintains her own personal notebook tracking system to try to ensure that inmates are

receiving appropriate follow-up (e.g., discussions with patients) after consultations, but this method does not always ensure that these visits occur as required.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA with respect to medical services. The Monitoring Team was unable to assess Baylor's compliance with this provision of the MOA in relation to mental health services, as there had been no recent referrals offsite for mental health care at the time of the Monitoring Team's visit.

C. DCC

1. Findings

The Monitoring Team found that from June 2007 until the beginning of August 2007, specialty referrals were not occurring because the person who was assigned to schedule appointments for inmates was on sick leave, and CMS had failed to find a temporary replacement. The Monitoring Team learned that after the Monitoring Team's visit, a new person had been assigned to assist with the task of scheduling; however, that person was not at DCC full-time, which resulted in additional delays in scheduling specialty appointments. After reviewing patients referred by a primary care physician from the beginning of August, the Monitoring team found that there were a total of 94 referrals generated in which there had been an authorization from CMS's central office for the service to be provided to an inmate.⁴⁹ However, at the time the Monitoring Team reviewed these records, no phone call had been made to schedule those inmate's appointment.

With respect to the process for ensuring that that the findings and recommendations of the specialty professionals are tracked and documented in inmates' medical files, and followed as clinically indicated, the Monitoring Team found that in half of the charts reviewed, reports were missing and follow-up visits between the primary care physician at the Facility and the inmate did not occur.

⁴⁹ The process that is in place is supposed to include a referral from the primary care physician along with an order and a progress note, which are then sent to the CMS central office. The CMS central office reviews the referral and responds by either authorizing the referral or recommending another strategy. The authorization is returned to the facility for scheduling to take place with the outside provider, and the inmate ultimately should be taken to the appointment.

The Monitoring Team found that referrals are typically received by the CMS central office within one day, and that the CMS central office typically responds within one or two days. This is satisfactory. Thus, the front end of the process is functioning. The problem lies in the delay in making the telephone call to outside providers to schedule appointments.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team reviewed charts of patients for whom consultations had been ordered. The Monitoring Team found that all of the records reviewed had a timely referral to specialty care and went to the appointment within the required timeframe. The Monitoring Team found that in half of the records reviewed, physician follow-up did not occur.⁵⁰ The Monitoring Team also found that, in a couple of cases, the specialty referral was most likely not necessary, and the unnecessary referral resulted from an inadequate physician assessment.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The records of approximately ten patients were reviewed and the Monitoring Team found that, in most of the cases reviewed, the referral and specialty care appointment occurred on a timely basis. The Monitoring Team found, however, that follow-up with a patient after a specialty consultation did not occur on a consistent basis, and reports from specialty consultations were not appearing in the file in a timely fashion.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

The Monitoring Team recommends that the State take the following actions at Baylor and DCC: (i) draft and implement procedures to ensure timely scheduling of specialty

⁵⁰ None of the specialty referrals reviewed at HRYCI were of an urgent nature. The Monitoring Team observed that the tracking system used currently does not allow for reporting on urgent requests.

services; and (ii) draft and implement procedures to ensure tracking and timely receipt and follow-up of all reports.

The Monitoring Team recommends that the State take the following actions at HRYCI: (i) implement procedures that ensure timely appointments, reports, follow-up visits and responses to reports; and (ii) begin self-monitoring of timeliness of availability of appointments deemed urgent and organize by specialty.

The Monitoring Team recommends that the State take the following actions at SCI: (i) draft and implement procedures to ensure timely and appropriate specialty services, including follow-up; and (ii) begin self-monitoring of compliance with Delaware Department of Correction policy.

14. Treatment or Accommodation Plans

A. Relevant MOA Provision

Paragraph 14 of the MOA provides:

Inmates with special needs shall have special needs plans. For inmates with special needs who have been at the facility for thirty (30) days, this shall include appropriate discharge planning. The DOJ acknowledges that for sentenced inmates with special needs, such discharge planning shall be developed in relation to the anticipated date of release.⁵¹

A treatment plan for a special needs inmate should include, at a minimum:

- the frequency of follow-up for medical evaluation and adjustment of the treatment modality;
- the type and frequency of diagnostic testing and therapeutic regimens; and
- when appropriate, instructions about diet, exercise, adaptation to the correctional environment, and medication.

J-G-01; P-G-01. Further, each Facility should maintain a list of special needs inmates for tracking purposes. *Id.* With respect to discharge planning, in cases of a *planned* discharge, (i) the health staff of a Facility should arrange for a sufficient supply of current medications to last until the inmate can be seen by a community health care provider; and (ii) for inmates with

⁵¹ According to Section II.F. of the MOA, “inmates with special needs” are,

[I]nmates who are identified as suicidal, mentally ill, developmentally disabled, seriously or chronically ill, who are physically disabled, who have trouble performing activities of daily living, or who are a danger to themselves.

critical medical or mental health needs, arrangements or referrals should be made for follow-up services with community providers. J-E-13; P-E-13.

B. Baylor

1. Findings

The Monitoring Team found that most of the medical files reviewed for mental health treatment plans had treatment plans that included medication management, group therapy (although that was not occurring), and independent journaling as the components of treatment. In general, the treatment plans did not appear to be made specific enough to the needs of each individual inmate. The Monitoring Team concluded that this lack of specificity might reflect the absence of services beyond crisis, initial assessments, and well-being visits.

2. Assessment

The Monitoring Team did not assess Baylor's compliance with this provision of the MOA as it relates to treatment plans and discharge planning for inmate with non-mental health related special needs. The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA with respect to treatment plans and discharge planning for inmates with special needs due to serious mental illness.

C. DCC

1. Findings

The Monitoring Team found that there is one discharge group for the entire facility, and that every clinician is required to track those inmates leaving within 30 to 90 days. The Monitoring Team was told that the elements of discharge planning are supposed to follow a CMS form to make contact for outpatient appointments, assess housing needs, support, and pharmacy information.

Upon review, the Monitoring Team found that CMS will make appointments for inmates being discharged if the inmate identifies a community provider. The Monitoring Team found that financial entitlements were expedited on only two occasions by filling out Medicaid applications for inmates. The State is aware of the need to assist soon-to-be released inmates with these applications, and is working to improve the process.

The Monitoring Team also found that referrals for the Delaware Psychiatric Center are rarely necessary. When such referrals are necessary, however, a psychiatrist sees the inmate and refers the inmate for involuntary admission.

The Monitoring found that distribution of medication to inmates being discharged is problematic. The Monitoring Team learned from mental health staff leadership that inmates being discharged are supposed to receive a 30-day supply of medication, that the nursing staff is supposed to notify the booking area (*i.e.*, the area from which inmates are discharged from the

Facility) when the medication is ready, and that the inmate is to receive the medication supply in the booking area. The Monitoring Team learned from correctional officers that, in their experience, it is rare for any inmate to be released with a supply of medication, but that if an inmate notifies them that medication is necessary, the officers will contact the nursing staff for the medication. This information was later verified, which means that medication is very rarely provided to inmates upon release from the Facility.

2. Assessment

The Monitoring Team deferred assessing DCC's compliance with this provision of the MOA as it relates to inmates that are regarded as special needs for reasons other than serious mental illness because the State and the Monitoring Team were attempting to resolve differing interpretations of the appropriate standards to apply in monitoring this provision of the MOA. The State and the Monitoring Team were able to resolve the differing interpretations to determine that special accommodation plans should be placed on the problem list in an inmate's medical record, and that the special accommodation plan should include an inmate's diagnosis, the date of the initial diagnosis in the DOC, a description of what special needs the inmate has that cause the need for a special accommodation plan, the planned accommodation strategies, and discharge planning prior to the patient's release. Also, there should be an assessment of the effectiveness of the accommodation plan within 30 days of development of the initial plan, and then no less frequently than every 90 days thereafter, similar to the process that should be in place for the chronic care program. The Monitoring Team will monitor the State's compliance with these requirements during the next period. .

The Monitoring Team found that the State is in partial compliance with this provision of the MOA with respect to treatment and discharge plans for inmates whose serious mental illness qualifies them as special needs inmates.

D. HRYCI

1. Findings

The Monitoring Team found that discharge plans for inmates often lack individualization, and include little or no intervention relating to entitlements for inmates being released. Discharge plans do, however, usually involve the following items: (i) a 30-day supply of medication upon release; (ii) a timely appointment with a community health center near the inmate's home if the inmate has remained "substance free;" and (iii) if the inmate is incarcerated for more than two years, the inmate is transferred to a step-down facility within the DOC where CMS continues to care for the inmate.

2. Assessment

The Monitoring Team did not assess HRYCI's compliance with this provision of the MOA as it relates to treatment plans and discharge planning for inmates with non-mental health related special needs for the same reason as stated above with respect to DCC. The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA

with respect to treatment plans and discharge planning for inmates with special needs due to serious mental illness.

E. SCI

1. Findings

The Monitoring Team found that treatment plans are generated on each patient. In addition, in one chart, the Monitoring Team found an excellent discharge plan. SCI earned a partial compliance rating, however, because a rating of substantial compliance cannot be founded on only one record. The Monitoring Team is hopeful that it will encounter additional discharge plans of the caliber noted above upon its next visit to monitor this provision of the MOA.

2. Assessment

The Monitoring Team did not assess SCI's compliance with this provision of the MOA as it relates to treatment plans and discharge planning for inmate with non-mental health related special needs. The Monitoring Team found that SCI is in partial compliance with this provision of the MOA with respect to treatment plans and discharge planning for inmates with special needs due to serious mental illness.

F. Recommendation

The Monitoring Team recommends that the State take the following action at DCC:

- With detainees, discharge planning should be at the time of the initial visit. This gathering of information should be done by the counselor at time of assessment and treatment planning.
- A system needs to be developed and implemented re: financial entitlements such as Medicaid and social security benefits.
- A QI needs to address discharge planning issues, especially discharge medications.

15. Drug and Alcohol Withdrawal

A. Relevant MOA Provision

Paragraph 15 of the MOA provides:

The State shall develop and implement appropriate written policies, protocols, and practices, consistent with standards of appropriate medical care, to identify, monitor, and treat inmates at risk for, or who are experiencing, drug or alcohol withdrawal. The State shall implement

appropriate withdrawal and detoxification programs. Methadone maintenance programs shall be offered for pregnant inmates who were addicted to opiates and/or participating in a legitimate methadone maintenance program when they entered the Facilities.

This provision of the MOA requires that the State develop and implement appropriate written policies, protocols, and practices, consistent with standards of appropriate medical care, to identify, monitor, and treat inmates at risk for, or who are experiencing, drug and alcohol withdrawal. The State has developed an adequate policy with respect to drug and alcohol withdrawal. *See* State Policy G-06.

Further, established protocols regarding the treatment and observation of individuals manifesting symptoms of intoxication or withdrawal should be followed in order to complete successful implementation of the policies. J-G-06; P-G-06. Inmates experiencing severe, life-threatening intoxication (overdose) or withdrawal should be transferred immediately to a licensed acute care facility. *Id.* Individuals at risk for progression to more severe levels of intoxication withdrawal should be kept under constant observation by qualified health care professionals or health-trained correctional staff, and whenever severe withdrawal symptoms are observed, a physician should be consulted promptly. *Id.* If a pregnant inmate is admitted with a history of *opiate* use, a physician should be contacted so that the opiate dependence can be assessed and treated appropriately. *Id.* The facility should have a policy that addresses the management of inmates, including pregnant inmates, on methadone or other similar substances. Pregnant inmates entering the facility who were addicted to opiates and/or participating in a legitimate methadone maintenance program should be offered methadone maintenance programs.

B. Baylor

1. Findings

The Monitoring Team studied the treatment of the two inmates identified as undergoing alcohol withdrawal. One of the patients' charts had no evidence of nursing evaluation, even though there was an order for the withdrawal protocol. The second patient's chart was incomplete. The Monitoring Team found that the patient had gone to the hospital and was diagnosed with heroin and alcohol withdrawal. The chart was unclear as to how the patient got to the hospital. At the time the patient came to the facility, the patient presented with a history of pancreatitis, current abdominal pain, and nausea. Laboratory tests ordered for this urgent presentation were not done for seven days after the patient returned from the hospital.

2. Assessment

The Monitoring Team found that Baylor is not in compliance with this provision of the MOA.

C. DCC

The Monitoring Team did not assess DCC's compliance with this provision of the MOA because at the time the Monitoring Team visited the Facility to review this item, the Monitoring Team had not received drafts of specific clinical guidelines for alcohol and opiate withdrawal monitoring and treatment.

D. HRYCI

The Monitoring Team did not assess HRYCI's compliance with this provision of the MOA. The Monitoring Team did make some preliminary observations, however. The Monitoring Team observed that the withdrawal policy and procedures were performed by LPNs without much supervision, and a nurse was permitted to initiate the protocol without a physician conducting an initial evaluation. For one patient reviewed by the Monitoring Team, there were no notes by the LPN, which made it difficult to determine the status of the patient, and gave the appearance of unmonitored detoxification.

E. SCI

1. Findings

The Monitoring Team reviewed one record of a patient with withdrawal, and the record demonstrated multiple serious problems. The inmate experienced severe symptoms of alcohol withdrawal, did not receive appropriate withdrawal treatment, and was placed in restraints without following clinically appropriate procedures. The DOC expressly informed the Monitoring Team of this incident, acknowledged the deficiencies, and has been working to improve the issues highlighted by the incident.

2. Assessment

The Monitoring Team found that SCI is not in compliance with this provision of the MOA.

F. Recommendation

The Monitoring Team recommends that the State draft and implement the policies and procedures required by this provision of the MOA, and provide training on those policies and procedures.

16. Pregnant Inmates

A. Relevant MOA Provision

Paragraph 16 of the MOA provides:

[t]he State 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.”

According to NCCHC standards, pregnant inmates shall receive timely and appropriate prenatal care, specialized obstetrical services when indicated, and postpartum care. J-G-07. Appropriate prenatal care should include medical examinations, laboratory and diagnostic tests (including offering HIV testing and prophylaxis when indicated), and advice on appropriate levels of activity, safety precautions, and nutritional guidance and counseling. *Id.*

B. Baylor

1. Findings

In general, care of pregnant inmates is good. With regard to timeliness, the Monitoring Team found that in about 80% of cases reviewed, pregnant inmates were seen on a timely basis. Care of pregnant inmates is provided by a nurse practitioner who works for a local obstetrician, and therefore, can hold clinic only one day per week. Thus, if an inmate arrives at Baylor the day after clinic, she will not be seen until a week later.

The Monitoring Team observed several cases in which the prenatal care offered to pregnant inmates was not adequate. In a couple of cases, the pregnant inmate was not seen for 3 or 4 weeks, when pregnant inmates should be seen within a few days of arrival or sooner if clinically indicated. Also, most of the pregnant inmates received appropriate laboratory tests in a timely manner. The Monitoring Team found that pregnant inmates with high risk pregnancies have access to hospital care.

One problem noted by the Monitoring Team was that pregnant inmates nearing labor or post-partum are housed in a room in the infirmary that is not within sight or sound of the nursing staff, which is not an appropriate housing location. This problem could be remedied by placing a camera and some sort of call button in that room.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

3. Recommendation

The Monitoring Team recommends that the State create a plan to improve timeliness of intake pregnancy assessments and a long-term plan for housing females who are near labor or are post partum.

17. Communicable and Infectious Disease Management

A. Relevant MOA Provision

Paragraph 17 of the MOA provides:

The State shall adequately maintain statistical information regarding contagious disease screening programs and other

relevant statistical data necessary to adequately identify, treat, and control infectious diseases.

The NCCHC recommends that facilities with populations over 500 inmates should have a committee to oversee infection control practices. P-B-01. The infection control committee should consist of representation from the facility's administration, the responsible physician or designee, nursing and dental services, and other appropriate professional personnel involved in sanitation or disease control. *Id.* Further, facilities should follow a TB control plan that is consistent with current published guidelines from the Centers for Disease Control.

B. Baylor

1. Findings

At the time the Monitoring Team visited Baylor to monitor this provision of the MOA, the infection control nurse had been in that position for six months, and spent 80% of her time in infection control. The infection control nurse did not have any computer or internet access. The infection control nurse should undergo training in infection control so that appropriate information is tracked and reported on to the Quality Improvement Committee on a quarterly basis.

Formal processes for tracking important diseases such as TB and MRSA⁵² were not in place. Although TB skin test information is maintained in the intake log book, the information is not used to track prevalence data. In the future, TB data should include the total number of TB tests, the number of previously positive inmates, the number of new positives, the results of any follow-up chest films that are taken as the result of positive TB tests, and the numbers of TB positive inmates who start and complete prophylactic therapy. Further, all active cases should be tracked. All inmates who are skin test negative should have an annual skin test, and the number of tests performed and the conversions from prior negative results to positive results in a new test should be tracked. Any conversions from prior negative skin test to a positive skin test should be investigated. In addition, all employee TB skin test data should be tracked.

MRSA also should be tracked, and the tracked data should include the date and housing location. Baylor has a MRSA tracking book, but at the time of the Monitoring Team's visit, the MRSA book was missing or lost, and had been reconstructed recently with two months' worth of data. The tracking book did not contain any entries for October 2007, although there was a woman in the infirmary for an extended period of time. She had had a MRSA wound weeks prior that was not documented, and staff informed the Monitoring Team that they estimated seeing about one MRSA case per month.

Hepatitis C is tracked on a log if the positive inmate is going to remain incarcerated for more than 18 months. HIV results are obtained from the state laboratory and positive patients are maintained on a log. HIV patients are not reported consistently. The

⁵² "MRSA" is the commonly known term for methicillin-resistant *staphylococcus aureus*, which is a type of bacteria that is resistant to certain antibiotics.

infection control nurse was not reporting people whom she thought had been previously positive. All HIV patients new to the facility should be reported to the State, even if there is redundancy. Chlamydia and gonorrhea testing is done for all women who consent to a Pap smear. A list of positives are maintained but prevalence data is not maintained. Infection control rounds are not currently done. OSHA training is not recorded. Needle stick injuries are tracked by the Health Service Administrator.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

The Monitoring Team did not assess DCC's compliance with this provision of the MOA.

D. HRYCI

The Monitoring Team did not assess HRYCI's compliance with this provision of the MOA. At the time of the Monitoring Team's visit to HRYCI to monitor this provision, the policy regarding communicable and infectious disease tracking was being modified.

E. SCI

1. Findings

The Monitoring Team found that an infection control nurse has been assigned at SCI, but she is only able to devote five days per month to this work. The infection control nurse was not trained with regard to conducting appropriate infection control rounds, or how to collect and track data. SCI does not have an infection control report, and there are no infection control meetings. SCI does not maintain TB prevalence data. At the time of the Monitoring Team's visit, the infection control nurse reported that from a review of 383 inmates' medical records, none of these individuals tested had a positive TB test, and the last positive skin test for TB occurred several months prior to the Monitoring Team's visit. That report should be investigated further. In a high risk population such as in a correctional facility, it is highly unlikely that there are no positive TB tests. If the data presented by the nurse is accurate, then it signifies that there may be improper techniques being employed in implanting TB tests or reading the tests. SCI has a MRSA log, but it only tracks positive skin cultures. SCI tracks vaccinations, which assists in adequately preventing infectious diseases.

2. Assessment

The Monitoring Team found that SCI is not in compliance with this provision of the MOA.

F. Recommendation

The Monitoring Team recommends that the State take the following action at Baylor and SCI: (i) implement policies and procedures to ensure comprehensive automated reporting and tracking of common diseases is implemented and used to monitor and reduce liability; and (ii) submit infection control plan to the Monitor, including duties of the Infection Control Nurse, along with training to be provided for these duties.

18. Clinic Space and Equipment

A. Relevant MOA Provision

Paragraph 18 of the MOA provides:

The State shall ensure that all face-to-face nursing and physician examinations occur in settings that provide appropriate privacy and permit a proper clinical evaluation including an adequately-sized examination room that contains an examination table, an operable sink for hand-washing, adequate lighting, and adequate equipment, including an adequate microscope for diagnostic evaluations. The State shall submit a comprehensive action plan as described in Paragraph 65 of [the MOA] identifying the specific measures the State intends to take in order to bring the Facilities into compliance with this paragraph.

An adequately-sized examination room is one that is large enough to accommodate the necessary equipment, supplies, and fixtures, and to permit privacy during clinical encounters. J-D-03; P-D-03. Facilities should have, at a minimum, the following equipment, supplies, and materials for the examination and treatment of patients:

- hand-washing facilities or appropriate alternate means of hand sanitization;
- examination tables;
- a light capable of providing direct illumination;
- scales;
- thermometers;
- blood pressure monitoring equipment;
- stethoscope;
- ophthalmoscope;

- otoscope;
- transportation equipment (e.g. wheelchair, stretcher);
- trash containers for biohazardous materials and sharps; and
- equipment and supplies for pelvic examinations if female inmates are housed in the facility.

Id.

B. Baylor

1. Findings

Overall, the Monitoring Team found that space is inadequate at Baylor. The space in the infirmary is too narrow and small to allow for adequate space to support staff functions. For a discussion of how the lack of space impacts privacy of clinical encounters, see the discussion above in relation to provision 11 of the MOA.

With regard to the impact of the clinic space on clinical examination and available equipment, the Monitoring Team found that the spaces in the infirmary at Baylor are not well-organized, and the sanitation is poor.⁵³ For instance, in the examination room that appears to be an optometry room, there are exposed pipes and valves of some sort, and the room contained a cot and a toilet to be used by an inmate patient. The optometry equipment is broken, and when the optometrist needs to perform a retina evaluation, he must go to the physician room to use the ophthalmoscope.

The mental health staff sees patients in the dental office when the dentist is not working. The infirmary has a single room for mental health observation, which has a single solid shelf used as a bed. The Monitoring Team was informed that as many as four acute mental health patients were kept in this room at one time.

2. Assessment

The Monitoring Team found that Baylor is not in compliance with this provision of the MOA.

C. DCC

1. Findings

⁵³ Sanitation is a reflection both of disinfection and neatness. In order for the Monitoring Team to determine that a space is sanitary, records or schedules of disinfection being performed need to be available.

The Monitoring Team observed the clinic space, satellite clinic rooms, and the infirmary unit in order to assess this provision of the MOA at DCC. In the clinic and satellite clinic rooms, the Monitoring Team found that there was no functioning otoscope, which is used to examine the ears, eyes, nose, and throat. Further, there was no sanitation and infection control schedule to list the types and frequency of activities to maintain a clean and safe environment. As a result, these rooms were not uniformly clean or adequately equipped or supplied. As an example, the Monitoring Team found the segregation unit satellite medical clinic floors to be dirty.

The infirmary space is inadequate. The lack of space affects clinical care, privacy, sanitation and hygiene, medication management, and staff's ability to perform administrative functions. In addition, the Monitoring Team found that certain equipment is either broken or not readily available. Examples of the lack of space and lack of certain equipment are as follows:

- There is capacity for 44 beds in the infirmary unit. Of these 44 beds, 21 are dormitory style. This affects the privacy that can be afforded to inmates because it is virtually impossible not to have other inmates overhear and/or see clinical encounters. Also, due to the crowding of the infirmary cells, it is difficult for inmates using wheelchairs to maneuver in these spaces.
- At the time of the Monitoring Team's visit, there was a broken Hoyer lift in the infirmary unit.⁵⁴ The broken Hoyer lift is partially disassembled in the shower area, and the tub in the infirmary unit is not used in part because patients who would benefit from using a tub instead of a shower are too heavy and cannot be lifted into it.
- On one day that the Monitoring Team visited the infirmary unit at DCC, an ear examination could not be performed because there was not a functioning otophthalmoscope on the unit.
- Also during a Monitoring Team visit, the Monitoring Team found that because there is so little storage space, boxes of material and supplies are kept in scattered locations of the floor even when they should be stored on shelves. The store room was not orderly or clean.
- There is no ice machine, so a cooler is kept on the counter near the only sink in the infirmary unit, making it difficult to use the sink. It is also problematic that there is only one sink for this unit.
- The medication room is not large enough (about 40 square feet) given the number of drugs which are required to be kept in stock.

⁵⁴ A Hoyer lift is used to lift incapacitated patients off of beds and onto a transfer device so that nurses can move the patient to a shower and clean the bed.

- The staff work space is approximately 80 square feet and is used by clinical staff to write notes, review records, write consultations, make phone calls and perform other charting.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA. The Monitoring Team noted that the conditions at DCC are better than at the other facilities and assigned the partial compliance rating as a result. However, the conditions at DCC do not meet standards and the State has to demonstrate substantial improvement in order to obtain a substantial compliance rating.

D. HRYCI

1. Findings

The areas assessed were the HRYCI infirmary (including the TB isolation room), the chronic clinic room, the main clinic, and the East Side clinic. The Monitoring Team found that all of these spaces are inadequate in size to allow staff to deliver clinically appropriate care. Sanitation is still a problem, although improvement has been made.

Additionally, the air conditioning unit in the infirmary was not functioning properly, leading to temperatures around 100 degrees Fahrenheit at times. The TB isolation room does not deliver negative air pressure when the air conditioning is on. High temperatures in the chronic care room have led to the door being kept open. The door opens into the waiting room, and it being left open causes privacy concerns, as well as difficulty in providing services due to noise from the waiting room. Likewise, the inadequacy of the clinic size also causes privacy concerns as doors are kept open and guards stand in doorways when patients are being examined.

2. Assessment

The Monitoring Team found that HRYCI is not in compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team reviewed the intake screening area, the main clinic, and the infirmary. The intake screening area is adequate. The other areas do not allow staff to deliver clinically appropriate care.

The infirmary consists of several rooms along a common hall. One room has three beds in it. All types of patients are mixed in this single room. The Monitoring Team was

informed that, at times, a psychotic person might be housed with an acutely ill patient. The Monitoring Team also learned that the prior week, a person in alcohol withdrawal was in the room with an ill person, and correctional officers had to intervene to remove one of the patients on the basis of a security concern for the ill patient.

The Monitoring Team has several concerns about the lack of privacy provided in these treatment areas. Nurses perform sick call in an open area without privacy. Treatments are also performed in an open space. The infirmary consists of several rooms along a common hall. The office where the doctor sees patients has the only staff restroom. As a result, people walk through this office to use the restroom while the doctor is seeing patients. Finally, in the intake screening area, medical records are not locked up but instead are available to any person walking through the area.

The Monitoring Team has learned that the State has plans to remediate the problems with infirmary space at SCI, which will be executed in the coming year. This item will be the subject of further review by the Monitoring Team.

2. Assessment

The Monitoring Team found that SCI is not in compliance with this provision of the MOA.

F. Recommendation

The Monitoring Team recommends that the State take the following actions with respect to Baylor: create a plan to ensure that professional and appropriate space is used for assessments and that patients' housing and equipment needs are met.

The Monitoring Team recommends that the State take the following action with respect to the DCC: (i) create a plan to address clinic area deficiencies; and (ii) create a plan to address infirmary area deficiencies.

The Monitoring Team recommends that the State take the following action at SCI: Create a plan that addresses the issues cited in the Findings. This plan may include short-term and long-term strategies.

ACCESS TO CARE

19. Access to Medical and Mental Health Services

A. Relevant MOA Provision

Paragraph 19 of the MOA provides:

The State shall ensure that all inmates have adequate opportunity to request and receive medical and mental health care. Appropriate medical staff shall screen all written requests for medical and/or mental health care within twenty-four (24) hours of submission, and see patients within the next 72 hours, or sooner if medically appropriate. The State shall maintain sufficient security staff to ensure that inmates requiring treatment are escorted in a timely manner to treatment areas. The State shall develop and implement a sick call policy and procedure which includes an explanation of the order in which to schedule patients, a procedure for scheduling patients, where patients should be treated, the requirements for clinical evaluations, and the maintenance of a sick call log. Treatment of inmates in response to a sick call slip should occur in a clinical setting.

NCCHC standards generally recommend that inmates have access to care to meet their serious medical, dental, and mental health needs, and that unreasonable barriers to inmates' access to health services are to be avoided.⁵⁵ J-E-01; P-E-01. The MOA provides the requirements for the Facilities' sick call process, which is a large part of affording inmates access to care. The MOA requires that appropriate medical staff screen⁵⁶ all written requests for medical and/or mental health care within 24 hours of submission, and see patients within the next 72 hours, or sooner if medically appropriate. Further, the MOA sets forth the required elements of the State's policies and procedures relating to the sick call process. Those elements are: (i) an explanation of the order in which to schedule patients, (ii) a procedure for scheduling patients, (iii) where patients should be treated, (iv) the requirements for clinical evaluations; and (v) the maintenance of a sick call log. With respect to patient scheduling, not every sick call slip requires an appointment; however, when a sick call slip describes a clinical symptom, a face-to-face encounter between the inmate and a health professional is required. J-E-07; P-E-07. The

⁵⁵ "Access to care" means that in a timely manner, a patient can be seen by a clinician, be given a professional clinical judgment, and receive care that is ordered. J-E-01; P-E-01. The NCCHC provides the following examples of unreasonable barriers to inmate health care: (i) punishing inmates for seeking care for their serious health needs; (ii) assessing excessive co-pays; and (iii) deterring inmates from seeking care for their serious health needs, such as by holding sick call at 2:00 a.m., when the practice is not reasonably related to the needs of the institution. *Id.*

⁵⁶ The process of screening the written requests for medical or mental health care is referred to as "triage." The NCCHC defines "triage" as "the sorting and classifying of inmates' health requests to determine priority of need and the proper place for health care to be rendered." J-E-07; P-E-07.

sick call encounters should take place in a clinical setting (*i.e.*, an examination or treatment room appropriately supplied and equipped to address the patient's health care needs). *Id.*

B. Baylor

1. Findings

There is a lack of a sufficient number of clean, well-equipped and supplied examination rooms that afford privacy to detainees and inmates. This issue presents an unreasonable barrier to an inmate accessing care in that it compromises confidentiality.

The Monitoring Team also found that nurses do not consistently see patients within 72 hours of receiving their health service requests. In fact, sometimes patients are not seen at all.

2. Assessment

The Monitoring Team found that Baylor is not in compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that sick call slips were not being collected on a timely basis, and consequently, inmates were not receiving timely access to care. In order to come to this conclusion, the Monitoring Team reviewed sick call collection logs for September, 2007, which showed that sick call slips from certain housing units (S, E, V, T1 and T2) were not collected on 13 of 30 days. Also, sick call slips from other housing units (C, DW, DE, and W) were not collected on 18 of the 30 days. The Monitoring Team was unable to determine whether staff simply did not complete the collection log on those days that did not demonstrate sick call slip pickup, or whether the sick call slips in fact were not picked up on those dates. Staff informed the Monitoring Team that the problems with collection of sick call slips were the result of staff turnover in the employees assigned the task of picking up sick call slips.

It was difficult to assess the timeliness of care provided in response to sick call slips, as the Monitoring Team found that staff was not time stamping the sick call requests until they had been triaged (instead of the time of receipt), which could be several days after the initial receipt of the sick call request. Staff also are not consistently signing and dating the triaged sick call slips, often signing them with only the word "medical." Further, the Monitoring Team reviewed the sick call slips being reviewed at DCC on October 3, 2007. Those slips contained forms collected on October 1 and 2, and many of the slips were dated September 25, 26, and 27.

The process is supposed to include the sick call slips being collected in the evening and triaged the following morning.⁵⁷

The Monitoring Team found that there is an additional delay in inmates being seen by a nurse or clinician within 72 hours of receipt of the sick call slip. Following nursing triage, patients are not immediately placed on the schedule, but are put onto a list of “to be scheduled” inmates. This list appears to have become the practice because there are only so many time slots per day in the schedule, and if the number of patients to be scheduled exceeds the number of slots for the day, the inmate’s name is put on the next open date. As a result of this process, however, some inmates were not seen for five to twelve days after nurse triage, and often not seen at all.

In addition, in the records reviewed, the Monitoring Team found that the care being provided in response to sick call slips was not adequate. Specifically, the quality of the histories taken and physical examinations performed is poor, nursing diagnoses are not appropriate, and the plan of care for the patient is not adequate.

Seven of the eight records reviewed showed that the patient was not evaluated in a timely manner or at all. Additionally, nursing assessments were inadequate and physician referrals did not consistently occur. Finally, the appointment scheduling system was dysfunctional and contributed to further delays in access to care.

The Monitoring Team believes that the Assistant Director of Nurses, who had then been at the facility for only two weeks, was taking a proactive approach to attempt to correct the above-mentioned problems.

2. Assessment

The Monitoring Team found that DCC is not in compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team monitored the sick call process at HRYCI twice to monitor this provision of the MOA. During the first visit, the Monitoring Team found that, particularly on the west wing of HRYCI, sick call slips were not consistently picked up on a daily basis, meaning that timely access to care was not occurring. Further, the Monitoring Team found that sick call slips were not being maintained in one place, and some had not been addressed at all even though they extended back over several weeks.

⁵⁷ The Monitoring Team also observed that some of the sick call slips indicated that they were the third, fourth, or fifth request for the same issue.

The Monitoring Team then reviewed a limited sample of records of patients who had been seen by the nurse practitioner. The records revealed that the nurse practitioner needs closer supervision from the physician, as there were quality issues with each of the assessments reviewed. Specifically, in reviewing sick call requests, the Monitoring Team found abnormal vital signs that were not noticed or identified and also found inadequate physical assessments and inadequate history taking in some instances.

During the Monitoring Team's second visit to review the sick call process, the Monitoring Team found that significant improvements have been made to the sick call examination room. The room had been cleared out, and an examination table had been added. The Monitoring Team was able to determine that sick call slips were being picked up daily from Monday through Friday, but not on the weekends. Sick call slips should be picked up each day.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA because the State has taken measures that have resulted in some improvement to the sick call process at HRYCI.

E. SCI

1. Findings

The Monitoring Team found that nursing sick call assessments are being performed by LPNs, and a review of those assessments reflected an inconsistent understanding by the LPN's of how to use the assessment form. Although LPNs are permitted to collect data to assist with assessments, integrating the data and clinical decision-making should be left to RNs.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

At DCC, the Monitoring Team recommends that the State: (i) draft and implement procedures to ensure that daily collection of sick call slips is documented and patients with symptoms are seen in face-to-face assessments within one business day of paper triage; (ii) draft and implement procedures that ensure that patients with symptoms that appear urgent are seen within one shift of paper triage; (iii) the vendor should ensure that only RNs whose competency has been validated perform sick call assessments; (iv) the vendor should ensure that clinical performance review with feedback is provided timely and documented for all nurses performing assessments; and (v) create a plan in which positive screens result in a timely mental health assessment.

At HRYCI, the Monitoring Team recommends that the State: (i) implement a process that ensures seven days-per-week pick up of health services requests for all units, timely and appropriate triage of the requests and face-to-face assessments; and (ii) monitor its compliance with this policy. Also, the Monitoring Team recommends that the screening process needs to be further studied and revised so that only appropriate referrals are made and that all inmates referred are seen on a timely.

At SCI, the Monitoring Team recommends that the State: (i) implement a plan to utilize registered nurses to perform nursing assessments; and (ii) self-monitor for timeliness and appropriateness of the assessments.

20. Isolation Rounds

A. Relevant MOA Provision

Paragraph 20 of the MOA provides:

The State shall ensure that medical staff⁵⁸ make daily sick call rounds in the isolation areas, and that nursing staff⁵⁹ make rounds at least three times a week, to give inmates in isolation⁶⁰ adequate opportunities to contact and discuss health and mental health concerns with medical staff and mental health professionals⁶¹ in a setting that affords as much privacy as security will allow.

⁵⁸ According to the MOA, the term “medical staff” includes “medical professionals, nursing staff, and certified medical assistants.” *See* MOA II.I. The term “medical professionals” includes “a licensed physician, licensed physician’s assistant, or a licensed nurse practitioner provision services at a facility and currently licensed to the extent required by the State of Delaware to deliver those health services he or she has undertaken to provide” *See* MOA II.J.

⁵⁹ According to the MOA, “Nursing Staff” means “registered nurses, licensed practical nurses, and licensed vocational nurses providing services at a facility and currently licensed to the extent required by the State of Delaware to deliver those health services he or she has undertaken to provide.” *See* MOA II.M.

⁶⁰ According to the MOA, “isolation” means “the placement of an individual alone in a locked room or cell, except that it does not refer to adults single celled in general population.” *See* MOA II.G.

⁶¹ “Mental Health Professionals” means “an individual with a minimum of a master’s-level education and training in psychiatry, psychology, counseling, psychiatric social work, activity therapy, recreational therapy or psychiatric nursing, currently licensed to the extent required by the State of Delaware to deliver those mental health services he or she has undertaken to provide.” *See* MOA II.K.

The purpose of this MOA provision is to ensure that inmates placed in isolation maintain their medical and mental health while physically and socially isolated from the rest of the inmate population. J-E-09; P-E-09. The NCCHC recommends that, upon notification that an inmate is placed in segregation,⁶² a qualified health care professional reviews the inmate's health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation, and that such an evaluation should be placed in the inmate's medical record. *Id.*

The Monitoring Team has identified some confusion over the proper interpretation of this provision of the MOA. The NCCHC standard that appears to be applicable to this provision of the MOA also appears to apply in a limited sense to provision 39 of the MOA. According to the NCCHC, monitoring of inmates in segregation should be dictated by the inmate's degree of isolation. *Id.* Inmates under extreme isolation⁶³ with little or no contact with other individuals should be monitored daily by medical staff and at least once a week by mental health staff. *Id.* Inmates who are segregated and have limited contact with staff or other inmates are monitored three days a week by medical or mental health staff. *Id.* Inmates who are allowed periods of recreation or other routine social contact among themselves while being segregated from the general population should be checked weekly by medical or mental health staff. *Id.*

It appears that this provision of the MOA imposes requirements relating only to monitoring of inmates in isolation (as defined by the MOA; *see* above) by medical staff for medical and mental health issues, and provision 39 imposes requirements relating to monitoring of inmates in isolation by mental health staff. This MOA provision requires that medical staff make daily sick call rounds, and nursing staff make sick call rounds three times per week.

The sick call rounds performed pursuant to this provision of the MOA should ensure that each isolated inmate has the opportunity to request care for medical or mental health problems and allow staff to ascertain the inmate's general medical and mental health status. *Id.* The NCCHC standard recommends also that documentation of isolation rounds be made on individual logs or cell cards, or in an inmate's health record and include: (1) the date and time of the contact; and (2) the signature or initials of the health staff member making the rounds. *Id.* Finally, any significant health findings should be documented in the inmate's health record. *Id.*

B. Baylor

1. Findings

⁶² A "segregated" inmate is one who is isolated from the general population and who receives services and activities apart from other inmates. J-E-09; P-E-09. Such segregation could include administrative segregation, protective custody, disciplinary segregation, or a supermax tier. *Id.*

⁶³ "Extreme isolation" means "situations in which inmates are seen by staff or other inmates fewer than three times a day." J-E-09; P-E-09.

The Monitoring Team found that isolation rounds were done regularly by mental health staff and inmates can be transported to a private setting if detailed contact is clinically indicated.

2. Assessment

The Monitoring Team did not assess Baylor for compliance with this provision with regard to the provision of medical services. The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA as it relates to mental health services.

C. DCC

1. Findings

The Monitoring Team observed that isolation rounds are taking place in a timely and adequate manner.

2. Assessment

The Monitoring Team found that DCC is in substantial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that isolation rounds are conducted on a timely basis (three days a week), and the rounds take one-half to one hour. The Monitoring Team found that training of clinicians with respect to conducting rounds was inadequate.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that isolation rounds are occurring on a timely basis and are documented. The documentation revealed that the progress notes were identical in content regardless of the inmate seen and what day of the week the inmate was seen.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

At SCI, the Monitoring Team recommends that the State implement self-monitoring to ensure both timeliness and appropriateness of the assessments.

21. Grievances

A. Relevant MOA Provision

Paragraph 21 of the MOA provides:

The State shall develop and implement a system to ensure that medical grievances are processed and addressed in a timely manner. The State shall ensure that medical grievances and written responses thereto are included in inmates' files, and that grievances and their outcomes are logged, reviewed, and analyzed on a regular basis to identify systemic issues in need of redress. The State shall develop and implement a procedure for discovering and addressing all systemic problems raised through the grievance system.

This MOA provision requires the State to develop and implement a system to ensure that medical grievances are processed and addressed in a timely manner. This requirement is similar to the NCCHC standards, which recommend that there be a grievance mechanism to address inmates' complaints about health services. *See* J-A-11; P-A-11. The State has developed a grievance policy. *See* State Policy A-11. The Monitoring Team finds that this policy is adequate. Appropriate timeliness of processing and addressing grievances is not defined by the NCCHC standards or the State's policy.

The NCCHC also recommends that in addition to the formal grievance mechanism, institutions attempt to informally resolve inmates' complaints about health services. J-A-11; P-A-11. The informal dispute resolution can consist of a face-to-face interview by a Health Services Administrator, responsible physician, or nursing supervisor, and is often an effective way to resolve problems and demonstrate health staff's concern. *Id.* The State has informed the Monitoring Team that such an informal process has been put in place in at least one of the Facilities, with the face-to-face meetings occurring with the Health Services Administrator. The Monitoring Team looks forward to reviewing that process.

This provision of the MOA also requires that the State shall ensure that medical grievances and written responses thereto are included in inmates' files. For this requirement of the MOA, the requirements of provision 3 of the MOA also will apply with respect to timeliness and appropriateness of filing grievance information in inmates' medical records.

Finally, this provision of the MOA also requires that the State ensure that grievances and their outcomes are logged, reviewed, and analyzed on a regular basis to identify

systemic issues in need of redress, and to develop and implement a procedure for discovering and addressing all systemic problems raised through the grievance system. This requirement is most appropriately addressed in relation to provisions 54 and 55 of the MOA, which relate to the State's quality assurance efforts. *See* J-A-06; P-A-06 (NCCHC standards for continuous quality improvement programs).

B. Baylor

The Monitoring Team deferred assessment of Baylor's compliance with this provision of the MOA due to changes in the grievance policy that were taking place at the time of the Monitoring Team's visit. The Monitoring Team was informed that, although grievances are supposed to be entered through DACS and transferred to the health care unit from DACS, after May 2007 there was a period of a few months where this process did not occur. In September 2007, the health care staff received 48 grievances out of the DACS from custody, and since that time, the health care unit has made an effort to keep pace with the timelines required by the grievance policy, which policy was being modified at the time of the Monitoring Team's visit.

C. DCC

The Monitoring Team did not assess DCC's compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team did not assess HRYCI's compliance with this provision of the MOA. Although not assessed, the Monitoring Team had a lengthy discussion with the staff regarding a grievance program. During that discussion, the Monitoring Team encouraged the health care administration to develop an informal dispute resolution process that is consistent with the NCCHC recommendation discussed above. The Monitoring Team has learned that the State has adopted that recommendation. The Monitoring Team expects that the adoption of the information process will reduce the number of grievances filed.

The Monitoring Team was informed that when a grievance is filed, the case is reviewed by the health care staff on site. The Monitoring Team found that to be a reasonable process, and requested that a tracking process be set up to facilitate future reviews.

E. SCI

The Monitoring Team did not assess SCI's compliance with this provision of the MOA.

CHRONIC DISEASE CARE

22. Chronic Disease Management Program

A. Relevant MOA Provision

Paragraph 22 of the MOA provides:

The State shall develop and implement a written chronic care disease management program, consistent with generally accepted professional standards, which provides inmates suffering from chronic illnesses with appropriate diagnosis, treatment, monitoring, and continuity of care. As part of this program, the State shall maintain a registry of inmates with chronic diseases.

An adequate chronic disease⁶⁴ management program should identify patients with chronic diseases with the goal of decreasing the frequency and severity of symptoms, including preventing disease progression and fostering improvement in function. J-G-02; P-G-02. A chronic disease program should incorporate a treatment plan and regular clinic visits. *Id.* The clinician responsible should monitor the patient's progress during clinic visits and, when necessary, change the treatment. *Id.* The program should also include patient education for symptom management. *Id.*

B. Baylor

1. Findings

Three weeks prior to the Monitoring Team's visit, a chronic disease nurse had been assigned to manage the chronic disease program. As a result, the chronic disease management program had not yet been worked out fully. Timeliness of patient follow-up appointments needs some improvement, although the physician is very sensitive to having patients seen on a timely basis. The Monitoring Team found other instances in which the assessments of degree of control were not consistent with the NCCHC guidelines. In other instances, services such as immunizations, which are required by the guidelines, were not provided.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

⁶⁴ A "chronic disease" is defined as "an illness or condition that affects an individual's well-being for an extended interval, usually (at least) 6 months, and generally is not curable but can be managed to provide optimum functioning within any limitations the condition imposes on the individual. J-G-02; P-G-02. Examples of a chronic disease include asthma, diabetes, high blood cholesterol, HIV, hypertension, seizure disorder, and TB. *Id.* Each chronic disease has a separate set of clinical guidelines that apply to appropriate treatment and control of the disease.

C. DCC

1. Findings

The Monitoring Team found that the chronic care list is not completely entered into the new DACS system yet, which means that appointment scheduling might not be occurring properly. In addition, a review of records demonstrated missed appointments, which is a deficiency with regard to the standard of follow-up or continuity. With respect to the quality of the chronic care being provided, the Monitoring Team found that inmates' medical histories are not always complete, and the assessment of the level of control of an inmate's chronic illness was not consistently accurate.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that physician time is inadequate to see all of the patients at HRYCI with chronic illnesses. A nurse practitioner has been assigned to see all of the chronic disease patients from the East Wing of HRYCI. Complicated diseases should be managed by a physician. HRYCI just initiated its chronic disease program in March 2007, and the program needs additional time to develop. The Monitoring Team found that support services for the chronic disease program at HRYCI are deficient. Specifically, medical record, laboratory and scheduling functions do not serve the clinic well as of the time of the Monitoring Team's observations.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

A review of records revealed that although physical assessments were usually adequate, the quality of chronic care was not adequate. The Monitoring Team reviewed 20 records of patients with chronic illness. Many of the records reviewed reflected either that no history had been taken of the patient, or an inadequate history had been taken. Also, the assessments of the degree of control of the patients' chronic illnesses frequently were not consistent with clinical guidelines. The Monitoring Team also noted that the chronic care notes

in the inmates' health records often do not record instances when patients have significant problems requiring admission to the infirmary.

The Monitoring Team also found that patients with serious chronic diseases were not well managed. The Monitoring Team believes that this is related to physician performance. Specifically, the Monitoring Team found that, in certain cases, procedures which should have been done were not done, symptoms illustrating the worsening of an inmate's condition were sometimes ignored, and follow-up visits and further monitoring of patients was not always done on a timely basis, and in some cases was not done at all. In one case, the patients' status was noted in his chart as having improved even though the particular test which served as evidence for this assessment clearly indicated the contrary. The Monitoring Team spoke with the CMS State Medical Director, who agreed that physician performance is inadequate and an issue at SCI.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

At Baylor, the Monitoring Team recommends that the State: (i) draft and implement policies and procedures to ensure compliance with the chronic care program requirements; (ii) create a Physician/Chronic Care Nurse team that supports each other's activities; and (iii) begin self-monitoring for timeliness of process elements of the guidelines.

At HRYCI, the Monitoring Team recommends that the State: (i) fully implement the chronic care program; and (ii) begin self-monitoring of the implementation.

At SCI, the Monitoring Team recommends that the State: (i) assign a chronic care nurse to work with the physician and nurse practitioner to facilitate timeliness of follow-up and performance of process measures; (ii) the State's Medical Director is to mentor and review physician performance; (iii) implement self-monitoring of the chronic care program; and (iv) ensure linkage between acute episodes and chronic care monitoring and assessments.

23. Immunizations

A. Relevant MOA Provision

Paragraph 23 of the MOA provides:

The State shall make reasonable efforts to obtain immunization records for all juveniles⁶⁵ who are detained at the Facilities for more than one (1) month. The State shall ensure that medical staff update immunizations for

⁶⁵ The term "juveniles" means "individuals detained at a facility who are under the age of eighteen (18)." See MOA II.H.

such juveniles in accordance with nationally recognized guidelines and state school admission requirements. The physicians who determine that the vaccination of a juvenile or adult inmate is medically inappropriate shall properly record such determination in the inmate's medical record. The State shall develop policies and procedures to ensure that inmates for whom influenza, pneumonia and Hepatitis A and B vaccines are medically indicated are offered these vaccines.

This provision of the MOA requires that the State make reasonable efforts to obtain immunization records for all juveniles who are detained at the Facilities for more than one month. This requirement means that the State will need a system to track which juveniles have been detained for more than one month. Although there are no official guidelines available to determine what reasonable efforts would be under these circumstances, the Monitoring Team believes that reasonable efforts would consist of an attempt to acquire the juvenile's school records, and records from any health care providers in the community that have provided care to the juvenile that the State is able to identify after asking the juvenile. The MOA further requires that, for juveniles, the State ensure that medical staff update immunizations for such juveniles in accordance with nationally recognized guidelines and state school admission requirements. Those guidelines and admission requirements are attached hereto as Appendix III.

This provision of the MOA also requires that the State develop procedures to ensure that inmates for whom influenza, pneumonia and Hepatitis A and B vaccines are medically indicated are offered these vaccines. For example, influenza vaccine is recommended to be administered in adults aged 50 and older unless there is evidence of immunity or prior vaccination. See <http://www.cdc.gov/mmwr/pdf/wk/mm5641-Immunization.pdf>. Further, if a physician determines that vaccination of a juvenile or adult inmate is medically inappropriate, the physician shall properly record such determination in the inmate's medical record. An example of when a vaccination might be medically inappropriate is in the case of a pregnant female and a vaccination that has not been deemed safe for pregnant females to have.

B. Baylor

The Monitoring Team did not assess Baylor's compliance with this provision of the MOA.

C. DCC

The Monitoring Team did not assess DCC's compliance with this provision of the MOA.

D. HRYCI

The Monitoring Team did not assess HRYCI's compliance with this provision of the MOA.

E. SCI

The Monitoring Team did not assess SCI's compliance with this provision of the MOA. The Monitoring Team notes, however, that SCI does have a tracking system in place for immunizations.

MEDICATION

24. Medication Administration

A. Relevant MOA Provision

Paragraph 24 of the MOA provides:

The State shall ensure that all medications, including psychotropic medications, are prescribed appropriately and administered in a timely manner to adequately address the serious medical and mental health needs of inmates. The State shall ensure that inmates who are prescribed medications for chronic illnesses that are not used on a routine schedule, including inhalers for the treatment of asthma, have access to those medications as medically appropriate. The State shall develop and implement adequate policies and procedures for medication administration and adherence. The State shall ensure that the prescribing practitioner is notified if a patient misses a medication dose on three consecutive days, and shall document that notice. The State's formulary shall not unduly restrict medications. The State shall review its medication administration policies and procedures and make any appropriate revisions. The State shall ensure that medication administration records (“MARs”) are appropriately completed and maintained in each inmate’s medical record.

Medications are appropriately prescribed if they are prescribed upon the order of a physician, dentist, or other legally authorized individual, and only when clinically indicated. J-D-02; P-D-02. Administration of medications should be done in a manner that complies with federal and State of Delaware laws. J-D-01; P-D-01. The NCCHC recommends that institutions maintain a self-medication program (“keep-on-person”),⁶⁶ which permits inmates to carry medications necessary for the emergency management of a condition as appropriate. J-D-01; P-D-01.

This provision of the MOA further requires that the State develop and implement policies and procedures for medication administration and adherence. Also, the State shall review its medication administration policies and procedures and make any appropriate revisions. The Monitoring Team finds that the State has adopted appropriate policies. *See* State Policy D-02.

B. Baylor

1. Findings

The Monitoring Team observed the nursing staff at medication call (*i.e.*, when inmates come to a window to receive medication) and medication administration (*i.e.*, when the

⁶⁶ “Self-medication programs” are programs which “permit responsible inmates to carry and administer their own medications.” J-D-02; P-D-02.

nurses bring medication to inmates in their cells). The Monitoring Team observed that the nurses were not following standard nursing practices in administering medications. Specifically, the Monitoring Team observed that as inmates approached the window to receive medication, the LPN administering medications retrieved the medication blister-pack and punched out a pill into a cup, without comparing the MAR against the medication label on the blister-pack. The MAR should have the most current medication orders on it. If a medication was changed or discontinued, the nurse administering medications would not know this simply by administering medications from the blister-pack. Also, the nurse did not document administration of medications until the end of pill call.

The Monitoring Team also observed the evening shift nurse, and observed her pre-pouring medications into soufflé cups and writing the inmate's name on it without other necessary information such as the name and dosage of the medication. The nurse also signed that she had given the medication to an inmate in advance of medication administration. She had also saved approximately ten soufflé cups of medication for inmates who had not come to pill call to take their medications two days prior. She planned to use those medications to administer them that evening. This presents a risk of medication error.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

1. Findings

Overall, medication administration is challenging due to the size of DCC, the institutional schedule, the multiple locations for medication administration, and the number of staff allocated to perform this function. Due to the fact that there are just two nurses on each shift (sometimes a third for afternoon medication administration) responsible for administering medications, this process takes place almost 24 hours a day.

The Monitoring Team spoke with the Director of Nurses. The Director of Nurses informed them that the first medication administration round begins at 2:30 a.m. for pretrial detainees. Despite the institutional schedule, requiring patients to get up at 2:30 a.m. is not reasonable and reflects inadequate staff to carry out this mission on a more reasonable schedule. Moreover, because of the multiple times and locations of medication administration, the timing of medication administration is not documented properly in inmate's MARs.

The Monitoring Team observed a nurse preparing medications for administration, and noted that she failed to observe appropriate procedure. Specifically, the nurse did not use the MAR and compare it to the blister-pack at the time she prepared the medications. This may lead to medication errors if the order was changed and the new blister pack had not arrived. The MARs showed that nurses were generally consistent in documenting medication administration, but most had blank spaces where nurses did not document the medication administration status

(administered, refused, etc.) In addition, nurses do not consistently document the discontinuation of medication orders.

The Monitoring Team also found that MARs that document receipt of self-administered medications (antihypertensive, seizure medications, etc.) are not filed into inmate's medical record in a timely manner. For example, some MARs from March 2007 were still not filed in October 2007 when the Monitoring Team visited DCC. As a result, clinicians are not reliably able to assess medication continuity and compliance from review of the record.

The Monitoring Team found that DCC is not in compliance with this provision of the MOA as it relates to the medication administration of mental health medications. The Monitoring Team found that psychiatrists are not learning about patient non-compliance with medication regimens, which can result in decompensation of an inmate's mental health status without a psychiatrist learning about it. In addition, stock medications periodically run out, which results in a lapse in treatment.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team observed significant problems in the medication administration process. In addition, staff acknowledged to the Monitoring Team that there is a lack of compliance with the policy regarding notifying physicians about non-compliance with medication. The Monitoring Team also found that MARs are often not legible or timely filed. Finally, the Monitoring Team found that although staff had knowledge regarding policies for the timely renewal of expiring medications and informed consent, the Monitoring Team was unable to determine if staff actually puts these policies into practice.

2. Assessment

The Monitoring Team found that HRYCI is not in compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team observed that medication administration is not done according to acceptable nursing practices. For example, the nurses document on the MAR that medication is received before the patient has actually come to receive the medication. Thus, if

the patient does not come to receive medication, it is left to the memory of the nurse administering the medication to return to the MAR to mark that inmate as absent.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

At Baylor, the Monitoring Team recommends that the State: (i) draft and implement policies and procedures to ensure appropriate medication administration and documentation consistent with State nursing practices; and (ii) begin self-monitoring of these practices.

Under the circumstances described above, the Monitoring Team recommends that the State, DCC's institutional leadership, and CMS leadership reassess the system for medication administration at DCC. The end result should be policy and procedure and practice that administers medications to inmates at reasonable hours and predictable times; and accurately documents administration status on the medication administration record that is filed in the health record in a timely manner. Staffing, mechanisms of delivery and perhaps institutional schedules may require adjustment to accomplish this goal. Many correctional systems administer medications on an approximate schedule of 6 a.m., 12 noon, 4 p.m. and 8 p.m. Exceptions are made for insulin-dependent inmates or in cases where meals conflict with medication administration requirements (e.g., insulin administered prior to meals or medications that must be administered with or without meals). Regardless, medications should be administered within a one-hour window period of designated times. Nurses must prepare medications in accordance with standard nursing practice by comparing the current MAR against the medication blister pack, administering medications from legal containers (not handwritten envelopes), and documenting administration at the time the medication is given to the patient, not before or after.

Also at DCC, the Monitoring Team recommends that the State: (i) create a plan that achieves reliable medication administration within reasonable time frames and in a manner that addresses the health needs of all patients, including those with insulin-dependent diabetes, mental illness, or other special needs; (ii) create a plan which will provide a list of all psychotropic non-formulary requests approved in the last three months, and information regarding how long the process takes from initiation to administration of the first dose; and (iii) perform a study which documents the average time frame for ordering non-formulary medication to patient receipt of such medication.

At HRYCI, the Monitoring Team recommend that the State: (i) implement procedures that address the areas identified in the findings section above adequately; and (ii) monitor for compliance with its policies.

At SCI, the Monitoring Team recommends that the State: (i) redesign the process so that documentation of medication administration occurs at the time of administration; and (ii)

create a plan that includes custody participation in mouth checks at the time of medication administration.

25. Continuity of Medication

A. Relevant MOA Provision

Paragraph 25 of the MOA provides:

The State shall ensure that arriving inmates who report that they have been prescribed medications shall receive the same or comparable medication as soon as is reasonably possible, unless a medical professional determines such medication is inconsistent with generally accepted professional standards. If the inmate's reported medication is ordered discontinued or changed by a medical professional, a medical professional shall conduct a face-to-face evaluation of the inmate as medically appropriate.

This provision of the MOA is meant to ensure continuity of care from the entry of an inmate into a facility. J-E-12; P-E-12. Further, this provision can assist with preventing adverse patient outcomes, which are more likely to happen with respect to medication services practices when a provider frequently changes orders, the provider fails to review patient medication histories, or treating staff are unaware of each other's prescribing behaviors. J-D-02; P-D-02.

B. Baylor

1. Findings

The Monitoring Team found that, based upon a review of records and staff interviews, physician orders for medications are not consistently transcribed in a timely manner. Also, medications are not administered in a timely manner following order transcription. Additionally, the Monitoring Team found multiple instances where inmates who entered the facility indicated they were on certain medications. However, their records show that they did not start receiving their medication at the facility until one to two weeks after first entering.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

The Monitoring Team did not assess DCC's compliance with this provision of the MOA. The Monitoring Team found that MARs are not timely filed in inmate files, which inhibited the Monitoring Team's ability to monitor this provision of the MOA.

Also, bridge orders upon intake for psychotropic medications were often not initiated by medical staff. A bridge order is an order for medications the person took outside the facility that is usually verified by jail nursing staff and then issued by a physician until the person is scheduled to be seen by a psychiatrist on site. That way there is as little disruption in their care as possible. In general, medications should be ordered that are the same preparation the person took outside the facility and not altered until a psychiatrist actually evaluates the individual and in their clinical judgment changes in prescriptions are safe and equally effective as the prior medication.

D. HRYCI

The Monitoring Team did not assess HRYCI's compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found problems with chronic care patients and inmates receiving other services being able to receive medications in a timely fashion. This occurred with both formulary and non-formulary medications; thus, the problem does not arise solely from a delay in ordering non-formulary medications. Additionally, the Monitoring Team found multiple instances where inmates who entered the facility indicated they were on certain medications. However, their records show that they did not start receiving their medication at the facility until one to two weeks after first entering.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

At Baylor, the Monitoring Team recommends that the State: (i) implement policies and procedures to ensure timely receipt of medication from the time of order; (ii) begin self-monitoring of medication continuity for timeliness.

At DCC, the Monitoring Team recommends that the State: (i) draft and implement procedures to ensure timely filing of MAR documents; (ii) implement self-monitoring of nursing performance with regard to actual and documented medication administration; and (iii) implement a procedure to ensure intake-generated bridge orders resulting in timely medication receipt by patients.

At HRYCI, the Monitoring Team recommends that the State implement a procedure to ensure intake-generated bridge orders resulting in timely medication receipt by patients.

At SCI, the Monitoring Team recommends that the State: (i) implement procedures that mitigate medication discontinuity on entry to the facility; and (ii) implement a self-monitoring system.

26. Medication Management

A. Relevant MOA Provision

Paragraph 26 of the MOA provides:

The State shall develop and implement guidelines and controls regarding the access to, and storage of, medication as well as the safe and appropriate disposal of medication and medical waste.

The guidelines and controls developed by the State should include the following components:

- The Facility complies with all applicable state and federal regulations with regard to prescribing, dispensing, administering, and procuring pharmaceuticals;
- The facility maintains a formulary for providers;
- The facility maintains procedures for the timely procurement, dispensing, distribution, accounting, and disposal of pharmaceuticals;
- The facility maintains records as necessary to ensure adequate control of and accountability for all medications;
- The facility maintains maximum security storage of, and accountability by use for, Drug Enforcement Agency (DEA)-controlled substances;
- The facility has an adequate method for notifying the responsible practitioner of the impending expiration of a drug order, so that the practitioner can determine whether the drug administration is to be continued or altered;
- Medications are kept under the control of appropriate staff members;
- Inmates do not prepare, dispense, or administer medication except for self-medication programs approved by the facility administrator and responsible physician (e.g., “keep-on-person” programs). Inmates are permitted to carry medications necessary for the emergency management of a condition when ordered by a clinician;

- Drug storage and medication areas are devoid of outdated, discontinued, or recalled medications;
- Where there is no staff pharmacist, a consulting pharmacist is used for documented inspections and consultation on a regular basis, not less than quarterly;
- All medications are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Antiseptics, other medications for external use, and disinfectants are stored separately for internal and injectable medications. Medications requiring special storage for stability (e.g., medications that need refrigeration are so stored);
- An adequate and proper supply of antidotes and other emergency medications, and related information (including posting of the poison control telephone number in areas where overdoses or toxicologic emergencies are likely) are readily available to the staff.

J-D-01; P-D-01.

B. Baylor

1. Findings

At the time of the Monitoring Team's visit to Baylor to monitor this provision, policies related to medication administration and management had not yet been finalized. The Monitoring Team observed that medications were administered from a small, cramped room that has a window opening into the main hallway. The medications and syringes are not in a secure environment, as the medication cabinets are not locked, and one was even missing a door. There is also no system of accountability for needles and syringes.

In addition, there is no accountability system for stock medications. The nurses do not document on a form each time stock medications are given out. This causes a risk of diversion of medications.

Narcotics are kept in a locked cabinet. The Monitoring Team found that two out of five narcotic counts were not correct. The Monitoring Team found that nurses were not following proper procedure for signing out the narcotics at the time of administration. Specifically, the nurse was not signing out narcotics at the time of administration of the narcotics, and administered narcotics from a blister pack that had been dispensed for a specific inmate to any inmate that was supposed to be on that narcotic medication. These practices are inconsistent with appropriate nursing practices, and possibly State of Delaware laws. *See e.g., 16 Del. C. §§ 4701, et seq.* and accompanying regulations at *24 Del. Admin. Uniform Controlled*

Substance Act Regulations. Further, the documentation regarding administration of narcotics revealed serious errors.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that the medication room has adequate space, but it is somewhat cluttered, and organization needs to be improved. External and internal medications are not separated and labeled. A random sample of injectable medications revealed that two out of ten medications had expired. Finally, DCC lacks a reliable system for needle and syringe accountability.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team observed that the medication room at HRYCI is disorganized and has cabinets with broken locks. There is also a hole in the ceiling. HRYCI also lacks an adequate system for accountability of narcotics, needles and syringes. Staff is required to account for lancets for checking capillary blood glucose levels on diabetics. This should not be required and takes up too much of staff time.

Also, there is not an adequate system for accountability of narcotics. Narcotics prescribed for individual inmates were being used for stock supplies.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

The Monitoring Team did not assess SCI's compliance with this provision of the MOA.

F. Recommendation

At Baylor, the Monitoring Team recommends that the State: (i) create a plan that addresses issues enumerated in the Findings above; (ii) implement the above plan; and (iii) begin self-monitoring.

At DCC, the Monitoring Team recommends that the State draft and implement procedures that ensure a clean and well-organized medication room, as well as monitoring of medication expirations and sharps control.

At HRYCI, the State recommends that the State create a plan to ameliorate the problems found in the medication room, the sharps control, and controlled substance accountability.

EMERGENCY CARE

27. Access to Emergency Care

A. Relevant MOA Provision

Paragraph 27 of the MOA provides:

The State shall train medical, mental health and security staff to recognize and respond appropriately to medical and mental health emergencies. Furthermore, the State shall ensure that inmates with emergency medical or mental health needs receive timely and appropriate care, including prompt referrals and transports for outside care when medically necessary.

The NCCHC recommends that the provision of 24-hour emergency medical, mental health, and dental services. J-E-08; P-E-08. In order to ensure timely and appropriate emergency services, the NCCHC recommends that institutions have a written plan including arrangements for emergency transport of the patient from the facility, use of an emergency medical vehicle, use of one or more designated hospital emergency departments or other appropriate facilities, emergency on-call physician, mental health, and dental services when the emergency health care facility is not located nearby, security procedures for the immediate transfer of patients for emergency medical care, and notification to the person legally responsible for the facility. *Id.* Further, emergency drugs, supplies, and medical equipment are regularly maintained. *Id.*

B. Baylor

1. Findings

The Monitoring Team found that patients are sent to outside hospitals for emergencies on a timely basis. However, all laboratory testing is routine even when urgent laboratory testing is indicated. Urgent medical evaluations occasionally are not recorded especially for persons detoxifying from alcohol.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

1. Findings

DCC established an urgent care log in December 2007, which lists the names of patients who require urgent care, their medical problems, and the dispositions of their care (*i.e.* if they are sent to the hospital, etc.). As a result of the newness of the program, the Monitoring

Team was unable to pull records with regard to urgent problems. A review of the new DACS system did provide some records for the Monitoring Team to review, and one of three of those records revealed an issue regarding the follow-up care provided to that patient.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that the on-site emergency evaluations by nurses and physicians are not of good quality, but there are no impediments to patients being sent to local emergency rooms. The Monitoring Team noted that when patients return from emergency visits, no record accompanies the patient and follow-up is not good.

The Monitoring Team found that psychiatric emergencies are managed initially at the infirmary, with mental health staff reporting emergencies up the chain of command as appropriate. HRYCI refers cases that it cannot handle to the Delaware Psychiatric Center, but space is limited there, and the process of referring inmates to that facility is logistically burdensome. The Monitoring Team found that, on occasion, inmates with psychiatric emergencies are sent to a community emergency room.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA with regard to emergency evaluations by medical staff. The Monitoring Team found that HRYCI is in substantial compliance with this provision of the MOA with regard to emergency evaluations by mental health staff.

E. SCI

1. Findings

The Monitoring Team found that there did not appear to be any impediment to transportation of patients to the hospital once a referral was made, but that emergency evaluations on-site by nurses were not adequate. For example, one patient reviewed by the Monitoring Team had a history of a serious heart issue and had four episodes, each of which should have resulted in a cardiology consultation but instead was not evaluated. However, the Monitoring Team found that there did not appear to be any impediment to transportation of patients to the hospital once such transportation was ordered.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

The Monitoring Team recommends that the State create a plan to address the deficiencies described above.

28. First Responder Assistance

A. Relevant MOA Provision

Paragraph 28 of the MOA provides:

The State shall train all security staff to provide first responder assistance (including cardiopulmonary resuscitation (“CPR”) and addressing serious bleeding) in an emergency situation. The State shall provide all security staff with the necessary protective gear, including masks and gloves, to provide first line emergency response.

This provision of the MOA defines the complete standard for first responder assistance. For further information, see discussions of provisions 9, 32, and 52.

B. Baylor

The Monitoring Team did not assess Baylor’s compliance with this provision of the MOA.

C. DCC

The Monitoring Team did not assess DCC’s compliance with this provision of the MOA.

D. HRYCI

The Monitoring Team did not assess HRYCI’s compliance with this provision of the MOA.

E. SCI

The Monitoring Team did not assess SCI’s compliance with this provision of the MOA.

MENTAL HEALTH CARE

29. Treatment

A. Relevant MOA Provision

Paragraph 29 of the MOA provides:

The State shall ensure that qualified mental health professionals provide timely, adequate, and appropriate screening, assessment, evaluation, treatment and structured therapeutic activities to inmates requesting mental health services, inmates who become suicidal, and inmates who enter with serious mental health needs or develop serious mental health needs while incarcerated.

This provision of the MOA is an overall standard governing the timeliness and appropriateness of the following components of mental health care to be provided at the Facilities:

- mental health screening;
- assessment;
- evaluation;
- treatment; and
- structured therapeutic activities.

The NCCHC recommends that there be mental health services⁶⁷ available for all inmates who require them. The MOA, on the other hand, requires that mental health services be available to all inmates *requesting* them, inmates who become suicidal, and inmates who enter with serious mental health needs or develop serious mental health needs while incarcerated. J-G-04; P-G-04. The NCCHC standards state that mental health treatment is more than prescribing psychotropic medications; treatment goals include the development of self-understanding, self-improvement, and development of skills to cope with and overcome disabilities associated with various mental disorders. *Id.* The NCCHC provides that facilities housing significant numbers of patients with mental health problems with longer lengths of stay are expected to offer more extensive mental health programming. *Id.* Correctional facilities that provide for the needs of patients requiring psychiatric hospitalization levels of care are expected to mirror treatment provided in inpatient settings in the community. *Id.*

⁶⁷ “Mental health services” includes “the use of a variety of psychosocial and pharmacological therapies, either individual or group, including biological, psychological, and social, to alleviate symptoms, attain appropriate functions, and prevent relapse.”

B. Baylor

1. Findings

The Monitoring Team found that mental health staff responds rapidly to referrals from the intake area and sick call requests. There remains a paucity of ongoing mental health counseling throughout the facility, however.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

1. Findings

The problems identified by the Monitoring Team in relation to DCC's ability to comply with this provision of the MOA are detailed throughout this report and include: (i) inadequate clinic space and equipment; (ii) mental health staffing shortages, including psychiatric coverage; (iii) lack of depth in the treatment services being provided to inmates; (iv) significant medication management issues; (v) inadequate grievance system; and (vi) problematic mental health referral system. Finally, one other problem is an issue with respect to access to inpatient psychiatric hospitalization for inmates in need of such treatment due to lack of space at the Delaware Psychiatric Center.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The problems identified by the Monitoring Team in relation to HRYCI's ability to comply with this provision of the MOA are detailed throughout this report and include: (i) inadequate clinic space and equipment; (ii) mental health staffing shortages, including psychiatric coverage; (iii) lack of depth in the treatment services being provided to inmates; and (iv) significant medication management issues. Finally, one other problem is an issue with respect to access to inpatient psychiatric hospitalization for inmates in need of such treatment due to lack of space at the Delaware Psychiatric Center.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that SCI conducts receiving screening, assessments, and some group counseling. The Monitoring Team found that treatment consists primarily of medication administration, and consequently, almost all mental health notes and treatment plans solely address this issue. A few structured activities are offered by the mental health staff, but those consist of only three groups for a facility housing approximately 1,200 inmates. The group counseling that was offered at the time of the Monitoring Team's visit was inadequate given the size of SCI.

The Monitoring Team found that documentation continues to demonstrate a paucity of detail regarding the patient's historical data and descriptors of the current symptomatology.

The Monitoring Team also found that follow-up visits are not occurring on a timely basis after a new diagnosis is made or medication is prescribed and initiated. A timely follow-up would be within two to three weeks, but patients at SCI are being seen on a quarterly basis. Quarterly follow-up visits would be timely only in the case of a patient who is stable on an established regimen.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

The Monitoring Team recommends that the State create plans for each of the Facilities in order to address the problems identified in the findings above.

30. Psychiatrist Staffing

A. Relevant MOA Provision

Paragraph 30 of the MOA provides:

The State shall retain sufficient psychiatrists to enable the Facilities to address the serious mental health needs of all inmates with timely and appropriate mental health care consistent with generally accepted professional standards. This shall include retaining appropriately licensed and qualified psychiatrists for a sufficient number of hours per week to see

patients, prescribe and adequately monitor psychotropic medications, participate in the development of individualized treatment plans for inmates with serious mental health needs, review charts in the context of rendering appropriate mental health care, review and respond to the results of diagnostic and laboratory tests, and be familiar with and follow policies, procedures, and protocols. The psychiatrist shall collaborate with the chief psychologist in mental health services management as well as clinical treatment, shall communicate problems and resource needs to the Warden and chief psychologist, and shall have medically appropriate autonomy for clinical decisions at the facility. The psychiatrist shall supervise and oversee the treatment team.

This provision of the MOA does not differ significantly from the standards applicable to provision 6 of the MOA with respect to the requirement for sufficient psychiatrist staffing, and therefore, the Monitoring Team refers to the standards set forth with respect to that provision. *See J-C-07; P-C-07.*

B. Baylor

The Monitoring Team did not assess Baylor's compliance with this provision of the MOA. At the time of the Monitoring Team's visit, they were not able to meet with the staff psychiatrist in order to discuss her interactions with the mental health staff. The Monitoring Team has learned, however, that there are approximately 20 hours per week of psychiatry time for a case load of 104 women. The Monitoring Team has not had the opportunity to assess the adequacy of that time.

C. DCC

1. Findings

At the time of the Monitoring Team's visit, the total psychiatric allocation was 60 hours per week, divided among four physicians and housing units. All but one of the psychiatrists do not have set days of work. Based upon interviews with line staff, the unpredictability of the psychiatrists' time has resulted in a barrier to inmate access to the psychiatrist time. The Monitoring Team found that psychiatrist staffing at DCC is inadequate, especially given the unpredictable hours the psychiatrist is available.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that psychiatrist time is inadequate. At the time of the Monitoring Team's visit, there were 40 hours of psychiatrist time per week, which was divided between two psychiatrists who cover at least three days per week. The Monitoring Team believes that the psychiatrist allocation should be 1.5 ("FTE") with at least six days per week coverage, most of which should be provided during regular business hours.

With respect to the psychiatrists' participation in the development of individualized treatment plans, the Monitoring Team found that the treatment plans were developed at the time of the inmate meeting with the counselor and psychiatrist and all sign the treatment plan. Sometimes the treatment plan is developed without the psychiatrist, and therefore, is submitted to the psychiatrist to review at a later date.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that there are 24 hours of psychiatrist time divided among 220 inmates, most of whom are seen every 90 days. In a stable population that amount of time might be adequate, but given the mixed nature of the population at SCI (pretrial detainees and sentenced inmates), more psychiatrist time is warranted.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

At DCC, the Monitoring Team recommends that the State create a plan that ensures timely patient access to services at least six days per week.

At HRYCI, the Monitoring Team recommends that the State create a plan that allows for more psychiatric involvement in the program, especially during normal work hours. Most likely 1.5 FTE psychiatrists divided over six days would be sufficient.

At SCI, the Monitoring Team recommends that, given the additional visits which will be required if a more aggressive schedule of follow-up is implemented post treatment initiation, the State should create a plan to adjust the number of psychiatric hours per week.

31. Administration of Mental Health Medications

A. Relevant MOA Provision

Paragraph 31 of the MOA provides:

The State shall develop and implement policies, procedures, and practices consistent with generally accepted professional standards to ensure that psychotropic medications are prescribed, distributed, and monitored properly and safely and consistent with generally accepted professional standards. The State shall ensure that all psychotropic medications are administered by qualified medical professionals or other health care personnel qualified under Delaware state law to administer medications, who consistently implement adequate policies and procedures to monitor for adverse reactions and potential side effects and to adequately document the administration of such medications in the MARs. Documentation in the MARs shall include a clear and consistent indication of whether the inmate refused or otherwise missed any doses of medication, as well as doses consumed. As part of the quality assurance program set forth in Section V of this Agreement, a qualified medical professional or registered nurse supervisor shall review MARs on a regular and periodic basis to determine whether policies and procedures are being followed.

The MOA provides that the State shall develop and implement policies, procedures, and practices consistent with generally accepted professional standards to ensure that psychotropic medications are prescribed, distributed, and monitored properly and safely and consistent with generally accepted professional standards. The State has developed policies consistent with generally accepted professional standards and the requirements of the MOA. *See* Policy D-02.

The State shall ensure that all psychotropic medications are administered by qualified medical professionals or other health care personnel qualified under Delaware state law to administer medications, who consistently implement adequate policies and procedures to monitor for adverse reactions and potential side effects and to adequately document the administration of such medications in the MARs. According to the MOA, adequate documentation in the MARs shall include a clear and consistent indication of whether the inmate refused or otherwise missed any doses of medications, as well as doses consumed. These standards have been addressed with respect to provisions 24 and 25 of the MOA.

The MOA also requires that the State have a qualified medical professional or registered nurse supervisor review MARs on a regular and periodic basis to determine whether policies and procedures are being followed. This can take place as a part of the CQI process. *See* discussion of paragraph 54.

B. Baylor

1. Findings

Almost all medications are administered at the pharmacy window. The Monitoring Team observed that psychotropic medications are being initiated at unduly high initial doses and without early review of the response to treatment. In addition, internal audits from September 2007 show only a 57% compliance rate with medication orders being obtained within 24 hours of intake medication verification, and 53% receiving their first dose within 24 hours following a physician's order.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team bases this assessment on the same findings that are discussed with reference to paragraphs 2, 24, 25, and 54 of the MOA.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team bases this assessment on the same findings that are discussed with reference to paragraphs 2, 24, 25, and 54 of the MOA.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

The Monitoring Team did not assess SCI's compliance with this provision of the MOA.

F. Recommendation

The Monitoring Team recommends that, at Baylor, the State change the practice to ensure that initial dosing is appropriate and is monitored timely during the initial period to facilitate patient adherence.

32. Mental Illness Training

A. Relevant MOA Provision

Paragraph 32 of the MOA provides:

The State shall conduct initial and periodic training for all security staff on how to recognize symptoms of mental illness and respond appropriately. Such training shall be conducted by a qualified mental health professional, registered psychiatric nurse, or other appropriately trained and qualified individual, and shall include instruction on how to recognize and respond to mental health emergencies.

This provision of the MOA does not differ significantly from provision 9 of the MOA, and therefore, the Monitoring Team refers to the standards set forth with respect to that provision. Also, the Monitoring Team notes that correctional officers should be trained at least every two years with respect to recognizing signs and symptoms of mental illness. J-C-04; P-C-04.

B. Baylor

1. Findings

See discussion of paragraph 9.

2. Assessment

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

C. DCC

1. Findings

See discussion of paragraph 9.

2. Assessment

The Monitoring Team found that DCC is in substantial compliance with this provision of the MOA.

D. HRYCI

1. Findings

See discussion of paragraph 9.

2. Assessment

The Monitoring Team found that HRYCI is in substantial compliance with this provision of the MOA.

E. SCI

1. Findings

See discussion of paragraph 9.

2. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

33. Mental Health Screening

A. Relevant MOA Provision

Paragraph 33 of the MOA provides:

The State shall develop and implement adequate policies, procedures, and practices consistent with generally accepted correctional mental health care standards to ensure that all inmates receive an adequate initial mental health screening by appropriately trained staff within twenty-four (24) hours after intake. Such screening shall include an individual private (consistent with security limitations) interview of each incoming inmate, including whether the inmate has a history of mental illness, is currently receiving or has received psychotropic medications, has attempted suicide, or has suicidal propensities. Documentation of the screening shall be maintained in the appropriate medical record. Inmates who have been on psychotropic medications prior to intake will be assessed by a psychiatrist as to the need to continue those medications, in a timely manner, no later than 7-10 days after intake or sooner if clinically appropriate. These inmates shall remain on previously prescribed psychotropic medications pending psychiatrist assessment. Incoming inmates who are in need of emergency mental health services shall receive such care immediately after intake. Incoming inmates who require resumption of psychotropic medications shall be seen by a psychiatrist as soon as clinically appropriate.

The NCCHC recommends that individuals conducting the receiving screening (*see* discussion of provision 10 of the MOA) make adequate efforts to explore the potential for

suicide. J-E-02; P-E-02. Both reviewing with an inmate any history of suicidal behavior and visually observing the inmate's behavior (delusions, hallucinations, communication difficulties, speech and posture, impaired level of consciousness, disorganization, memory defects, depression, or evidence of self-mutilation) should be done at the screening. *Id.*

Within 24 hours after the intake screening takes place, the initial mental health screening should take place and include a structured interview with inquiries into:

- a history of:
 - psychiatric hospitalization and outpatient treatment;
 - suicidal behavior;
 - violent behavior;
 - victimization;
 - special education placement;
 - cerebral trauma or seizures, and
 - sex offenses; and
- the current status of:
 - psychotropic medications;
 - suicidal ideation;
 - drug or alcohol use, and
 - orientation to person, place, and time;
- emotional response to incarceration; and
- a screening for intellectual functions (i.e., mental retardation, developmental disability, learning disability).

J-E-05; P-E-05. The NCCHC further recommends that the inmate's health record contains results of the initial screening. *Id.*

B. Baylor

1. Findings

The Monitoring Team found that mental health screenings were complete and appropriate referrals were made to mental health.

2. Assessment

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that appropriate policies are in place, but the implementation has been problematic as described in other portions of this report.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that appropriate policies are in place at HRYCI, but their implementation has been problematic as described in other sections of this report.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team measured the timeliness of the psychiatric review by measuring the time against the referral by the mental health staff. The Monitoring Team found that mental health screenings are consistently completed in a timely fashion, and mental health referrals are reliably generated through DACS.

2. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

F. Recommendation

The Monitoring Team recommends that the State implement a procedure to ensure timely and appropriate screening and follow-up, including for bridge medications. *See also* recommendation for MOA ¶ 10.

34. Mental Health Assessment and Referral

A. Relevant MOA Provision

Paragraph 34 of the MOA provides:

The State shall develop and implement adequate policies, procedures, and practices consistent with generally accepted professional standards to ensure timely and appropriate mental health assessments by qualified mental health professionals for those inmates whose mental health histories, or whose responses to initial screening questions, indicate a need for such an assessment. Such assessments shall occur within seventy-two (72) hours of the inmate's mental health screening or the identification of the need for such assessment, whichever is later. The State shall also ensure that inmates have access to a confidential self-referral system by which they may request mental health care without revealing the substance of their request to security staff. Written requests for mental health services shall be forwarded to a qualified mental health professional and timely evaluated by him or her. The State 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.

Any inmates with positive screenings for mental health problems should be referred to qualified mental health professionals for further evaluation. J-G-04; P-G-04. The health record should contain the results of the evaluations with documentation of referral or initiation of treatment when indicated. *Id.* Patients with needs that require acute mental health services beyond those available at the facility are transferred to an appropriate facility. *Id.*

B. Baylor

1. Findings

The Monitoring Team found that inmates were seen quickly and assessed by the mental health staff. Specifically, eleven out of eleven charts reviewed demonstrated rapid and appropriate referrals to mental health services. Further, the inmates interviewed in a pretrial unit by the Monitoring Team denied having difficulty accessing mental health services. One of the charts demonstrated that at least one new intake should have been referred to mental health upon screening in July 2007.

In addition, the Monitoring Team found one case in which an older woman was referred to mental health from intake, but refused further assessment. The Monitoring Team believes that follow-up in that case could have been better. Despite noting that the woman was "mildly MR," and would not listen or understand, no follow-up was scheduled. Four days later, nursing staff made another referral to mental health for the woman after she urinated on the floor. The record does not reflect any follow-up from mental health until four days later. The notes from that follow-up reflect that the inmate was cooperative, but no history was taken. The Monitoring Team interacted with the woman and believed that further assessment should have been done, and asked for such assessments to be done. The Monitoring Team believes that the woman should have been placed on the mental health caseload and referred for psychiatric

evaluation. One isolated instance, such as is recounted here, is not sufficient to prevent the State from earning the substantial compliance assessment noted below. *See* MOA ¶ 61.

2. Assessment

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that the inmate self-referral program was problematic. This was evidenced by a recent suspension of a mental health clinician assigned to maximum security housing units who had not been responding to self-referrals from August 2007 to December 2007.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

At the time of the Monitoring Team's visit, the Monitoring Team found that sick call slips for mental health care were being processed timely, reaching the appropriate mental health staff, and triaged on a timely basis. In the past, this function had not been completed reliably.

The process that was in place for responding in a timely fashion to mental health referrals at the time of the Monitoring Team's visit was that a clerk would print out the referrals from DACS Monday through Friday, and there were individuals assigned to performing that task on Saturdays and Sundays. Thus, referrals are being printed seven days a week.

The process that was in place for responding in a timely fashion to sick call slips was that they were picked up every morning by nursing staff. This was an improvement from prior visits by the Monitoring Team, which revealed that sick call slips were not picked up reliably. The mental health sick call slips were separated and placed in a wall bin assigned for mental health sick call slips. The next morning, mental health staff would pick up these sick call slips. Thus, the timeliness of mental health sick call has improved.

Both the referrals and sick call slips are alphabetized, entered in the sick call and referral log, assigned to the appropriate mental health clinician by housing area, and placed into the mental health clinicians' mailboxes, to be seen within 24 hours. On weekends, all sick calls

and referrals are assigned to the mental health staff providing coverage, regardless of housing area.

The mental health staff is initialing and dating the entries in the sick call and referral log when inmates have been seen. All mental health contacts, including psychiatry visits, are entered into DACS by the mental health clerk.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that mental health staff provides rapid evaluations on cases referred to them once the referral is received. The Monitoring Team found that there was a learning curve with the new DACS, in that SCI had some difficulty with accessing the appropriate DACS-generated report in order to be aware of all of the referrals coming through the system, but with education, it appears that this issue has been resolved.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

At DCC, the Monitoring Team recommends that the State: (i) implement a procedure to ensure timely and appropriate responses to all referrals, including patient generated referrals; and (ii) monitor this process with regard to timeliness and appropriateness of the responses.

The Monitoring Team recommends that the State begin self-monitoring the timeliness and appropriateness of Mental Health assessments and referrals at SCI.

35. Mental Health Treatment Plans

A. Relevant MOA Provision

Paragraph 35 of the MOA provides:

The State shall ensure that a qualified mental health professional prepares in a timely manner and regularly updates an individual mental health treatment plan for each inmate who requires mental health services. The

State shall also ensure that the plan is timely and consistently implemented. Implementation of and any changes to the plan shall be documented in the inmate's medical/mental health record.

A mental health treatment plan should include, at a minimum, a description of: (i) the frequency of follow-up for medical evaluation and adjustment of treatment modality; (ii) the type and frequency of diagnostic testing and therapeutic regimens; and (iii) when appropriate, instructions about diet, exercise, adaptation to the correctional environment, and medication. J-G-01; P-G-01. Further, the plans should include ways to address the patients' problems and enhance their strengths, involve patients in their development, and include relapse prevention risk management strategies, which should describe signs and symptoms associated with relapse or recurring difficulties, how the patient thinks that a relapse can be averted, and how best to help him or her manage crises that occur. *Id.*

B. Baylor

1. Findings

The Monitoring Team found that the treatment plans are completed, but they lack specificity for individual inmates.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that treatment plans were completed in all charts reviewed, but were not useful in that they lacked measurable goals and objectives. Most of the plans reviewed by the Monitoring Team cluster all mental health problems together, and list the outcomes as an increase in reports of mental health symptoms rather than how and to what extent symptoms will be reduced. In addition, rather than a progress update being included every 90 days, the plan is completely rewritten every 90 days. An update rather than a re-write would be more helpful in tracking the inmate's progress. Finally, the treatment plans indicate that the treatment the inmate receives is likely not individualized.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that in some cases, treatment plans were not present in inmates' files. In addition, the treatment plans reviewed were particularly weak from the perspective of planned interventions, and often lacked individualization. Inmate interviews revealed that their meetings with the mental health clinicians were brief welfare checks in contrast to counseling sessions.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that, in the charts reviewed, treatment plans were located which had a patient signature and 90-day updates. The Monitoring Team found that the treatment plans focused on the medications that the inmate receives but do not address psychosocial needs or include programming alternatives.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

At Baylor, the Monitoring Team recommends that the State implement training so that treatment plans include more patient-specific components.

At DCC, the Monitoring Team recommends that the State create a redesigned treatment plan program that addresses the issues raised in the findings section for that Facility.

At HRYCI, the Monitoring Team recommends that the State create a plan that results in more individualized treatment plans, and enhanced quality of counseling sessions.

At SCI, the Monitoring Team recommends that the State implement training of staff regarding a comprehensive approach to treatment plans.

36. Crisis Services

A. Relevant MOA Provision

Paragraph 36 of the MOA provides:

The State shall ensure an adequate array of crisis services to appropriately manage psychiatric emergencies. Crisis services shall not be limited to administrative/disciplinary isolation or observation status. Inmates shall have access to appropriate in-patient psychiatric care when clinically appropriate.

An adequate array of crisis services should include not only observation beds, but also some form of a crisis intervention specialist or team.

B. Baylor

The Monitoring Team did not assess Baylor's compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that the inadequate psychiatric staffing has resulted in significant coverage and treatment issues within the infirmary. *See* discussion of provision 30 of the MOA. Those problems are exacerbated by a lack of adequate space in the infirmary.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The problems that the Monitoring Team found were that crisis care services in the infirmary lack adequate office space for meeting with inmates in an office setting for adequate sound privacy. Based on the Monitoring Team's observations, initial crisis assessments are taking place in an area that does not afford sufficient privacy.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

The Monitoring Team did not assess SCI's compliance with this provision of the MOA.

F. Recommendation

At DCC, the Monitoring Team recommends that the State create a plan that addresses the issues described in the above findings.

At HRYCI, the Monitoring Team recommends that the State create a plan that ensures a professional appropriate environment for mental health assessments, including the ability to discuss confidential information.

37. Treatment for Seriously Mentally Ill Inmates

A. Relevant MOA Provision

Paragraph 37 of the MOA provides:

The State 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 staff to provide treatment, and an adequate array of therapeutic programming. The State shall ensure that inmates who are being treated with psychotropic medications are seen regularly by a physician to monitor responses and potential reactions to those medications, in accordance with generally accepted correctional mental health care standards.

This provision of the MOA will assist the State with providing continuity of mental health care, and provides a complete general standard against which to assess the State's compliance with this provision of the MOA, or the standards are discussed with regard to other provisions of the MOA (*see, e.g.*, discussions of provisions 6, 18, 24, 25, 31 and 33 of the MOA). To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Findings

Seriously mentally ill inmates are being seen on a monthly basis by the mental health staff, and have regularly scheduled psychiatric appointments. At the time of the Monitoring Team's visit, therapeutic group programming in the Harbor House unit was in disarray for the seriously mentally ill inmates. The State has informed the Monitoring Team that remedial actions with respect to Harbor House have been taken. Unfortunately, some psychiatric visits have been taking place every 90 days, which is a frequency not responsive to the needs of the patient. In addition, medication side effects, laboratory monitoring, and dosing regimens are problematic as mentioned above. The most recent psychiatrist's practices are an improvement over previous providers and the Monitoring Team is optimistic positive changes will be instituted by the time of the next audit.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that there is a problem with a lack of adequate therapeutic group programming for the seriously mentally ill inmates. Further, the individualized treatment plans are not adequate in form or in function, and should be completed with the inmate's input, not presented as a completed document for signature.

The special needs units are comprised of two housing units, with a maximum capacity of 49 inmates per unit. At the time of the Monitoring Team's visit, both units were under capacity.

The Monitoring Team interviewed inmates and two day-shift correctional officers in one of the units. The inmates told the Monitoring Team that the correctional officers point and laugh at them, which intensifies their sense of paranoia. Both of the officers interviewed had not completed the four-hour mental health training, but, based on the inmate reports, the correctional officers later received additional training.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team refers to the findings discussed in reference to paragraph 29 of the MOA.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that mental health staff sees inmates every 30 days for well-being checks, and in response to sick call requests, but ongoing programming services

are limited. The Monitoring Team further found that patients receiving medication are not being monitored adequately for adverse reactions or negative side effects.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

At Baylor, the Monitoring Team recommends that the State create a plan to address the issues raised in the findings.

At DCC, the Monitoring Team recommends that the State create a plan that addresses the findings raised above in regard to individualized treatment plans, an elimination of program lapses, standing hours of service, including the patient in treatment plan in design, and stabilizing correctional officer staffing where seriously mentally ill patients are housed.

At HYRCI, the Monitoring Team recommends that the State create a plan to address the issues addressed in the findings above, regarding housing and management of patients in the programs for serious mental illness.

At SCI, the Monitoring Team recommends that the State (i) implement clinical protocols consistent with community standards regarding monitoring of specific psychotropic medications; (ii) implement self-monitoring of clinical monitoring.

38. Review of Disciplinary Charges for Mental Illness Symptoms

A. Relevant MOA Provision

Paragraph 38 of the MOA provides:

The State shall ensure that disciplinary charges against inmates with serious mental illness who are placed in Isolation are reviewed by a qualified mental health professional to determine the extent to which the charge may have been related to serious mental illness, and to determine whether an inmate's serious mental illness should be considered by the State as a mitigating factor when punishment is imposed on inmates with a serious mental illness.

This provision of the MOA will assist the State with providing continuity of mental health care, and provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

The Monitoring Team did not assess Baylor's compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that mental health staff did not have any formal input into the disciplinary process; the only input that occurs, happens when a correctional officer comes to them to receive a verbal report. At the time of the Monitoring Team's visit, the State was in the process of developing a policy relevant to this requirement.

2. Assessment

The Monitoring Team found that DCC is not in compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that hearing officers receive input verbally from the mental health supervisor concerning mentally ill inmates in isolation. The mental health clinician does not always see the incident report or interview the inmate. At the time of the Monitoring Team's visit, the State was in the process of developing a policy relevant to this requirement.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that medical and mental health staff could complete an incident report at the time of an occurrence, but the Monitoring Team was unable to determine if mental health staff's input is solicited if they fail to submit a report on their own.

As discussed above, the Monitoring Team was informed of an inmate incident in which mental health staff were not given the opportunity to provide adequate input to the disciplinary process.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

At DCC, the Monitoring Team recommends that the State develop and implement a policy and procedure that includes the following elements: (i) the criteria that triggers a mental health assessment/input relevant to the disciplinary process; (ii) the question(s) to be addressed by the mental health assessment; (iii) the nature of the assessment (e.g., interview, review of incident reports, etc.); (iv) how the mental health input is to be utilized by the hearing officer, and (v) how the mental health input process will be assessed relevant to its impact.

At HYRCI, the Monitoring Team recommends that the State develop and implement a policy and procedure that includes the following elements: (i) the criteria that triggers a mental health assessment/input relevant to the disciplinary process; (ii) the question(s) to be addressed by the mental health assessment; (iii) the nature of the assessment (e.g., interview, review of incident reports, etc.); (iv) how the mental health input is to be utilized by the hearing officer, and (v) how the mental health input process will be assessed relevant to its impact.

At SCI, the Monitoring Team recommends that the State create a plan that facilitates Mental Health input regarding disciplinary incidents for patients on the Mental Health caseload.

39. Procedures for Mentally Ill Inmates in Isolation or Observation Status

A. Relevant MOA Provision

Paragraph 39 of the MOA provides:

The State shall implement policies, procedures, and practices consistent with generally accepted professional standards to ensure that all mentally ill inmates on the facility's mental health caseload and who are housed in Isolation receive timely and appropriate treatment, including completion and documentation of regular rounds in the Isolation units at least once per week by qualified mental health professionals in order to assess the serious mental health needs of those inmates. Inmates with serious mental illness who are placed in Isolation shall be evaluated by a qualified mental health professional within twenty-four [sic] hours and regularly thereafter to determine the inmate's mental health status, which shall include an assessment of the potential effect of the Isolation on the inmate's mental health. During these regular evaluations, the State shall evaluate whether continued Isolation is appropriate for that inmate, considering the assessment of the qualified mental health professional, or whether the inmate would be appropriate for graduated alternatives. The State shall adequately document all admissions to, and discharges from, Isolation, including a review of treatment by a psychiatrist. The State shall provide

adequate facilities for observation, with no more than two inmates per room.

This provision of the MOA makes clear that those inmates already on the mental health caseload must receive appropriate and timely treatment, regardless of their status as being in isolation. This means that these inmates must have adequate access to mental health care. *See* J-E-07; P-E-07. According to this MOA language, this treatment includes, but is not limited to, weekly rounds in the isolation units. *See* discussion of provision 20 above.

B. Baylor

1. Findings

At the time of the Monitoring Team's visit, there were no inmates in isolation, but the Monitoring Team was able to observe segregation rounds, which occur according to appropriate standards.

2. Assessment

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that, pursuant to the requirements contained in paragraph 20 of the MOA, mental health rounds are taking place three days per week in the segregation units (*i.e.*, that houses administrative, disciplinary and protective custody inmates).

The Monitoring Team found that there is not a process in place to notify mental health staff of newly admitted inmates to isolation within 24 hours of their admission. Additionally, mental health staff do not evaluate such inmates within 24 hours to determine the inmate's mental health status, which should include an assessment of the potential effect of the isolation on the inmate's mental health.

Based on review of the isolation progress notes form present in segregated inmates' health records, as well as direct observation of rounds, the Monitoring Team found that the initial evaluation (regardless of the time frame of such an evaluation) does not appear to be any different than the welfare check performed during the mental health rounds process. It is the Monitoring Team's belief that the initial assessment should minimally include a brief suicide risk assessment that should be performed out of cell in an office setting unless the inmate refuses to participate in such a setting. Regarding the provision that the "State shall adequately document all admissions to, and discharges from Isolation [our interpretation—the infirmary], including a review of treatment by a psychiatrist. The State shall provide adequate facilities for observation,

with no more than two inmates per room,” there is partial compliance. Problems relevant to physical plant issues and lack of daily presence of a psychiatrist onsite remain.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that, pursuant to the requirements contained in paragraph 20 of the MOA, mental health rounds are taking place three days per week in the segregation units (*i.e.*, that houses administrative, disciplinary and protective custody inmates). The rounds assignments are rotated among all staff rather than assigning one or two clinicians to this duty for three to six month rotations, which can affect the continuity of care provided to these inmates. These rounds were reported to take one-half hour to an hour.

The Monitoring Team found that HRYCI did not have a process in place to ensure that mental health staff is notified within 24 hours of their admission to isolation. Additionally, mental health staff does not evaluate such inmates within 24 hours to determine the inmate’s mental health status, which shall include an assessment of the potential effect of the isolation on the inmate’s mental health.

The Monitoring Team found that, upon a review of progress notes in inmate’s medical records and direct observation, the initial evaluation amounted to a welfare check that was no different than that performed by mental health staff during regular rounds. The evaluation should include, at a minimum, a brief suicide risk assessment performed out-of-cell in an office setting, unless the inmate refuses to participate in such a setting.

The Monitoring Team found that HRYCI has problems relevant to physical plant issues and the lack of the daily presence of a psychiatrist on-site.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that segregation rounds are occurring three times per week, but that the progress notes related to these rounds were identical regardless of the inmate seen and what day of the week they were seen. These notes revealed an inadequacy in the

rounds. Also, the Monitoring Team reviewed one inmate who appeared to be mentally ill and had been seen on three occasions by two different mental health counselors (once by one mental health counselor and twice by another mental health counselor). The progress notes for this inmate ranged from an assessment of a completely normal mental status exam to an assessment that demonstrated significant psychopathology.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

3. Recommendation

At DCC, the Monitoring Team recommends that the State create a plan that facilitates mental health input into the disciplinary process.

At HYRCI, the Monitoring Team recommends that the State and the DOJ clarify the provision.

At SCI, the Monitoring Team recommends that the State begin monitoring its compliance with the applicable policies and procedures.

40. Mental Health Services Logs and Documentation

A. Relevant MOA Provision

Paragraph 40 of the MOA provides:

The State shall ensure that the State maintains 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(s) 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.

This provision of the MOA will assist the State with providing continuity of mental health care, and provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Findings

The Monitoring Team observed that Baylor maintains a computerized chronic care list in compliance with this provision of the MOA.

2. Assessment

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that all of the elements required by the MOA are contained in a spreadsheet.

2. Assessment

The Monitoring Team found that DCC is in substantial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that the tracking spreadsheet at HRYCI generally contains the dosages of medication prescribed. In addition, the State has implemented a new DACS, which was expanded from the original version to include healthcare-related information. The Monitoring Team found that the spreadsheet should be revised to include the date of the inmate's next scheduled appointment.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that a current and comprehensive database is maintained by the mental health staff at SCI, but based upon a chart review, in spite of that database, some inmates were missed.

2. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

F. Recommendation

At HRYCI, the Monitoring Team recommends that the spreadsheet used by the facility be revised to include the inmate's next scheduled appointment.

At SCI, the Monitoring Team recommends that the facility implement self-monitoring for completeness of Mental Health Services tracking.

SUICIDE PREVENTION

41. Suicide Prevention Policy

A. Relevant MOA Provision

Paragraph 41 of the MOA provides:

The State shall review and, to the extent necessary, revise its suicide prevention policy to ensure that it includes the following provisions: 1) training; 2) intake screening/assessment; 3) communication; 4) housing; 5) observation; 6) intervention; and 7) mortality and morbidity review.

The MOA provides the complete standard against which the State is to be assessed for this provision of the MOA. The required substance of the required policy is, in large part, set forth in the MOA provisions and standards applying to each of the categories enumerated in this provision of the MOA.

The Monitoring Team found that the State is in substantial compliance with this provision of the MOA, because it has an adequate suicide prevention policy in place. The Monitoring Team notes that this provision of the MOA does not relate to the implementation of the suicide prevention policy; this provision requires only that the State review and revise its policy. Therefore, this rating of substantial compliance should not be construed as assessing the State in substantial compliance with the implementation of its suicide prevention policy.

42. Suicide Prevention Training Curriculum

A. Relevant MOA Provision

Paragraph 42 of the MOA provides:

The State shall review and, to the extent necessary, revise its suicide prevention training curriculum, which shall include the following topics: 1) the suicide prevention policy as revised consistent with this Agreement; 2) why facility environments may contribute to suicidal behavior; 3) potential predisposing factors to suicide; 4) high risk suicide periods; 5) warning signs and symptoms of suicidal behavior; 6) case studies of recent suicides and serious suicide attempts; 7) mock demonstrations regarding the proper response to a suicide attempt; and 8) the proper use of emergency equipment.

The MOA provides the complete standard against which the State is to be assessed for this provision of the MOA. The required substance of the training curriculum is, in large part, set forth in the MOA provisions and standards applying to each of the categories enumerated in this provision of the MOA.

The Monitoring Team found that the State is in substantial compliance with this provision of the MOA, because it has an adequate suicide prevention training curriculum. The

Monitoring Team notes that this provision of the MOA requires the State to review and revise its suicide prevention training curriculum, and does not relate to conducting the training. Thus, the Monitoring Team's assessment of substantial compliance is limited only to an assessment that the State has reviewed and revised its suicide prevention training curriculum.

43. Staff Training

A. Relevant MOA Provision

Paragraph 43 of the MOA provides:

Within twelve months of the effective date of this Agreement, the State shall ensure that all existing and newly hired correctional, medical, and mental health staff receive an initial eight-hour training on suicide prevention curriculum described above. Following completion of the initial training, the State shall ensure that a minimum of two hours of refresher training on the curriculum are completed by all correctional care, medical, and mental health staff each year.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

The Monitoring Team did not assess Baylor's compliance with this provision of the MOA. At the time of the Monitoring Team's visit to Baylor to assess this provision of the MOA, the policies were pending.

C. DCC

1. Findings

While the Monitoring Team found that all correctional and mental health staff had received the initial training pursuant to the MOA, the Monitoring Team was unable to verify if the medical staff had completed this training.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that some of the medical staff had not yet received the training required by this provision of the MOA. The Monitoring Team found that correctional staff and mental health staff had been trained as required by the MOA.

2. Assessment

The Monitoring Team found that HRYCI was in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that more than half of the mental health staff had completed the required training. Specifically, five of the seven mental health clinicians at SCI have completed training and two new hires are waiting to be scheduled. The Monitoring Team did not receive data on other medical staff.

2. Assessment

The Monitoring Team found that SCI was in partial compliance with this provision of the MOA.

44. Intake Screening/Assessment

A. Relevant MOA Provision

Paragraph 44 of the MOA provides:

The State shall develop and implement policies and procedures pertaining to intake screening in order to identify newly arrived inmates who may be at risk for suicide. The screening process shall include inquiry regarding: 1) past suicidal ideation and/or attempts; 2) current ideation, threat, plan; 3) prior mental health treatment/hospitalization; 4) recent significant loss (job, relationship, death of family member/close friend, etc.); 5) history of suicidal behavior by family member/close friend; 6) suicide risk during prior confinement in a state facility; and 7) arresting/transporting officer(s) belief that the inmate is currently at risk.

The requirement for intake screening and assessment to include these factors is discussed above, with regard to provision 33 of the MOA.

B. Baylor

1. Findings

The Monitoring Team found that initial screens are completed in a timely fashion and an internal audit from September 2007 indicates 100% compliance.

2. Assessment

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

C. DCC

1. Findings

A review of records found that the intakes have been occurring pursuant to the State's policy.

2. Assessment

The Monitoring Team found that DCC is in substantial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team reviewed audits relevant to this provision of the MOA, which were consistent with compliance although the size of the sampling was not adequate.

2. Assessment

The Monitoring Team found that HRYCI is in substantial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that all of the initial screens reviewed were complete and included questions regarding suicide risk with elaboration when a positive response was recorded, and those inmates were referred to mental health.

2. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

45. Mental Health Records

A. Relevant MOA Provision

Paragraph 45 of the MOA provides:

Upon admission, the State shall immediately request all pertinent mental health records regarding the inmate's prior hospitalization, court-ordered evaluations, medication, and other treatment. DOJ acknowledges that the State's ability to obtain such records depends on the inmate's consent to the release of such records.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Findings

Upon review of health records, the Monitoring Team did not find any community mental health records. It is not known whether the lack of community health records is due to lack of requests or lack of responses to requests.

2. Assessment

The Monitoring Team found that Baylor is not in compliance with this provision of the MOA.

C. DCC

1. Findings

The Monitoring Team found that DCC requests that inmates complete the release of information form during the intake process that takes place upon their arrival at a Facility, and then the request form is sent. The clerk that is assigned to mental health functions will attempt to send the release three times by facsimile to any outpatient provider identified by the inmate. The response rate to the requests for information has been poor, but the reason for this poor response rate has not been analyzed to determine if the form of request is inhibiting a response to the request.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that HRYCI follows the same process as DCC with the same results.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

Upon a review of health records, the Monitoring Team could find only one instance in which there was documentation of a request for prior records.

2. Assessment

The Monitoring Team found that SCI is not in compliance with this provision of the MOA.

F. Recommendation

At Baylor, the Monitoring Team recommends that the State implement procedures to ensure timely request and tracking of community records.

At SCI, the Monitoring Team recommends that the State: (i) implement a procedure to ensure prior mental health records are requested upon admission to the Department of Correction; and (ii) implement self-monitoring of this procedure. The Monitoring Team recommends that the State create a plan that addresses the more timely receipt of information from outside providers.

46. Identification of Inmates at Risk of Suicide

A. Relevant MOA Provision

Paragraph 46 of the MOA provides:

Inmates at risk for suicide shall be placed on suicide precautions until they can be assessed by qualified mental health personnel. Inmates at risk of suicide include those who are actively suicidal, either threatening or engaging in self-injurious behavior; inmates who are not actively suicidal, but express suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or have a recent prior history of self-destructive behavior; and inmates who deny suicidal ideation or do not

threaten suicide, but demonstrate other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury.

The MOA requires that the State place any inmate at risk for suicide⁶⁸ on suicide precautions until they can be assessed by qualified mental health personnel. Suicide precautions refer to the housing and observation requirements set forth in paragraphs 49 through 51 below. The State has developed a policy that suicide precautions will consist of placing the inmate under constant observation by correctional staff in a safe cell while an order for placement on psychiatric observation is obtained from the appropriate medical or mental health personnel. G-05. The Monitoring Team finds that this policy conforms to generally accepted professional standards. *See* J-G-05; P-G-05. As set forth in paragraph 47 below, the assessment by qualified mental health personnel should be performed within 24 hours of the initiation of suicide precautions.

B. Baylor

1. Findings

The Monitoring Team found that inmates are readily placed on watch if staff determines that they are at risk of self-injury.

2. Assessment

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

C. DCC

1. Findings

Specifically, the Monitoring Team found that, during its visit in September 2007, DCC had problems implementing the daily monitoring by a mental health professional and the one-day follow-up after discharge. The Monitoring Team noted significant improvement with these problems during the December 2007 visit.

2. Assessment

⁶⁸ The MOA defines an “inmate at risk for suicide” as one who is (i) actively suicidal by threatening or engaging in self-injurious behavior; (ii) not actively suicidal, but expresses suicidal ideation; and/or has a recent prior history of self-destructive behavior; and (iii) who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior indicating the potential for self-injury.

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that the records of patients who had been placed on suicide watch demonstrated that the State complied with the requirements above.

2. Assessment

The Monitoring Team found that HRYCI is in substantial compliance with this provision of the MOA.

E. SCI

1. Findings

Inmates at risk of suicide are rapidly assessed and moved to psychiatric observation, and SCI follows the State's policies.

2. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

F. Recommendation

At DCC, the Monitoring Team recommends that the State closely monitor this area via the QI process.

47. Suicide Risk Assessment

A. Relevant MOA Provision

Paragraph 47 of the MOA provides:

The State shall ensure that a formalized suicide risk assessment by a qualified mental health professional is performed within an appropriate time not to exceed 24 hours of the initiation of suicide precautions. The assessment of suicide risk by qualified mental health professionals shall include, but not be limited to, the following: description of the antecedent events and precipitating factors; suicidal indicators; mental status examination; previous psychiatric and suicide risk history, level of lethality; current medication and diagnosis; and recommendations/

treatment plan. Findings from the assessment shall be documented on both the assessment form and health care record.

This provision of the MOA requires a formalized suicide risk assessment to be performed by a qualified mental health professional⁶⁹ within an appropriate period of time, which, in any event, is not to exceed 24 hours of the initiation of suicide precautions as described above in relation to paragraph 46 of the MOA. The formalized suicide risk assessment should designate the individual's level of suicide risk, level of supervision needed, and the need for transfer to an inpatient mental health facility or program. J-G-05; P-G-05. In addition, the MOA provides that the assessment of the individual's level of suicide risk should include at least: (i) a 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/treatment plan.

B. Baylor

The Monitoring Team deferred assessing Baylor's compliance with this provision of the MOA because they were not able to find any relevant cases.

C. DCC

The Monitoring Team deferred assessing DCC's compliance with this provision of the MOA due to a lack of time. The Monitoring Team did observe, however, that the initial evaluation form being used by the State for the purposes of the suicide risk assessment should be modified to include current medication and diagnosis, so that the form will require that all information required by the MOA to be recorded will be recorded.

D. HRYCI

The Monitoring Team has the same comments regarding HRYCI as with DCC.

E. SCI

1. Findings

The Monitoring Team found that assessments are reliably and informatively completed on all inmates placed on psychiatric observation and meet the time frames established by the MOA.

2. Assessment

⁶⁹ The State has developed a policy that a mental health staff (*i.e.*, an employee with a masters degree or greater level of certification) is qualified for the purposes of initiating an order for psychiatric observation, but that only a psychologist with a Ph.D., or a psychiatrist may discharge or downgrade an inmate's level of risk while on psychiatric observation. *See* State Policy G-05. The Monitoring Team found that policy to be adequate.

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

F. Recommendation

At HRYCI, the Monitoring Team recommends that the State create a plan that addresses the privacy issues and improvement in the psychiatric observation, initial evaluation forms as described in the findings.

48. Communication

A. Relevant MOA Provision

Paragraph 48 of the MOA provides:

The State shall ensure that any staff member who places an inmate on suicide precautions shall document the initiation of the precautions, level of observation, housing location, and conditions of the precautions. The State shall develop and implement policies and procedures to ensure that the documentation described above is provided to mental health staff and that in-person contact is made with mental health staff to alert them of the placement of an inmate on suicide precautions. The State shall ensure that mental health staff thoroughly review an inmate's health care record for documentation of any prior suicidal behavior. The State shall promulgate a policy requiring mental health to utilize progress notes to document each interaction and/or assessment of a suicidal inmate. The decision to upgrade, downgrade, discharge, or maintain an inmate on suicide precautions shall be fully justified in each progress note. An inmate shall not be downgraded or discharged from suicide precautions until the responsible mental health staff has thoroughly reviewed the inmate's health care record, as well as conferred with correctional personnel regarding the inmate's stability. Multidisciplinary case management team meetings (to include facility officials and available medical and mental health personnel) shall occur on a weekly basis to discuss the status of inmates on suicide precautions.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

The Monitoring Team deferred assessing Baylor's compliance with this provision of the MOA because no relevant cases were found.

C. DCC

1. Findings

The Monitoring Team found that the multidisciplinary team meetings are taking place on a weekly basis, and at the meeting observed by the Monitoring Team, there was very good multidisciplinary discussion generated that centered essentially on current status and management plans for many difficult mental caseload inmates. The psychiatrist was not present at that meeting, which means that vital input might be missed.

2. Assessment

The Monitoring Team found that DCC is in substantial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that the multidisciplinary team meetings have not been occurring regularly on a formal basis. The Monitoring Team did note, however, that regular discussions regarding inmates on suicide precautions take place via security briefings that have included both security personnel and mental health staff. The psychiatrist does not attend the meetings, which means that vital input might be missed.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team observed that all inmates on suicide precautions have individualized forms posted on their observation cell door specifying the level of watch and to what property they have access.

2. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

F. Recommendation

At HRYCI, the Monitoring Team recommends that the State implement a multidisciplinary case management team consistent with the requirements of this paragraph.

49. Housing

A. Relevant MOA Provision

Paragraph 49 of the MOA provides:

The State shall ensure that all inmates placed on suicide precautions are housed in suicide-resistant cells (*i.e.*, cells without protrusions that would enable inmates to hang themselves). The location of the cells shall provide full visibility to staff. At the time of placement on suicide precautions, medical or mental health staff shall write orders setting forth the conditions of the observation, including but not limited to allowable clothing, property, and utensils, and orders addressing continuation of privileges, such as showers, telephone, visiting, recreation, etc., commensurate with the inmate's security level. Removal of an inmate's prison jumpsuit (excluding belts and shoelaces) and the use of any restraints shall be avoided whenever possible, and used only as a last resort when the inmate is engaging in self-destructive behavior. The Parties recognize that security and mental health staff are working towards the common goal of protecting inmates from self-injury and from harm inflicted by other inmates. Such orders must therefore take into account all relevant security concerns, which can include issues relating to the commingling of certain prison populations and the smuggling of contraband. Mental health staff shall give due consideration to such factors when setting forth the conditions of the observation, and any disputes over the privileges that are appropriate shall be resolved by the Warden or his or her designee. Scheduled court hearings shall not be cancelled because an inmate is on suicide precautions.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings. The State has developed a policy that addresses these issues with more specificity. *See* State Policy G-05. The State's policy classifies differing levels of suicide risk as Levels I through III.

B. Baylor

1. Findings

The Monitoring Team found that the infirmary at Baylor has enough space to accommodate three inmates on suicide precautions. If there is a need for more space, the inmates are housed in a clean cell on the isolation wing with one-to-one observation.

The Monitoring Team found that inmates' housing while on suicide precaution is not specifically tailored to a given inmate's suicide precaution level. The Monitoring Team found that all inmates are allowed access to the same items, regardless of their suicide precaution level. Each inmate receives a Ferguson blanket, gown, and finger foods. None of the inmates on suicide precautions receive a mattress unless medically indicated.

2. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

C. DCC

1. Findings

One problem that the Monitoring Team observed is that there are 10 suicide-resistant cells, but one of these cells has a "toilet," which essentially is a hole in the ground. Such a toilet is not clinically appropriate and is dehumanizing. The Monitoring Team observed that DCC is providing shred-resistant mattresses, which allows inmates on suicide precautions to have a mattress, without presenting an unreasonable risk of allowing that inmate to injure himself.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found the State provides shred resistant mattresses, suicide-resistant blankets, and Ferguson gowns. The Monitoring Team found that two of the cells used for suicide precautions had the same type of toilet as described above with regard to DCC. Inmates are allowed to attend court hearings.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that all inmates on observation levels I and II (as defined by State policy) are housed in the infirmary in clean cells, and inmates on observation level III are housed either in the infirmary if space is available, or in another area. The property that each inmates is allowed is listed on the forms specifying the inmate's watch level. Inmates are consistently given safety gowns and blankets, and maintained on a 15-minute watch. The Monitoring Team found that the watch logs are completed and filed in the inmate's health records. The Monitoring Team did not find any omissions. Therefore, the Monitoring Team found that the appropriate housing conditions for an inmate on suicide precaution are documented and carried out appropriately.

2. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

F. Recommendation

At DCC and HRYCI, the Monitoring Team recommends that the State develop a plan to replace the toilets with more appropriate facilities.

50. Observation

A. Relevant MOA Provision

Paragraph 50 of the MOA provides:

The State shall develop and implement policies and procedures pertaining to observation of suicidal inmates, whereby an inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior, or an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, shall be placed under close observation status and observed by staff at staggered intervals not to exceed every 15 minutes (e.g., 5, 10, 7 minutes). An inmate who is actively suicidal, either threatening or engaging in self-injurious behavior, shall be placed on constant observation status and observed by staff on a continuous, uninterrupted basis. Mental health staff shall assess and interact with (not just observe) inmates on suicide precautions on a daily basis.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

The Monitoring Team deferred assessing Baylor’s compliance with this provision of the MOA because there were no relevant cases.

C. DCC

1. Findings

The Monitoring Team found that there were some issues with the daily mental health assessments which were occurring on a daily basis that appear to have been remedied, but those assessments were significantly hampered by the lack of adequate sound privacy from either correctional officers or other inmates.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Monitoring Team found that while the daily mental health assessments were occurring, those assessments were significantly hampered by the lack of adequate sound privacy from either correctional officers or other inmates.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

The Monitoring Team deferred assessing SCI’s compliance with this provision of the MOA because the policy was not final at the time the Monitoring Team visited the Facility to monitor this provision.

F. Recommendation

The Monitoring Team recommends that the State create a plan for DCC and HRYCI to provide professionally appropriate space for mental health assessments.

51. “Step-Down Observation”

A. Relevant MOA Provision

Paragraph 51 of the MOA provides:

The State shall develop and implement a “step-down” level of observation whereby inmates on suicide precaution are released gradually from more restrictive levels of supervision to less restrictive levels for an appropriate period of time prior to their discharge from suicide precautions. The State shall ensure that all inmates discharged from suicide precautions continue to receive follow-up assessment in accordance with a treatment plan developed by a qualified mental health professional.

This provision of the MOA provides a complete general standard against which to assess the State’s compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

The Monitoring Team deferred assessing Baylor’s compliance with this provision of the MOA because there were no relevant cases to review.

C. DCC

1. Findings

The State has developed a policy, and appears to have implemented it appropriately. Although the Monitoring Team found that there had been issues with follow-up that is required to occur with respect to inmates who have been stepped down, those issues appear to have been corrected.

2. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.

D. HRYCI

1. Findings

Audits have demonstrated relatively good compliance with the follow-up that is required to occur within 24 hours, there are some problems with the required follow-up within five to seven days, and compliance with the follow-up within 21 to 30 days.

2. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

E. SCI

1. Findings

The Monitoring Team found that all inmates are stepped down by a psychiatrist order.

2. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

F. Recommendation

The Monitoring Team recommends that, at DCC and HRYCI, the State begin and/or continue to monitor the performance of this provision of the MOA on a regular basis. The Monitoring Team recommends that, at SCI, the State ensure that there is sufficient psychiatrist time to avoid inmate's having to staff on observation status for longer than necessary for the simple reason that no psychiatrist is available to make the order.

52. Intervention

A. Relevant MOA Provision

Paragraph 52 of the MOA provides:

The State shall develop and implement an intervention policy to ensure that all staff who come into contact with inmates are trained in standard first aid and cardiopulmonary resuscitation; all staff who come into contact with inmates participate in annual "mock drill" training to ensure a prompt emergency response to all suicide attempts; and shall ensure that an emergency response bag that includes appropriate equipment, including a first aid kit and emergency rescue tool, shall be in close proximity to all housing units. All staff who come into regular contact with inmates shall know the location of this emergency response bag and be trained in its use.

As provided by the MOA, all staff coming into contact with the inmate should be trained in standard first aid procedures and CPR. Further, the "mock drill" training should include training for staff coming into contact with inmates regarding what to do when coming into contact with an inmate engaging in self-harm, or who has engaged in self-harm. Hayes, Lindsay M. Hayes, *Guide to Developing and Revising Suicide Prevention Protocols*, included as Appendix C to the NCCHC Standards cited above. The staff member coming upon an inmate engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and to start first aid and/or CPR as necessary, even if the inmate appears to have died until relieved by arriving medical personnel. *Id.* The emergency response equipment available to staff should be checked on a

daily basis to determine that it is in working order. Finally, all suicide attempts, regardless of their severity should result in an immediate intervention and assessment by mental health staff. *Id.*

B. Baylor

The Monitoring Team did not assess Baylor’s compliance with this provision of the MOA.

C. DCC

The Monitoring Team did not assess DCC’s compliance with this provision of the MOA.

D. HRYCI

1. Findings

The Health Service Administrator maintains records of mock drill training. Additionally, all relevant staff are CPR trained.

2. Assessment

The Monitoring Team found that HRYCI is in substantial compliance with this provision of the MOA.

E. SCI

The Monitoring Team did not assess SCI’s compliance with this provision of the MOA.

53. Mortality and Morbidity Review

A. Relevant MOA Provision

Paragraph 53 of the MOA provides:

The State shall develop and implement policies, procedures, and practices to ensure that a multidisciplinary review is established to review all suicides and serious suicide attempts (e.g., those incidents requiring hospitalization for medical treatment). At a minimum, the review shall comprise an inquiry of: a) circumstances surrounding the incident; b) facility procedures relevant to the incident; c) all relevant training received by involved staff; d) pertinent medical and mental health services/reports involving the victim; e) possible precipitating factors leading to the suicide; and, f) recommendations, if any, for changes in policy, training,

physical plant, medical or mental health services, and operational procedures. When appropriate, the review team shall develop a written plan (and timetable) to address areas that require corrective action.

An appropriate procedure in the event of an inmate death from suicide or a serious suicide attempt is one in which the State determines the appropriateness of clinical care that was provided to the inmate, ascertains whether corrective action in the State's policies, procedures, or practices is warranted; and identifies trends that require further study. J-A-10; P-A-10. If the inmate has committed suicide, the State should immediately notify the State of Delaware medical examiner, and, within 30 days of the suicide, conduct a clinical mortality review⁷⁰ and a psychological autopsy⁷¹ in a manner consistent with this MOA provision, which provides the minimum inquiries necessary for these studies. J-A-10; P-A-10.

B. Baylor

The Monitoring Team deferred assessing Baylor's compliance with this provision of the MOA due to the pending finalization of new mortality and morbidity policies and procedures.

C. DCC

The Monitoring Team deferred assessing Baylor's compliance with this provision of the MOA due to the pending finalization of new mortality and morbidity policies and procedures.

D. HRYCI

The Monitoring Team deferred assessing DCC's compliance with this provision of the MOA due to the pending finalization of new mortality and morbidity policies and procedures.

E. SCI

The Monitoring Team deferred assessing Baylor's compliance with this provision of the MOA due to the pending finalization of new mortality and morbidity policies and procedures.

⁷⁰ A "clinical mortality review" is "an assessment of the clinical care provided and the circumstances leading up to the death" in order to "identify any areas of patient care or the system's policies and procedures that can be improved." J-A-10; P-A-10.

⁷¹ A "psychological autopsy" is "usually conducted by a psychologist or other qualified mental health professional" and consists of "a written reconstruction of an individual's life with an emphasis on factors that may have contributed to the individual's death." J-A-10; P-A-10.

QUALITY ASSURANCE

54. Policies and Procedures

A. Relevant MOA Provision

Paragraph 54 of the MOA provides:

The State shall develop and implement written quality assurance policies and procedures to regularly assess and ensure compliance with the terms of this Agreement. These policies and procedures should include, at a minimum: provisions requiring an annual quality management plan and annual evaluation; quantitative performance measurement with tools to be approved in advance by DOJ; tracking and trending of data; creation of a multidisciplinary team; morbidity and mortality reviews with self-critical analysis, and periodic review of emergency room visits and hospitalizations for ambulatory-sensitive conditions.

The Facilities should create a comprehensive CQI program⁷² that performs the following functions in a fashion that complements the requirements contained in this provision of the MOA:

- establishes a multidisciplinary quality improvement committee⁷³ that meets at least quarterly and designs quality improvement monitoring activities, discusses the results, and implements corrective action;
- reviews, at least annually, access to care, receiving screening, health assessment, continuity of care (sick call, chronic disease management, discharge planning), infirmary care, nursing care, pharmacy services, diagnostic services, mental health care, dental care, emergency care, and hospitalizations, adverse patient occurrences including all deaths, critiques of disaster drills, environmental inspection reports, inmate grievances, and infection control;
- completes an annual review of the effectiveness of the CQI program by reviewing minutes of its committee meetings;

⁷² A “comprehensive CQI program” is defined as including, “a multidisciplinary quality improvement committee, monitoring of the areas specified in the compliance indicators, and an annual review of the effectiveness of the CQI program itself.” J-A-06; P-A-06. “CQI” means “Continuous Quality Improvement.”

⁷³ A “multidisciplinary quality improvement committee” is defined as “a group of health staff from various disciplines that designs quality improvement monitoring activities, discusses the results, and implements corrective action. J-A-06; P-A-06.

- performs at least one process quality improvement study⁷⁴ a year; and
- performs at least one outcome quality improvement study⁷⁵ a year.

J-A-06; P-A-06.

B. Baylor

The Monitoring Team deferred assessing Baylor’s compliance with this provision of the MOA pending the adoption of final policies.

C. DCC

The Monitoring Team did not assess DCC’s compliance with this provision of the MOA pending the adoption of final policies.

D. HRYCI

1. Findings

The Monitoring Team found that one committee meeting had taken place. The Monitoring Team found that there was not a disciplined approach to performing the functions that such a committee is to perform.

With respect to mental health services, the Monitoring Team found HRYCI in non-compliance. The QI process is very rudimentary with significant methodological problems with the sample size and selection of the samples.

2. Assessment

The Monitoring Team did not assess HRYCI’s compliance with this provision of the MOA, but with respect to mental health services, the Monitoring Team found HRYCI not in compliance with this provision of the MOA.

E. SCI

The Monitoring Team did not assess SCI’s compliance with this provision of the MOA.

55. Corrective Action Plans

⁷⁴ “Process quality improvement studies” are studies that “examine the effectiveness of the health care delivery process.” J-A-06; P-A-06.

⁷⁵ “Outcome quality improvement studies” are studies that “examine whether expected outcomes of patient care were achieved.” J-A-06; P-A-06.

A. Relevant MOA Provision

Paragraph 55 of the MOA provides:

The State shall develop and implement policies and procedures to address problems that are uncovered during the course of quality assurance activities. The State shall develop and implement corrective action plans to address these problems in such a manner as to prevent them from occurring again in the future.

This provision of the MOA requires that the State develop and implement policies and procedures in response to the uncovering of problems during the quality assurance activities that are discussed in paragraph 54 of the MOA. In addition, the State is required to develop and implement corrective action plans to address these problems in such a manner as to prevent them from occurring again in the future. The Monitoring Team suggests that an adequate corrective action plan will include a description of the problem that has, the specific steps that the State plans to take to remedy the problem, and a deadline for correction of the problem. Finally, the State should make provisions for a responsible party to follow-up after the deadline to ensure that the corrective action plan was followed appropriately.

B. Baylor

The Monitoring Team did not assess Baylor's compliance with this provision of the MOA because final policy and procedure has not been completed.

C. DCC

The Monitoring Team did not assess DCC's compliance with this provision of the MOA pending the completion of policies and procedures.

D. HRYCI

The Monitoring Team did not assess HRYCI's compliance with this provision of the MOA.

E. SCI

The Monitoring Team did not assess SCI's compliance with this provision of the MOA.

CONCLUSION

The State has been making progress towards the goal of becoming substantially compliant with all of the MOA Provisions. However, the State has much work to do before this goal can ultimately be obtained. While it is a positive sign to see the State is in non-compliance with very few of the provisions (17 of 217 total provisions), the fact that the State is only in substantial compliance with a small number of provisions (31 of 217 total provisions) shows the amount of work the State still has to do. The assessment of partial compliance that the Monitoring Team has used is a very broad designation and in some instances reflects minimal progress that the State has made in eliminating the constitutional deficiencies that motivated the parties to enter into the MOA. The Department of Correction and particularly the Office of Health Services have been very cooperative in providing information and access to the Monitoring Team as we have assessed the four facilities. We have every reason to believe that this will continue.

The Third Report of the Monitoring Team will be issued in June 2008. During the monitoring which will provide support for that report, the Monitoring Team looks forward to seeing the impact of some of the remedial efforts taken by State that have not yet been monitored or took place after the experts' visits to facilities. Similarly, the Monitoring Team looks forward to seeing the State's implementation of some of the recommendations found in this Report, which will hopefully aide the State in acquiring substantial compliance ratings for some of the MOA Provisions. The Monitoring Team plans to continue to provide technical assistance to the State through recommendations and advice which will improve medical and mental health care in the facilities.

In the next report, all MOA provisions should have a rating. As a result, a baseline assessment will be complete which will allow the Monitoring Team, and interested parties to see the progress the State is making during future reports. For provisions that have been rated in this second report, the Monitoring Team will be able to offer a comprehensive analysis in the Third Report and will be able to provide a comparison with findings and assessments contained in this report.

The Third Report might have a different format, and a different mode of assessment for some provisions based on the substantial compliance metrics that should be finalized in the near future by the parties. Finally, the next report will most likely reflect the addition of at least one new member to the medical and mental health experts on the Monitoring Team.

APPENDIX I

**MEMORANDUM OF AGREEMENT BETWEEN THE UNITED STATES
DEPARTMENT OF JUSTICE AND THE STATE OF DELAWARE REGARDING
THE DELORES J. BAYLOR WOMEN'S CORRECTIONAL INSTITUTION, THE
DELAWARE CORRECTIONAL CENTER, THE HOWARD R. YOUNG
CORRECTIONAL INSTITUTION, AND THE SUSSEX CORRECTIONAL
INSTITUTION IS ATTACHED**

**MEMORANDUM OF AGREEMENT BETWEEN THE UNITED STATES
DEPARTMENT OF JUSTICE AND THE STATE OF DELAWARE REGARDING THE
DELORES J. BAYLOR WOMEN'S CORRECTIONAL INSTITUTION, THE
DELAWARE CORRECTIONAL CENTER, THE HOWARD R. YOUNG
CORRECTIONAL INSTITUTION, AND THE SUSSEX CORRECTIONAL
INSTITUTION**

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I. INTRODUCTION

- A. On March 7, 2006, the United States Department of Justice (“DOJ”), notified the State of Delaware (“the State”) of DOJ’s intent to investigate the adequacy of medical and mental health care services in five facilities operated by the State’s Department of Correction pursuant to the Civil Rights of Institutionalized Persons Act (“CRIPA”), 42 U.S.C. § 1997 to determine whether those services violated inmates’ constitutional rights. The facilities investigated were:
1. Delores J. Baylor Women’s Correctional Institution (“Baylor”);
 2. Howard R. Young Correctional Institution, (“Howard Young”);
 3. John L. Webb Correctional Facility (“Webb”);
 4. Delaware Correctional Center (“DCC”); and
 5. Sussex Correctional Institution (“Sussex”).
- B. DOJ staff toured the five facilities on June 22, 2006, July 17-19, 2006 and August 14-16, 2006. In addition, DOJ staff, accompanied by consultants in medical care, mental health care and suicide prevention, toured Howard Young on October 4-6, 2006, Baylor and Webb on October 23-25, 2006 and Baylor again on November 15-17, 2006.
- C. On December 29, 2006, the DOJ issued a findings letter pursuant to 42 U.S.C. § 1997b(a)(1) which alleged that certain conditions at Baylor, DCC, Howard Young, and Sussex violated the constitutional rights of Delaware inmates. It is the position of the DOJ that deficiencies in medical care, mental health care and suicide prevention at these four facilities [collectively referred to herein as “the Facilities”; see Definitions, paragraph A] were inconsistent with constitutional standards of care. The DOJ made no findings with respect to Webb.
- D. Before the investigation began, the State had initiated its own efforts to improve conditions at the Facilities. During the investigation, the State also commissioned an extensive internal review of the Facilities with the assistance of medical, mental health, and legal consultants, the detailed results of which they subsequently shared with DOJ and DOJ’s consultants. Throughout the course of the investigation, the State of Delaware and the staff at each Facility cooperated thoroughly and indicated a willingness to proactively and voluntarily undertake measures to improve conditions throughout the system. Consequently, the Parties enter into this Memorandum of Agreement (“Agreement”) for the purpose of utilizing their resources in support of improving medical and mental health care at the Facilities, rather than allocating such resources to the risks and burdens of litigation.

- E. The Parties to this Agreement do not intend to create in any non-party the status of third party beneficiary. This Agreement shall not be construed so as to create a private right of action to any non-party against the State or the United States. The rights, duties and obligations contained in this Agreement shall bind only the Parties to this Agreement.
- F. In entering into this Agreement, the State does not admit any violations of the constitutional rights of inmates confined at the Facilities nor does it admit any violation of state or federal law. This Agreement may not be used as evidence of liability in any other legal proceeding. However, the State remains firmly committed to improving medical and mental health care at the Facilities.
- G. The Parties acknowledge that Correctional Medical Services (“CMS”) currently provides medical and mental health care to inmates at the Facilities and that such care is provided pursuant to a contract with CMS that sets forth the terms and conditions of the relationship between the State and CMS. The State shall be responsible for ensuring that CMS (or any successor contractor) complies with the terms of this Agreement. Nothing in this paragraph shall abrogate the State's responsibility to comply fully with the terms of this Agreement.
- H. It is expressly understood and acknowledged that, while this Agreement makes no distinctions between those issues concerning inmate medical and mental health care that were previously modified and improved prior to the issuance of the findings letter and those that shall be modified and/or improved by virtue of the terms of this Agreement, the Parties acknowledge that a number of the policies and/or procedures which this Agreement addresses were implemented or in the process of being implemented prior to the issuance of the findings letter.

II. DEFINITIONS

In this Agreement, the following definitions apply:

- A. “The Facilities” means Baylor, DCC, Howard Young, and Sussex, collectively, as well as any facility that is built to replace or supplement any one of them.
- B. “Effective date” means the date the Agreement is executed by the Parties.
- C. “Generally accepted professional standards” means those industry standards accepted by a significant majority of professionals in the relevant field, and reflected in the standards of care such as those published by the National Commission on Correctional Health Care (NCCHC) . DOJ acknowledges that NCCHC has established different standards for jail and prison populations, and that the relevant standard that applies under this Agreement may differ for pre-trial and sentenced inmates. As used in this Agreement, the terms “adequate,” “appropriate,” and “sufficient” refer to standards established by clinical

guidelines in the relevant field. The Parties shall consider clinical guidelines promulgated by professional organizations in assessing whether generally accepted professional standards have been met.

- D. "Include" or "including" means "include, but not be limited to" or "including, but not limited to."
- E. "Inmates" means individuals sentenced to, incarcerated in, detained at, or otherwise confined at any of the Facilities.
- F. "Inmates with special needs" means inmates who are identified as suicidal, mentally ill, developmentally disabled, seriously or chronically ill, who are physically disabled, who have trouble performing activities of daily living, or who are a danger to themselves.
- G. "Isolation" means the placement of an inmate alone in a locked room or cell, except that it does not refer to adults single celled in general population.
- H. "Juveniles" means individuals detained at a facility who are under the age of eighteen (18).
- I. "Medical staff" means medical professionals, nursing staff, and certified medical assistants.
- J. "Medical professional" means a licensed physician, licensed physician assistant, or a licensed nurse practitioner providing services at a facility and currently licensed to the extent required by the State of Delaware to deliver those health services he or she has undertaken to provide.
- K. "Mental health professional" means an individual with a minimum of masters-level education and training in psychiatry, psychology, counseling, psychiatric social work, activity therapy, recreational therapy or psychiatric nursing, currently licensed to the extent required by the State of Delaware to deliver those mental health services he or she has undertaken to provide.
- L. "Monitor" as used in this Agreement means the Monitor established by Section VII of this Agreement, and all persons or entities associated by the Monitor to assist in performing the monitoring tasks.
- M. "Nursing staff" means registered nurses, licensed practical nurses, and licensed vocational nurses providing services at a facility and currently licensed to the extent required by the State of Delaware to deliver those health services they have undertaken to provide.

- N. "The Parties" means the State and the DOJ.
- O. "Security staff" means all employees, irrespective of job title, whose regular duties include the supervision of inmates at the Facilities.
- P. "The State" means officials of the State of Delaware, including officials of the Department of Correction and its Bureau of Prisons, and their successors, contractors and agents.
- Q. "Train," when the term is used in remedial provisions of this Agreement, means to adequately instruct in the skills addressed, including assessment of mastery of instructional material.

III. MEDICAL AND MENTAL HEALTH CARE

GENERAL PROVISIONS

- (1) **Standard** The State shall ensure that services to address the serious medical and mental health needs of all inmates meet generally accepted professional standards.
- (2) **Policies and Procedures** The State shall develop and revise its policies and procedures including those involving intake, communicable disease screening, sick call, chronic disease management, acute care, infection control, infirmary care, and dental care to ensure that staff provide adequate ongoing care to inmates determined to need such care. Medical and mental health policies and procedures shall be readily available to relevant staff.
- (3) **Record keeping** The State shall develop and implement a unitary record-keeping system to ensure adequate and timely documentation of assessments and treatment and adequate and timely access by medical and mental health care staff to documents that are relevant to the care and treatment of inmates. A unitary-record-keeping system consists of a system in which all clinically appropriate documents for the inmate's treatment are readily available to each clinician. The State shall maintain a unified medical and mental health file for each inmate and all medical records, including laboratory reports, shall be timely filed in the medical file. The medical records unit shall be adequately staffed to prevent significant lags in filing records in an inmate's medical record. The State shall maintain the medical records such that persons providing medical or mental health treatment may gain access to the record as needed. The medical record should be complete, and should include information from prior incarcerations. The State shall implement an adequate system for medical records management.
- (4) **Medication and Laboratory Orders** The State shall develop and implement policies, procedures, and practices consistent with generally accepted professional standards to ensure timely responses to orders for medications and laboratory tests. Such policies,

procedures, and practices shall be periodically evaluated to ensure that delays in inmates' timely receipt of medications and laboratory tests are prevented.

Staffing and Training

- (5) **Job Descriptions and Licensure** The State 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. The State shall establish a credentialing program that meets generally accepted professional standards, such as those required for accreditation by the National Committee for Quality Assurance.
- (6) **Staffing** The State shall maintain sufficient staffing levels of qualified medical staff and mental health professionals to provide care for inmates' serious medical and mental health needs that meets generally accepted professional standards.
- (7) **Medical and Mental Health Staff Management** The State shall ensure that a full-time medical director is responsible for the management of the medical program. The State shall also provide a director of nursing and adequate administrative medical and mental health management. In addition, the State shall ensure that a designated clinical director shall supervise inmates' mental health treatment at the Facilities. These positions may be filled either by State employees, by independent contractors retained by the State, or pursuant to the State's contract with a correctional health care vendor.
- (8) **Medical and Mental Health Staff Training** The State shall continue to ensure that all medical staff and mental health professionals are adequately trained to meet the serious medical and mental health needs of inmates. All such staff shall continue to receive documented orientation and in-service training in accordance with their job classifications, and training topics shall include suicide prevention and the identification and care of inmates with mental disorders.
- (9) **Security Staff Training** The State shall ensure that security staff are adequately trained in the identification, timely referral, and proper supervision of inmates with serious medical or mental health needs. The State shall ensure that security staff assigned to mental health units receive additional training related to the proper supervision of inmates suffering from mental illness.

Screening and Treatment

- (10) **Medical Screening** The State shall ensure that all inmates receive an appropriate and timely medical screening by a medical staff member upon arrival at a facility. The State shall ensure that such screening enables staff to identify individuals with serious medical or mental health conditions, including acute medical needs, infectious diseases, chronic conditions, physical disabilities, mental illness, suicide risk, and drug and/or alcohol

withdrawal. Separate mental health screening shall be provided as described in Paragraph 34.

- (11) Privacy The State shall make reasonable efforts to ensure inmate privacy when conducting medical and mental health screening, assessments, and treatment. However, maintaining inmate privacy shall be subject to legitimate security concerns and emergency situations.
- (12) Health Assessments The State shall ensure that all inmates receive timely medical and mental health assessments. Upon intake, the State shall ensure that a medical professional identifies those persons who have chronic illness. Those persons with chronic illness shall receive a full health assessment between one (1) and seven (7) days of intake, depending on their physical condition. Persons without chronic illness should receive full health assessment within fourteen (14) days of intake. The State will ensure that inmates with chronic illnesses will be tracked in a standardized fashion. A re-admitted inmate or an inmate transferred from another facility who has received a documented full health assessment within the previous twelve (12) months, and whose receiving screening shows no change in health status, need not receive a new full medical and mental health assessment. For such inmates, medical staff and mental health professionals shall review prior records and update tests and examinations as needed.
- (13) Referrals for Specialty Care The State shall ensure that: a) inmates whose serious medical or mental health needs exceed the services available at their facility shall be referred in a timely manner to appropriate medical or mental health care professionals; b) the findings and recommendations of such professionals are tracked and documented in inmates' medical files; and c) treatment recommendations are followed as clinically indicated.
- (14) Treatment or Accommodation Plans Inmates with special needs shall have special needs plans. For inmates with special needs who have been at the facility for thirty (30) days, this shall include appropriate discharge planning. The DOJ acknowledges that for sentenced inmates with special needs, such discharge planning shall be developed in relation to the anticipated date of release.
- (15) Drug and Alcohol Withdrawal The State shall develop and implement appropriate written policies, protocols, and practices, consistent with standards of appropriate medical care, to identify, monitor, and treat inmates at risk for, or who are experiencing, drug or alcohol withdrawal. The State shall implement appropriate withdrawal and detoxification programs. Methadone maintenance programs shall be offered for pregnant inmates who were addicted to opiates and/or participating in a legitimate methadone maintenance program when they entered the Facilities.

- (16) Pregnant Inmates The State 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.
- (17) Communicable and Infectious Disease Management The State shall adequately maintain statistical information regarding contagious disease screening programs and other relevant statistical data necessary to adequately identify, treat, and control infectious diseases.
- (18) Clinic Space and Equipment The State shall ensure that all face-to-face nursing and physician examinations occur in settings that provide appropriate privacy and permit a proper clinical evaluation including an adequately-sized examination room that contains an examination table, an operable sink for hand-washing, adequate lighting, and adequate equipment, including an adequate microscope for diagnostic evaluations. The State shall submit a comprehensive action plan as described in Paragraph 65 of this Agreement identifying the specific measures the State intends to take in order to bring the Facilities into compliance with this paragraph.

Access to Care

- (19) Access to Medical and Mental Health Services The State shall ensure that all inmates have adequate opportunity to request and receive medical and mental health care. Appropriate medical staff shall screen all written requests for medical and/or mental health care within twenty-four (24) hours of submission, and see patients within the next 72 hours, or sooner if medically appropriate. The State shall maintain sufficient security staff to ensure that inmates requiring treatment are escorted in a timely manner to treatment areas. The State shall develop and implement a sick call policy and procedure which includes an explanation of the order in which to schedule patients, a procedure for scheduling patients, where patients should be treated, the requirements for clinical evaluations, and the maintenance of a sick call log. Treatment of inmates in response to a sick call slip should occur in a clinical setting.
- (20) Isolation Rounds The State shall ensure that medical staff make daily sick call rounds in the isolation areas, and that nursing staff make rounds at least three times a week, to give inmates in isolation adequate opportunities to contact and discuss health and mental health concerns with medical staff and mental health professionals in a setting that affords as much privacy as security will allow.
- (21) Grievances The State shall develop and implement a system to ensure that medical grievances are processed and addressed in a timely manner. The State shall ensure that medical grievances and written responses thereto are included in inmates' files, and that grievances and their outcomes are logged, reviewed, and analyzed on a regular basis to identify systemic issues in need of redress. The State shall develop and implement a

procedure for discovering and addressing all systemic problems raised through the grievance system.

Chronic Disease Care

- (22) **Chronic Disease Management Program** The State shall develop and implement a written chronic care disease management program, consistent with generally accepted professional standards, which provides inmates suffering from chronic illnesses with appropriate diagnosis, treatment, monitoring, and continuity of care. As part of this program, the State shall maintain a registry of inmates with chronic diseases.
- (23) **Immunizations** The State shall make reasonable efforts to obtain immunization records for all juveniles who are detained at the Facilities for more than one (1) month. The State shall ensure that medical staff update immunizations for such juveniles in accordance with nationally recognized guidelines and state school admission requirements. The physicians who determine that the vaccination of a juvenile or adult inmate is medically inappropriate shall properly record such determination in the inmate's medical record. The State shall develop policies and procedures to ensure that inmates for whom influenza, pneumonia and Hepatitis A and B vaccines are medically indicated are offered these vaccines.

Medication

- (24) **Medication Administration** The State shall ensure that all medications, including psychotropic medications, are prescribed appropriately and administered in a timely manner to adequately address the serious medical and mental health needs of inmates. The State shall ensure that inmates who are prescribed medications for chronic illnesses that are not used on a routine schedule, including inhalers for the treatment of asthma, have access to those medications as medically appropriate. The State shall develop and implement adequate policies and procedures for medication administration and adherence. The State shall ensure that the prescribing practitioner is notified if a patient misses a medication dose on three consecutive days, and shall document that notice. The State's formulary shall not unduly restrict medications. The State shall review its medication administration policies and procedures and make any appropriate revisions. The State shall ensure that medication administration records ("MARs") are appropriately completed and maintained in each inmate's medical record.
- (25) **Continuity of Medication** The State shall ensure that arriving inmates who report that they have been prescribed medications shall receive the same or comparable medication as soon as is reasonably possible, unless a medical professional determines such medication is inconsistent with generally accepted professional standards. If the inmate's reported medication is ordered discontinued or changed by a medical professional, a medical professional shall conduct a face-to-face evaluation of the inmate as medically appropriate.

- (26) Medication Management The State shall develop and implement guidelines and controls regarding the access to, and storage of, medication as well as the safe and appropriate disposal of medication and medical waste.

Emergency Care

- (27) Access to Emergency Care The State shall train medical, mental health and security staff to recognize and respond appropriately to medical and mental health emergencies. Furthermore, the State shall ensure that inmates with emergency medical or mental health needs receive timely and appropriate care, including prompt referrals and transports for outside care when medically necessary.
- (28) First Responder Assistance The State shall train all security staff to provide first responder assistance (including cardiopulmonary resuscitation (“CPR”) and addressing serious bleeding) in an emergency situation. The State shall provide all security staff with the necessary protective gear, including masks and gloves, to provide first line emergency response.

Mental Health Care

- (29) Treatment The State shall ensure that qualified mental health professionals provide timely, adequate, and appropriate screening, assessment, evaluation, treatment and structured therapeutic activities to inmates requesting mental health services, inmates who become suicidal, and inmates who enter with serious mental health needs or develop serious mental health needs while incarcerated.
- (30) Psychiatrist Staffing The State shall retain sufficient psychiatrists to enable the Facilities to address the serious mental health needs of all inmates with timely and appropriate mental health care consistent with generally accepted professional standards. This shall include retaining appropriately licensed and qualified psychiatrists for a sufficient number of hours per week to see patients, prescribe and adequately monitor psychotropic medications, participate in the development of individualized treatment plans for inmates with serious mental health needs, review charts in the context of rendering appropriate mental health care, review and respond to the results of diagnostic and laboratory tests, and be familiar with and follow policies, procedures, and protocols. The psychiatrist shall collaborate with the chief psychologist in mental health services management as well as clinical treatment, shall communicate problems and resource needs to the Warden and chief psychologist, and shall have medically appropriate autonomy for clinical decisions at the facility. The psychiatrist shall supervise and oversee the treatment team.
- (31) Administration of Mental Health Medications The State shall develop and implement policies, procedures, and practices consistent with generally accepted professional standards to ensure that psychotropic medications are prescribed, distributed, and

monitored properly and safely and consistent with generally accepted professional standards. The State shall ensure that all psychotropic medications are administered by qualified medical professionals or other health care personnel qualified under Delaware state law to administer medications, who consistently implement adequate policies and procedures to monitor for adverse reactions and potential side effects and to adequately document the administration of such medications in the MARs. Documentation in the MARs shall include a clear and consistent indication of whether the inmate refused or otherwise missed any doses of medication, as well as doses consumed. As part of the quality assurance program set forth in Section V of this Agreement, a qualified medical professional or registered nurse supervisor shall review MARs on a regular and periodic basis to determine whether policies and procedures are being followed.

- (32) Mental Illness Training The State shall conduct initial and periodic training for all security staff on how to recognize symptoms of mental illness and respond appropriately. Such training shall be conducted by a qualified mental health professional, registered psychiatric nurse, or other appropriately trained and qualified individual, and shall include instruction on how to recognize and respond to mental health emergencies.
- (33) Mental Health Screening The State shall develop and implement adequate policies, procedures, and practices consistent with generally accepted correctional mental health care standards to ensure that all inmates receive an adequate initial mental health screening by appropriately trained staff within twenty-four (24) hours after intake. Such screening shall include an individual private (consistent with security limitations) interview of each incoming inmate, including whether the inmate has a history of mental illness, is currently receiving or has received psychotropic medications, has attempted suicide, or has suicidal propensities. Documentation of the screening shall be maintained in the appropriate medical record. Inmates who have been on psychotropic medications prior to intake will be assessed by a psychiatrist as to the need to continue those medications, in a timely manner, no later than 7-10 days after intake or sooner if clinically appropriate. These inmates shall remain on previously prescribed psychotropic medications pending psychiatrist assessment. Incoming inmates who are in need of emergency mental health services shall receive such care immediately after intake. Incoming inmates who require resumption of psychotropic medications shall be seen by a psychiatrist as soon as clinically appropriate.
- (34) Mental Health Assessment and Referral The State shall develop and implement adequate policies, procedures, and practices consistent with generally accepted professional standards to ensure timely and appropriate mental health assessments by qualified mental health professionals for those inmates whose mental health histories, or whose responses to initial screening questions, indicate a need for such an assessment. Such assessments shall occur within seventy-two (72) hours of the inmate's mental health screening or the identification of the need for such assessment, whichever is later. The State shall also ensure that inmates have access to a confidential self-referral system by which they may request mental health care without revealing the substance of their request to security

staff. Written requests for mental health services shall be forwarded to a qualified mental health professional and timely evaluated by him or her. The State 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.

- (35) Mental Health Treatment Plans The State shall ensure that a qualified mental health professional prepares in a timely manner and regularly updates an individual mental health treatment plan for each inmate who requires mental health services. The State shall also ensure that the plan is timely and consistently implemented. Implementation of and any changes to the plan shall be documented in the inmate's medical/mental health record.
- (36) Crisis Services The State shall ensure an adequate array of crisis services to appropriately manage psychiatric emergencies. Crisis services shall not be limited to administrative/disciplinary isolation or observation status. Inmates shall have access to appropriate in-patient psychiatric care when clinically appropriate.
- (37) Treatment for Seriously Mentally Ill Inmates The State 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 staff to provide treatment, and an adequate array of therapeutic programming. The State shall ensure that inmates who are being treated with psychotropic medications are seen regularly by a physician to monitor responses and potential reactions to those medications, in accordance with generally accepted correctional mental health care standards.
- (38) Review of Disciplinary Charges for Mental Illness Symptoms The State shall ensure that disciplinary charges against inmates with serious mental illness who are placed in Isolation are reviewed by a qualified mental health professional to determine the extent to which the charge may have been related to serious mental illness, and to determine whether an inmate's serious mental illness should be considered by the State as a mitigating factor when punishment is imposed on inmates with a serious mental illness.
- (39) Procedures for Mentally Ill Inmates in Isolation or Observation Status The State shall implement policies, procedures, and practices consistent with generally accepted professional standards to ensure that all mentally ill inmates on the facility's mental health caseload and who are housed in Isolation receive timely and appropriate treatment, including completion and documentation of regular rounds in the Isolation units at least once per week by qualified mental health professionals in order to assess the serious mental health needs of those inmates. Inmates with serious mental illness who are placed in Isolation shall be evaluated by a qualified mental health professional within twenty-four hours and regularly thereafter to determine the inmate's mental health status, which shall include an assessment of the potential effect of the Isolation on the inmate's mental

health. During these regular evaluations, the State shall evaluate whether continued Isolation is appropriate for that inmate, considering the assessment of the qualified mental health professional, or whether the inmate would be appropriate for graduated alternatives. The State shall adequately document all admissions to, and discharges from, Isolation, including a review of treatment by a psychiatrist. The State shall provide adequate facilities for observation, with no more than two inmates per room.

- (40) Mental Health Services Logs and Documentation The State shall ensure that the State maintains 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(s) 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.

IV. SUICIDE PREVENTION

- (41) Suicide Prevention Policy The State shall review and, to the extent necessary, revise its suicide prevention policy to ensure that it includes the following provisions: 1) training; 2) intake screening/assessment; 3) communication; 4) housing; 5) observation; 6) intervention; and 7) mortality and morbidity review.
- (42) Suicide Prevention Training Curriculum The State shall review and, to the extent necessary, revise its suicide prevention training curriculum, which shall include the following topics: 1) the suicide prevention policy as revised consistent with this Agreement; 2) why facility environments may contribute to suicidal behavior; 3) potential predisposing factors to suicide; 4) high risk suicide periods; 5) warning signs and symptoms of suicidal behavior; 6) case studies of recent suicides and serious suicide attempts; 7) mock demonstrations regarding the proper response to a suicide attempt; and 8) the proper use of emergency equipment.
- (43) Staff Training Within twelve months of the effective date of this Agreement, the State shall ensure that all existing and newly hired correctional, medical, and mental health staff receive an initial eight-hour training on suicide prevention curriculum described above. Following completion of the initial training, the State shall ensure that a minimum of two hours of refresher training on the curriculum are completed by all correctional care, medical, and mental health staff each year.
- (44) Intake Screening/Assessment The State shall develop and implement policies and procedures pertaining to intake screening in order to identify newly arrived inmates who may be at risk for suicide. The screening process shall include inquiry regarding: 1) past suicidal ideation and/or attempts; 2) current ideation, threat, plan; 3) prior mental health treatment/hospitalization; 4) recent significant loss (job, relationship, death of family

member/close friend, etc.); 5) history of suicidal behavior by family member/close friend; 6) suicide risk during prior confinement in a state facility; and 7) arresting/transporting officer(s) belief that the inmate is currently at risk.

- (45) Mental Health Records Upon admission, the State shall immediately request all pertinent mental health records regarding the inmate's prior hospitalization, court-ordered evaluations, medication, and other treatment. DOJ acknowledges that the State's ability to obtain such records depends on the inmate's consent to the release of such records.
- (46) Identification of Inmates at Risk of Suicide Inmates at risk for suicide shall be placed on suicide precautions until they can be assessed by qualified mental health personnel. Inmates at risk of suicide include those who are actively suicidal, either threatening or engaging in self-injurious behavior; inmates who are not actively suicidal, but express suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or have a recent prior history of self-destructive behavior; and inmates who deny suicidal ideation or do not threaten suicide, but demonstrate other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury.
- (47) Suicide Risk Assessment The State shall ensure that a formalized suicide risk assessment by a qualified mental health professional is performed within an appropriate time not to exceed 24 hours of the initiation of suicide precautions. The assessment of suicide risk by qualified mental health professionals shall include, but not be limited to, the following: description of the antecedent events and precipitating factors; suicidal indicators; mental status examination; previous psychiatric and suicide risk history, level of lethality; current medication and diagnosis; and recommendations/treatment plan. Findings from the assessment shall be documented on both the assessment form and health care record.
- (48) Communication The State shall ensure that any staff member who places an inmate on suicide precautions shall document the initiation of the precautions, level of observation, housing location, and conditions of the precautions. The State shall develop and implement policies and procedures to ensure that the documentation described above is provided to mental health staff and that in-person contact is made with mental health staff to alert them of the placement of an inmate on suicide precautions. The State shall ensure that mental health staff thoroughly review an inmate's health care record for documentation of any prior suicidal behavior. The State shall promulgate a policy requiring mental health to utilize progress notes to document each interaction and/or assessment of a suicidal inmate. The decision to upgrade, downgrade, discharge, or maintain an inmate on suicide precautions shall be fully justified in each progress note. An inmate shall not be downgraded or discharged from suicide precautions until the responsible mental health staff has thoroughly reviewed the inmate's health care record, as well as conferred with correctional personnel regarding the inmate's stability. Multidisciplinary case management team meetings (to include facility officials and

available medical and mental health personnel) shall occur on a weekly basis to discuss the status of inmates on suicide precautions.

- (49) Housing The State shall ensure that all inmates placed on suicide precautions are housed in suicide-resistant cells (i.e., cells without protrusions that would enable inmates to hang themselves). The location of the cells shall provide full visibility to staff. At the time of placement on suicide precautions, medical or mental health staff shall write orders setting forth the conditions of the observation, including but not limited to allowable clothing, property, and utensils, and orders addressing continuation of privileges, such as showers, telephone, visiting, recreation, etc., commensurate with the inmate's security level. Removal of an inmate's prison jumpsuit (excluding belts and shoelaces) and the use of any restraints shall be avoided whenever possible, and used only as a last resort when the inmate is engaging in self-destructive behavior. The Parties recognize that security and mental health staff are working towards the common goal of protecting inmates from self-injury and from harm inflicted by other inmates. Such orders must therefore take into account all relevant security concerns, which can include issues relating to the commingling of certain prison populations and the smuggling of contraband. Mental health staff shall give due consideration to such factors when setting forth the conditions of the observation, and any disputes over the privileges that are appropriate shall be resolved by the Warden or his or her designee. Scheduled court hearings shall not be cancelled because an inmate is on suicide precautions.
- (50) Observation The State shall develop and implement policies and procedures pertaining to observation of suicidal inmates, whereby an inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior, or an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, shall be placed under close observation status and observed by staff at staggered intervals not to exceed every 15 minutes (e.g., 5, 10, 7 minutes). An inmate who is actively suicidal, either threatening or engaging in self-injurious behavior, shall be placed on constant observation status and observed by staff on a continuous, uninterrupted basis. Mental health staff shall assess and interact with (not just observe) inmates on suicide precautions on a daily basis.
- (51) "Step-Down Observation" The State shall develop and implement a "step-down" level of observation whereby inmates on suicide precaution are released gradually from more restrictive levels of supervision to less restrictive levels for an appropriate period of time prior to their discharge from suicide precautions. The State shall ensure that all inmates discharged from suicide precautions continue to receive follow-up assessment in accordance with a treatment plan developed by a qualified mental health professional.
- (52) Intervention The State shall develop and implement an intervention policy to ensure that all staff who come into contact with inmates are trained in standard first aid and

cardiopulmonary resuscitation; all staff who come into contact with inmates participate in annual "mock drill" training to ensure a prompt emergency response to all suicide attempts; and shall ensure that an emergency response bag that includes appropriate equipment, including a first aid kit and emergency rescue tool, shall be in close proximity to all housing units. All staff who come into regular contact with inmates shall know the location of this emergency response bag and be trained in its use.

- (53) Mortality and Morbidity Review The State shall develop and implement policies, procedures, and practices to ensure that a multidisciplinary review is established to review all suicides and serious suicide attempts (e.g., those incidents requiring hospitalization for medical treatment). At a minimum, the review shall comprise an inquiry of: a) circumstances surrounding the incident; b) facility procedures relevant to the incident; c) all relevant training received by involved staff; d) pertinent medical and mental health services/reports involving the victim; e) possible precipitating factors leading to the suicide; and f) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. When appropriate, the review team shall develop a written plan (and timetable) to address areas that require corrective action.

V. QUALITY ASSURANCE

- (54) Policies and Procedures The State shall develop and implement written quality assurance policies and procedures to regularly assess and ensure compliance with the terms of this Agreement. These policies and procedures should include, at a minimum: provisions requiring an annual quality management plan and annual evaluation; quantitative performance measurement with tools to be approved in advance by DOJ; tracking and trending of data; creation of a multidisciplinary team; morbidity and mortality reviews with self-critical analysis, and periodic review of emergency room visits and hospitalizations for ambulatory-sensitive conditions.
- (55) Corrective Action Plans The State shall develop and implement policies and procedures to address problems that are uncovered during the course of quality assurance activities. The State shall develop and implement corrective action plans to address these problems in such a manner as to prevent them from occurring again in the future.

VI. IMPLEMENTATION

- (56) Revision of Activities and Documents The State shall revise and/or develop as necessary its current policies, procedures, protocols, training, staffing and practices to ensure that they are consistent with, incorporate, address and implement all provisions of this Agreement. The State shall revise and/or develop as necessary other written documents such as screening tools, logs, handbooks, manuals, and forms, to effectuate the provisions of this Agreement.

- (57) Dissemination of Agreement Within thirty (30) days of the effective date of this Agreement, the State shall distribute copies of the Agreement to all relevant staff, including all medical, mental health and security staff at the Facilities and explain it as appropriate.
- (58) In Service Training Training academy staff shall develop, on an on-going basis, scripts for in service training directed at issues related to effective implementation of the Agreement. In service training shall be provided regularly and shall be documented. In service training scripts shall be provided to DOJ for its review in accordance with the time frames for compliance set forth below.

VII. MONITORING, ENFORCEMENT AND TERMINATION

- (59) Termination This Agreement shall terminate three (3) years after its effective date.
- (60) Satisfaction of the Agreement and Early Termination This Agreement may be terminated prior to the conclusion of the three (3) year period described in Paragraph 59 if the State reaches substantial compliance with all provisions of this Agreement and sustains it for one (1) year. "Substantial Compliance" with each and every term of this Agreement for a period of one (1) year shall fully satisfy the Agreement. Noncompliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance, shall not constitute failure to maintain substantial compliance. At the same time, temporary compliance during a period of otherwise sustained noncompliance shall not constitute substantial compliance. The State may submit a written request for early termination of the Agreement based upon an assertion of one (1) year of substantial compliance with all substantive paragraphs set forth in Sections III through VIII of this Agreement. The DOJ, in its good faith discretion, will determine whether the State has maintained substantial compliance for the one (1) year period.
- (61) Review and Approval All policies, procedures, plans and protocols required by, or referenced in, this Agreement shall be consistent with the substantive terms of this Agreement. All policies, procedures, plans and protocols required by, or referenced in, this Agreement shall be submitted to the DOJ for its review and approval within sixty (60) calendar days after approval of the Action Plan described in Paragraph 65 of this Agreement. Any such plans, policies, procedures and protocols for which this Agreement requires review and approval by DOJ shall be expeditiously reviewed by the DOJ. The DOJ shall not unreasonably withhold any such approval. Absent unforeseen circumstances beyond the Parties' control, if DOJ does not provide a written objection to said materials within sixty (60) days of receipt of same, the materials will be deemed approved by DOJ.
- (62) State Response to DOJ Questions Within thirty (30) days of receipt of written questions from the DOJ concerning the State's compliance with this Agreement, the State shall

provide the DOJ with written answers and any requested documents regarding the State's compliance with the requirements of this Agreement.

- (63) State Documentation of Compliance The State shall maintain sufficient records to document its compliance with all of the requirements of this Agreement. The State shall also maintain (so long as this Agreement remains in effect) any and all records required by or developed under this Agreement.
- (64) Implementation The State shall implement policies, procedures, plans, and protocols consistent with the Action Plan referred to in Paragraph 65 of this Agreement.
- (65) Action Plan Within one hundred and twenty (120) days after the effective date of this Agreement, the State shall prepare and submit to the DOJ a comprehensive action plan ("Action Plan") identifying the specific measures the State intends to take in order to bring the Facilities into compliance with each paragraph containing substantive requirements in Sections III through V of this Agreement ("Substantive Provisions"), including a timeline for completion of each of the measures.
- (66) Compliance Reporting The State shall prepare and submit reports regarding compliance ("Compliance Reports") with each of the Substantive Provisions of this Agreement. The State shall submit its first Compliance Report within ninety (90) days after submitting the Action Plan described in Paragraph 65 of this Agreement, and then every six (6) months. The Compliance Reports shall identify the State's progress in implementing the Action Plan, any revisions to the Action Plan, and shall include a summary of steps taken to implement this Agreement, along with supporting documentation and certifications. Upon achieving substantial compliance as determined by DOJ with any substantive paragraph(s) of this Agreement for one (1) year, no further reporting shall be required on that paragraph.
- (67) Selection of Monitor Within ninety (90) days after entry of this Agreement, the State and DOJ shall together select a Monitor. If the Parties are unable to agree on a Monitor, each Party shall submit two names of persons who have experience in corrections and who may have served as a correctional practices expert or monitor, or as a Federal, state, or county prosecutor or judge along with resumes or curricula vitae and cost proposals to a third party neutral, selected with the assistance of the Federal Mediation and Conciliation Service, and the third party neutral shall appoint the Monitor from among the names of qualified persons submitted. The selection of the Monitor shall be conducted solely pursuant to the procedures set forth in this Agreement, and will not be governed by any formal or legal procurement requirements.
- (68) Limitations on Public Disclosures by Monitor The Monitor shall not be retained by any current or future litigant or claimant in a claim or suit against the State, its agents or employees. The Monitor shall not issue statements or make findings with regard to any act or omission of the State, or their agents or representatives, except as required by the

terms of this Agreement. The Monitor may testify in any case brought by any Party to this Agreement regarding any matter relating to the implementation, enforcement, or dissolution of this Agreement.

- (69) Monitoring Resources The Monitor, at any time, may associate such additional persons or entities as are reasonably necessary to perform the monitoring tasks specified by this Agreement. The Monitor shall notify in writing DOJ and the State if and when such additional persons or entities are selected for association by the Monitor. The notice shall identify and describe the qualifications of the person or entity to be associated and the monitoring task to be performed.
- (70) Monitor's Fees The State shall bear all reasonable fees and costs of the Monitor. In selecting the Monitor, DOJ and the State recognize the importance of ensuring that the fees and costs borne by the State are reasonable, and accordingly fees and costs shall be one factor considered in selecting the Monitor. In the event that any dispute arises regarding the payment of the Monitor's fees and costs, the State, DOJ, and the Monitor shall attempt to resolve such dispute cooperatively.
- (71) Monitor's Duties and Responsibilities The Monitor shall review and report on the State's implementation of, and assist with the State's compliance with, this Agreement. The Monitor shall only have the duties, responsibilities and authority conferred by this Agreement. The Monitor shall not, and is not intended to, replace or take over the role and duties of the State or the Commissioner of the Delaware Department of Corrections. The Monitor may testify in any action brought to enforce this Agreement regarding any matter relating to the implementation or enforcement of the Agreement. The Monitor shall not testify in any other litigation or proceeding with regard to any act or omission of the State, or any of their agents, representatives, or employees related to this Agreement or regarding any matter or subject that the Monitor may have received knowledge of as a result of his or her performance under this Agreement. Unless such conflict is waived by the Parties, the Monitor shall not accept employment or provide consulting services that would present a conflict of interest with the Monitor's responsibilities under this Agreement, including being retained (on a paid or unpaid basis) by any current or future litigant or claimant, or such litigant's or claimant's attorney, in connection with a claim or suit against the State or its departments, officers, agents or employees. The Monitor is not a state or local agency, or an agent thereof, and accordingly the records maintained by the Monitor shall not be deemed public records. The Monitor shall not be liable for any claim, lawsuit, or demand arising out of the Monitor's performance pursuant to this Agreement. Provided, however, that this paragraph does not apply to any proceeding before a court related to performance of contracts or subcontracts for monitoring this Agreement.
- (72) Technical Assistance by the Monitor The Monitor shall offer the State technical assistance regarding compliance with this Agreement. The Monitor may not modify, amend, diminish, or expand this Agreement.

- (73) Monitor's Access The State shall provide the Monitor with full and unrestricted access to all of the Facilities, relevant State and facility staff and employees, and any documents (including databases) necessary to carry out the duties assigned to the State by this Agreement. The Monitor's right of access includes, but is not limited to, all documents regarding medical care, mental health care, suicide prevention, or protocols or analyses involving one of those subject areas. The Monitor shall retain any non-public information in a confidential manner and shall not disclose any non-public information to any person or entity, other than a Court or DOJ, absent written notice to the State and either written consent by the State or a court order authorizing disclosure.
- (74) Monitor's Communication with the Parties In monitoring the implementation of this Agreement, the Monitor shall maintain regular contact with the State and DOJ. The Monitor shall be permitted to initiate and receive ex parte communications with the Parties and the Parties' consultants.
- (75) Compliance Monitoring In order to monitor and report on the State's implementation of each substantive provision of this Agreement, the Monitor shall conduct periodic reviews as the Monitor deems appropriate, but no less than quarterly at each of the Facilities. The Monitor may make recommendations to the Parties regarding measures necessary to ensure full and timely implementation of this Agreement.
- (76) Compliance Coordinator The Parties agree that the State shall hire and retain, or reassign a current State employee, for the duration of this Agreement, a Compliance Coordinator. The Compliance Coordinator shall serve as a liaison between the State, the Monitor and DOJ, and shall assist with the State's compliance with this Agreement. At a minimum, the Compliance Coordinator shall: (a) coordinate the State's compliance and implementation of activities required by this Agreement; (b) facilitate the provision of data, documents and other access to State employees and material to the Monitor and DOJ as needed; (c) ensure that all documents and records are maintained as provided in this Agreement; (d) assist in assigning compliance tasks to State personnel, as directed by the Commissioner of the Delaware Department of Corrections or his designee; take primary responsibility for collecting information to provide the State's status reports specified in paragraph 61.
- (77) DOJ Access DOJ shall continue to have full and unrestricted access to all documents (including databases), staff, inmates and the Facilities that are relevant to evaluate compliance with this Agreement, except any documents protected by the attorney-client privilege or applicable self-evaluative privileges (e.g., 24 Del. C § 1768). Should the State decline to provide DOJ with access to a document based on attorney-client privilege, the State shall provide the Monitor and DOJ with a log describing the document. DOJ's right of access includes, but is not limited to, all documents regarding medical care, mental health care, suicide prevention and any protocols or analyses involving those subject areas. This Agreement does not authorize, nor shall it be construed to authorize, access to any State documents, except as expressly provided by

this Agreement, by persons or entities other than DOJ, the State, and the Monitor. DOJ shall retain any non-public information in a confidential manner and shall not disclose any non-public information to any person or entity, other than a Court or the Monitor, absent written notice to the State and either written consent by the State or a court order authorizing disclosure. Throughout the duration of this Settlement Agreement, letters between counsel for the DOJ and counsel for the State shall be confidential and subject to the Confidentiality Agreement between the DOJ and the State entered into on May 3, 2006 and supplemented by the Non-Waiver Agreement dated September 28, 2006.

- (78) Timeliness of DOJ Review of Documents and Information DOJ shall review documents and information provided by the State and the Monitor and shall provide its analysis and comments to the State and the Monitor at appropriate times and in an appropriate manner, consistent with the purpose of this Agreement to promote cooperative efforts.
- (79) Monitor Reports The Monitor shall issue semi-annual public reports detailing the State's compliance with and implementation of this Agreement. The first report shall issue six months from the effective date of this Agreement. The Monitor may issue reports more frequently if the Monitor determines it appropriate to do so. At least ten business days prior to issuing a report, the Monitor shall provide a draft to the Parties for review and comment to determine if any factual errors have been made. The Monitor shall consider the Parties' responses and then promptly issue the report.
- (80) Noncompliance If DOJ believes that the State has failed to substantially comply with any obligation under this Agreement, DOJ will, prior to seeking judicial action to enforce the terms of this Agreement, give written notice of the failure to the State. The Parties shall conduct good-faith discussions to resolve the dispute. If the Parties are unable to reach agreement within 15 days of the DOJ's written notice, the Parties shall submit the dispute to mediation. Michael Bromwich, Esq., shall serve as the mediator unless the Parties expressly agree to an alternative selection. The Parties shall split the cost of the mediator. The Parties shall attempt in good faith to mediate the dispute for a minimum of 30 days prior to initiating any court action. DOJ commits to work in good faith with the State to avoid enforcement actions. However, in case of an emergency posing an immediate threat to the health or safety of inmates, the DOJ may omit the notice and cure requirements herein (including the provision regarding mediation), before seeking judicial action. Non-action by the DOJ shall not constitute a waiver of the right to seek judicial action.
- (81) Successors This Agreement shall be binding on all successors, assignees, employees, and all those working for or on behalf of the State.
- (82) Defense of Agreement The Parties agree to defend the provisions of this Agreement. The Parties shall notify each other of any court challenge to this Agreement. In the event any provision of this Agreement is challenged in any local or state court, the Parties shall seek to remove the matter to a federal court.

- (83) Enforcement Failure by either Party to enforce this entire Agreement or any provision thereof with respect to any deadline or any other provision herein shall not be construed as a waiver of its right to enforce other deadlines or provisions of this Agreement.
- (84) Non-Retaliation The State agrees that it shall not retaliate against any person because that person has filed or may file a complaint, provided information or assistance, or participated in any other manner in an investigation or proceeding relating to this Agreement.
- (85) Severability In the event any provision of this Agreement is declared invalid for any reason by a court of competent jurisdiction, said finding shall not affect the remaining provisions of this Agreement.
- (86) Notice "Notice" under this Agreement shall be provided via overnight delivery and shall be provided to the Governor of the State of Delaware and to the Attorney General of the State of Delaware.
- (87) Subheadings All subheadings in this Agreement are written for convenience of locating individual provisions. If questions arise as to the meanings of individual provisions, the Parties shall follow the text of each provision.

For the DOJ:

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SHANETTA Y. CUTLAR
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Dated: December 29, 2006

APPENDIX II

**THE STATE OF DELAWARE DEPARTMENT OF CORRECTION
COMPREHENSIVE ACTION PLAN IS ATTACHED**

The State of Delaware
Department of Correction
Action Plan

April 30, 2007

Delaware Department of Correction Action Plan

I. Introduction

This Action Plan has been developed in accordance with the December 29, 2006 Memorandum of Agreement Between the State of Delaware and the United States Department of Justice (the MOA). In particular, paragraph 65 of the MOA requires the State to submit a “comprehensive action plan” to the United States identifying the specific measures the State intends to take in order to bring four Department of Correction facilities¹ into compliance with each paragraph of the MOA containing substantive requirements relating to three general areas: Medical and Mental Health Care, Suicide Prevention, and Quality Assurance. As is required by paragraph 65, each item addressed in the Action Plan contains a timeline for completion.

The measures described in this Action Plan are intended to provide the United States Department of Justice (the DOJ) with a roadmap of specific remedial steps to be taken by the Delaware Department of Correction (the DOC). The Action Plan has been developed with an emphasis on achievable, realistic, and, in most cases, incremental steps towards full compliance. All measures described here have been developed with the expectation that the DOC will ultimately meet or exceed requirements of the MOA and generally accepted professional standards, such as those published by the National Commission on Correctional Health Care (NCCHC).

The Action Plan is organized so that paragraph numbers refer to corresponding paragraphs in Sections III through V of the MOA. “Timeline for Completion” references in each section indicate the date by which the DOC expects to have fully implemented the proposed actions. Target deadlines for achieving incremental steps towards full compliance are also noted where appropriate. Most of the efforts described in this Action Plan will require continuing attention. To the extent that an effort does not have any defined endpoint or deadline for completion, it is noted to be “continuing.”

As will be described more fully in the DOC’s first Compliance Report, substantial work has already begun on many of the MOA requirements, and many improvements in the quality of inmate care are already apparent. However, most of the substantive MOA provisions discussed here involve the development or revision of policies and procedures. The corresponding sections of this Action Plan necessarily reflect a certain level of generality, because those policies and procedures are not yet complete. In those cases, the Action Plan:

¹ The Delaware DOC facilities covered by the MOA are the Delores J. Baylor Women’s Correctional Institution (Baylor); the Delaware Correctional Center (DCC); the Howard R. Young Correctional Institution (HRYCI); and the Sussex Correctional Institution (SCI) (collectively, the “Facilities”).

- addresses each substantive requirement;
- affirms the DOC's commitment to completing the work necessary to establish appropriate policies and procedures;
- identifies the entities or individuals responsible for achieving compliance with the underlying substantive issues;
- identifies those areas in which auditing and quality improvement efforts will be concentrated in order to assure that new policies and procedures are achieving the desired result; and
- establishes timelines for training staff on new policies and procedures, performing quality assurance, and achieving full compliance.

The MOA compliance officer will have global responsibility for assuring compliance with the MOA.

II. Medical and Mental Health Care

1. Standard

All of the steps described in the pages that follow are designed to satisfy the ultimate, most fundamental requirement of the MOA: ensuring that services provided by the State address the serious medical and mental health needs of inmates in a manner that satisfies generally accepted professional standards. To accomplish this, the DOC plans to:

- diligently pursue compliance with each substantive provision of the MOA;
- rely on a multi-disciplinary, problem-solving approach to identify and overcome obstacles to improvement;
- solicit the advice of experts and consultants, where appropriate; and
- refer to NCCHC or other appropriate correctional health care standards when evaluating the services provided to inmates.

Timeline for Completion: Continuing

2. Policies and Procedures

The DOC is currently drafting and revising DOC policies and procedures that will eventually replace those currently provided by the medical vendor. In the event of vendor turnover or a transition to self-operation of DOC health care services, stand-alone DOC policies will provide continuity in both the standards of care and the performance expected of staff.

- Some of the most critical policies are identified in the MOA, and relate to intake, communicable disease screening, sick call, chronic disease management, medication delivery, laboratory testing, acute care, infection control, infirmary care, and dental care. The DOC will focus its initial efforts on these most essential policies.
- The DOC will continue seeking policies and procedures from correctional facilities in other jurisdictions in an attempt to identify good models for its own manuals.
- Individuals with appropriate experience in mental health, quality assurance, medical, and nursing protocols are being assigned responsibility for drafting DOC policies and procedures, including the Director of Health Services, Mental Health Treatment Program Administrator, and the Quality Improvement Administrator
- Policies and procedures will also be subject to review and comment by the Deputy Attorney General and DOC Bureau of Prisons Chief.

- The DOC will continually review and update policies and procedures as needed. At a minimum, a yearly review will be conducted by the Office of Health Services.

Timeline for Completion:

The critical policies and procedures identified above will be drafted and available for DOJ review by 07/01/07.

Additional policies and procedures will be promulgated as needed throughout the term of the MOA, and on a continuing basis thereafter.

As noted above, policies will be continually updated as needed. A yearly review will take place, with the first yearly review to be completed by 07/01/08.

3. Record keeping

3a. Develop and Implement Unitary Record Keeping System

The DOC currently has a unitary system that includes both medical and mental health records. This paper medical record will be available to practitioners who need access to the record for treatment, quality assurance, and auditing purposes. The DOC also plans to issue a Request For Proposals during the next fiscal year to evaluate the feasibility, costs, and benefits of an electronic medical record (“EMR”).

Additionally, the DOC plans substantial improvements in the integration of medical and mental health information contained in the Delaware Automated Correction System (DACS) records. These efforts began in April 2006, and are continuing. Jim Welch, Joyce Talley, the Mental Health Treatment Program Administrator, the medical vendor, and individuals from the Delaware Management Information Systems department will continue working on enhancements to the Health and Medical Modules of DACS.

The DACS software vendor has been provided with a list of 178 requirements for improvements to the following 12 system functions in the Health and Medical Modules:

- Intake Screening
- Scheduling
- Medical Transfers
- Chronic Care
- Sick Call
- Outside Consults
- Pregnancy
- Mental Health
- Administrative Segregation
- Infirmary Care

- Dental
- General/Reports

Timeline for Completion:

Software development: approximately 6/18/07
System testing: 6/07 - 7/07
Revisions: 8/07
Training vendor and DOC staff: 8/07 - 9/07
Full implementation: 10/30/07
Issuance of RFP for an EMR: 7/01/08

3b. Medical Records Staffing

The DOC will facilitate the provision of additional medical records staffing to reduce the potential for significant lags in filing records in the patient's medical record.

Timeline for Completion:

DOC will evaluate current medical records staffing and the need for additional staff by 4/1/07 (completed).

DOC negotiated an amendment to its agreement with the current medical vendor to provide for additional medical records staff, and staff are expected to be hired by no later than 10/30/07.

4. Medication and Laboratory Orders

4a. Policies, Procedures, and Practices for Medication and Laboratory Orders

Policies and procedures relating to medication and laboratory orders will be included in review and drafting process described in ¶ 2, above.

Timeline for Completion:

Policies: 07/01/07

4b. Periodic Evaluation

The DOC has begun and is continuing to develop an auditing system to assure that medications are ordered and delivered in a timely manner. The auditing system will also assure that laboratory orders are taken off the chart, and tests ordered are completed and results reported to the ordering practitioner in a timely manner. This process will include continued monitoring under the DOC's audit system.

Timeline for Completion:

Full development of medication audit system: 10/30/07
Auditing: Continuing

Staffing and Training

5. Job Descriptions and Licensure

5a. Appropriate Licensing/Certification of Medical and Mental Health Staff

The DOC will ensure that any person requiring a license or certification to practice under State law has the necessary credentials prior to employment.

- The vendor will be required to submit documentation regarding a prospective employee's licensure or certification to the DOC before the individual begins working at the Facilities.
- The licensure and certification list will be updated monthly by the medical vendor and submitted to the senior fiscal officer for the DOC, who will be responsible for reviewing the list and responding to any deficiencies.

Timeline for Completion:

Policies: 07/01/07

5b. Establish Credentialing Program

The DOC will establish a credentialing program to ensure that all licensed and certified staff have satisfied initial education requirements, as well as any continuing education standards set by the relevant licensing and credentialing bodies.

Timeline for Completion: 01/01/08

6. Staffing

The DOC plans to continue assessing staffing levels and to enter into negotiations when necessary for additional clinical and non-clinical positions. The Director of Health Services and the medical vendor share responsibility for compliance with this provision.

- An additional 14.33 FTE mental health staff and 24.82 FTE medical staff are scheduled to be hired because of staffing increases negotiated in April 2007 with the current medical vendor.

- The DOC will continue evaluating staffing alternatives and options for contending with a serious local and national shortage of qualified nurses.
- DOC will continue efforts to identify and hire qualified individuals to fill the following new positions established in the Office of Health Services:
 - MOA Compliance Officer;
 - Quality Improvement Administrator
 - Administrative Specialist
 - Nurse Practitioner; and
 - Physician

Timeline for Completion: Continuing

7. Medical and Mental Health Staff Management

The medical vendor has been delegated responsibility for assuring compliance with this provision.

7a. Full-Time Medical Director

A full time Medical Director is in place, provided by the contracted medical vendor.

Timeline for Completion: Completed

7b. Director of Nursing

A full time Director of Nursing is in place, provided by the contracted medical vendor.

Timeline for Completion: Completed

7c. Administrative Medical and Mental Health Management

A full time Mental Health Director is in place, provided by the contracted medical vendor. The DOC will facilitate the hiring of additional administrative management staff. This will occur through increased staffing levels negotiated in April 2007 with the current vendor.

Timeline for Completion:

Hiring additional administrative staff: 10/30/07

7d. Facility Clinical Director of Mental Health

On site clinical mental health director positions are currently established and staffed at each of the facilities.

Timeline for Completion: Completed

8. Medical and Mental Health Staff Training

The Mental Health Treatment Services Administrator, Director of Health Services, the medical vendor, and the Educational Development Center (“EDC”) will share responsibility for compliance with requirements in this provision.

8a. Training to Meet Serious Medical and Mental Health Needs

- Initial and in-service training activities will continue to be scheduled by the vendor to provide mental health and special needs medical and mental health populations training.
- Documentation of training and copies of training materials will be available for examination.

Timeline for Completion: 01/01/08

8b. Suicide Prevention

- Qualified mental health professionals will obtain Monitor approval of a curriculum for training on suicide prevention, as described in ¶ 42 below.
- Documentation of attendance at suicide prevention training, as described in ¶ 43 below, will be available for examination.

Timeline for Completion: 01/01/08

8c. Identification and Care of Inmates With Mental Disorders

- Training for medical and mental health staff on the identification and care of inmates with mental health disorders will continue to be provided by the vendor.
- Documentation of training and copies of training materials will be available for examination.
- The Office of Health Services and the EDC will work together to audit compliance with training requirements. Attendance records will be maintained and available for examination.

Timeline for Completion: 01/01/08

9. Security Staff Training

The Director of Health Services, Mental Health Treatment Program Administrator, the medical vendor, and the EDC will share responsibility for compliance with requirements in this provision.

9a. Identification, Referral, and Supervision of Inmates with Serious Medical and Mental Health Needs

- Training in the identification, referral, and supervision of inmates with serious medical and mental health needs will continue to be provided by the vendor.
- Documentation of training and copies of training materials will be available for examination.
- The Office of Health Services and the EDC will work together to audit compliance with training requirements. Attendance records will be maintained and available for examination.

Timeline for Completion: 07/01/08

9b. Additional Mental Health Training for Staff Assigned to Mental Health Units

- The medical vendor will continue to provide training to staff assigned to work in mental health units.
- Documentation of training and copies of training materials will be available for examination.
- The Office of Health Services will work with the EDC to audit compliance with training requirements. Attendance records will be maintained and available for examination.

Timeline for Completion: 07/01/08

Screening and Treatment

10. Medical Screening

The DOC will use the updated DACS intake module for the medical and mental health screening as required under this provision. A printed copy of the medical/mental health screening will be placed in the permanent medical chart.

The medical screening addresses the following issues:

- identification of individuals with serious medical and mental health issues;
- identification of acute medical needs;
- infectious diseases;
- chronic conditions;
- physical disabilities;

- mental illness;
- suicide risk; and
- identification of potential for drug and alcohol withdrawal.

This module includes a full mental health screening. Notification of a mental health provider for issues requiring immediate attention and follow-up will occur via this module system. The DOC is currently using a version of this system that is, as noted above, scheduled for full implementation by 10/30/07. Emergent referrals are currently made via telephone.

The Director of Health Services, the medical vendor, and the Quality Improvement Administrator share responsibility for compliance with this provision.

Timeline for Completion: 10/30/07

11. Privacy

The Commissioner of Correction is leading the effort to achieve full compliance with this provision.

- The DOC is reviewing long-term expansion plans at the Facilities in an effort to assure that privacy is accommodated in all areas where a medical or mental health service will be provided.
- The DOC will study the feasibility of consolidating a range of medical and mental health services into a centralized facility.
- A capital improvements plan is being prepared for presentation to the legislature.
- Because capital improvements require long range planning and substantial funding, staff are evaluating all of the Facilities to identify strategies for:
 - making the best possible use of existing space and;
 - addressing privacy issues.
- Examples of improvements already made include:
 - At HRYCI, an additional patient examination room has been created from space previously used to store records.
 - At BWCI, two offices outside the medical area, previously used for other purposes, have been provided for mental health services, freeing up an additional office in the medical area for an exam room.
 - At SCI, a large storage closet outside the medical area was appropriately modified and converted into an interview room for the psychiatrist.
- Site Wardens and the Director of Health Services are jointly responsible for the Facility evaluations.

Timeline for Completion:

Facility evaluations: 07/01/07

Implementation of short-term changes to available space: 12/30/07

Capital improvements plan to be presented to the bond bill committee in June 2007.
Full compliance: Continuing

12. Health Assessments

The Director of Health Services, the medical vendor, and the Quality Improvement Administrator will be responsible for facilitating compliance with the requirements of this provision.

12a. Timely Medical and Mental health Assessments

- The DOC will use the updated DACS module to track intakes and referrals to chronic care and mental health.
- As noted above, the DOC is currently using a telephone system for emergent referrals to mental health. This system will be used until full implementation of the updated DACS module.
- Referrals will be made directly from the intake system to either the sick call scheduling process, or to the mental health supervisor on call.
- This system allows for quick turnaround of any chronic disease or mental health issue identified during the intake process.
- The referral will be made within 24 hours, and appointments with providers will be scheduled within the time frame prescribed in the MOA.
- All inmates will receive a full health assessment, regardless of identified illness, within 14 days, while inmates identified at intake with a chronic illness will receive a full health assessment within 7 days.
- In accordance with NCCHC standards, any inmate who was previously incarcerated and received an intake physical exam within the previous 12 months will receive an intake screening and chart review. If that screening and chart review indicate no change in health status from the previous intake, a new full physical exam will not be required.
- The Office of Health Services will audit intake procedures quarterly to monitor compliance with these standards.

Timeline for Completion:

Final roll out of updated DACS module: 10/30/07

Quarterly auditing: Continuing

12b. Tracking of Inmates with Chronic Illness

- DOC will use the DACS system and manual lists to track those inmates who are identified (at intake or subsequently) as having a chronic condition.
- Procedures for running chronic care clinics are being amended so that scheduling decisions will be based on the degree of control of the illness.
 - Inmates whose illnesses are under poor control will have more frequent visits to the provider for appropriate evaluation and treatment.

- At a minimum, the DOC plans to assure that all chronic care patients are evaluated by a provider at least once per quarter.
- Quality improvement evaluations will be conducted by the Office of Health Services, using a DOC audit tool, every two months for the first two quarters after full implementation occurs, and every three months for the following quarters.

Timeline for Completion:

Full implementation of new chronic care scheduling procedures: 10/30/07

A paper tracking and scheduling system currently exists.

Quality improvement and audit evaluations have already begun. Auditing of the new system is expected to begin by 12/30/07.

13. Referrals for Specialty Care

The medical vendor and the Quality Improvement Administrator will share responsibility for assuring compliance with this provision.

13a. Referral of Inmates Whose Needs Exceed Facility Capabilities

- The DOC has established a consult tracking system.
- The efficacy of the tracking system will be audited on a quarterly basis to evaluate whether:
 - inmates are referred in a timely manner;
 - consultants' recommendations are reviewed by appropriate referring staff; and
 - clinician responses to consultants' recommendations are documented.

Timeline for Completion:

Consult tracking system identification: Completed

Initial quality improvement audits: 10/30/07

13b. Tracking and Documenting Specialist Findings and Recommendations

After each consultant visit, immediately on return to the institution, a nurse will:

- review the documentation provided by the consultant;
- schedule a follow-up appointment with the referring (DOC vendor) provider to review the consultant's findings and see the patient.

The follow up visit with the provider is to occur no later than 7 days after the consultant appointment.

Recommendations made by the specialist and discussion with the patient will be noted in the progress notes of the patient chart.

The DOC audit tool is used on a quarterly basis to assure that appropriate follow up occurs and is properly documented.

Timeline for Completion:

The DOC's goal is to achieve full compliance with this provision by 10/30/07. Auditing has already begun, and is conducted every two months for the first two audits and quarterly thereafter. Review of the audit results is immediate, and corrective action is taken with the medical vendor to reinforce DOC policy.

14. Treatment or Accommodation Plans

The Facility wardens and the medical vendor will share responsibility for assuring compliance with this provision.

14a. Special Needs Plans

Special needs treatment plans will be developed by the medical and/or mental health providers for all special needs inmates, as defined in NCCHC standards. These plans will include, at a minimum, frequency of follow-up, the type and frequency of diagnostic testing and therapeutic regimens, and when appropriate instructions about diet, exercise, adaptation to the correctional environment, and medication.

Timeline for Completion: 10/30/07

14b. Discharge Planning

For inmates with special needs, who have been in our facilities longer than 30 days, appropriate discharge planning will be included in the treatment plan. Such discharge planning shall be made in relation to the anticipated date of release.

Timeline for Completion: 10/30/07

15. Drug and Alcohol Withdrawal

The Substance Abuse Treatment Program Administrator, Director of Health Services and medical vendor will share responsibility for assuring compliance with this provision.

15a. Policies, Protocols, and Practices to Identify, Monitor, and Treat Withdrawal

The DOC will develop or revise appropriate policies, protocols, and practices for the identification, monitoring and treatment of inmates at risk for, or who are experiencing,

drug or alcohol withdrawal. The intake screening process will be the first line of defense for identifying at-risk individuals and implementing these policies and procedures. The DOC plans to work with the medical vendor and security staff to assure that appropriate personnel are trained on any new policies.

Timeline for Completion:

Drafting and revision of policies: 07/01/07
Staff training: 12/30/07

15b. Withdrawal and Detoxification Programs

The DOC will follow the policies developed for appropriate withdrawal and detoxification of inmates who are at risk of or who have symptoms of drug or alcohol withdrawal.

Timeline for Completion:

Policies: 07/01/07

15c. Methadone Maintenance for Pregnant Inmates

The DOC will work with a community provider to establish an appropriate methadone maintenance program for those inmates who are identified as pregnant at intake and are in a community methadone maintenance program or addicted to opiates.

The DOC will evaluate local and national standards for women who are pregnant and on a methadone maintenance program to assure that the DOC program meets generally accepted professional standards.

Timeline for Completion:

Development of policies: 07/01/07
Full implementation: 12/30/07

16. Pregnant Inmates

The medical vendor, Quality Improvement Administrator, and the Director of Health Services will work together to achieve compliance with this provision.

- The DOC will develop or revise and implement policies and procedures consistent with the appropriate screening, treatment and follow-up of pregnant inmates.

- Policies will be developed to specifically address those patients identified as “high risk” pregnancies.
- All women are currently screened for pregnancy at intake, and the DOC plans to continue this practice.
- The Director of Health Services and the medical vendor are jointly responsible for auditing and assuring compliance with this item.

Timeline for Completion:

Development of policies: 07/01/07

Training on policies: 10/30/07

Full implementation: 12/30/07

17. Communicable and Infectious Disease Management

The DOC Quality Improvement Administrator, Director of Health Services, and the medical vendor will share responsibility for assuring compliance with this provision.

- Policies will be developed and/or revised relating to the identification of individuals in DOC custody with communicable diseases.
- Appropriate screening and treatment for inmates with communicable diseases will be instituted.
- Communicable and infectious disease statistics will be collected, analyzed, and available for review by the Monitor.
- Monthly reports will be instituted to assist with consistency of treatment and control of identified diseases.

Timeline for Completion:

Policy development: 07/01/07

Full implementation: 10/30/07

18. Clinic Space and Equipment

The Commissioner of Correction, bureau chiefs, and wardens will work with appropriate State authorities to achieve compliance with this provision.

- The DOC is reviewing expansion plans at the Facilities to assure that in all areas where a medical or mental health service is provided that adequate space for private, face-to-face nursing and physical examinations is available.
- The DOC will study the feasibility of consolidating a range of medical and mental health services into a centralized facility.

- Because capital improvements are long term solutions, sites are reviewing initial strategies for addressing space and privacy needs.
- Examples of improvements already made include:
 - At HRYCI, an additional patient examination room has been created from space previously used to store records.
 - At BWCI, two offices outside the medical area, previously used for other purposes, have been provided for mental health services, freeing up an additional office in the medical area for an exam room.
 - At SCI, a large storage closet outside the medical area was appropriately modified and converted into an interview room for the psychiatrist.

Timeline for Completion:

Site evaluations: 07/01/07

Initial solutions to be implemented: 12/30/07

Capital improvements plan to be presented to the bond bill committee: 06/07

18a. Privacy for Clinical Exams

Evaluations of each site are taking place to make any initial modifications to the layout of each clinic area. Each site will conduct an audit to identify the specific areas where such changes are possible.

Timeline for Completion:

Evaluations: 07/01/07

Initial modifications/changes: 12/30/07

18b. Adequately Sized and Equipped Exam Rooms

Evaluations of each site are taking place to make any initial changes to the layout of each clinic area. Each site will conduct an audit to identify the specific areas where such changes are possible.

Timeline for Completion:

Evaluations due 07/01/07

Minor modifications/changes due 12/30/07

18c. Action Plan (Paragraph 65) Regarding Bringing Facilities Into Compliance

The DOC expects to present a capital improvements plan to the bond bill committee in June 2007.

Access to Care

19. Access to Medical and Mental Health Services

The Commissioner of Correction, Facility wardens, medical vendor, and Director of Health Services share responsibility for assuring compliance with these provisions.

19a. Opportunity to Request and Receive Medical and Mental Health Care

The DOC will develop or revise and implement policies assuring that inmates have both the opportunity to request and receive medical and mental health care.

Timeline for Completion:

Policies: 07/01/07

Implementation: 10/30/07

19b. Medical Response to Requests

- Currently, and according to the policy in development, all written requests for medical/mental health care will be screened within 24 hours.
- If a clinical symptom is reported, a face-to-face encounter will occur within 72 hours from the time of request, at the latest; or earlier if the screening process identifies that the patient needs to be seen more promptly.

Timeline for Completion:

Policies: 07/01/07

Implementation: 10/30/07

19c. Adequate Security Staffing to Ensure Timely Escort

- The DOC will ensure that adequate security staff are available and accessible to inmates who need to be escorted to the medical/mental health appointment as necessary.
- Facility Wardens and local medical vendor staff will be responsible for assuring compliance with this requirement. Scheduling delays, canceled sick call visits, and/or missed appointments will be evaluated through the DOC audit mechanism to identify the root cause of the delay in providing services. Security-related reasons for the delay will be noted, and evaluated for appropriate corrective action.

Timeline for Completion:

Policies: 07/01/07

Implementation: 10/30/07

19d. Develop and Implement Sick Call Policy

The DOC will develop or revise and implement a sick call policy that will address the following areas:

- an explanation of the order in which patients are scheduled;
- a specific procedure for scheduling patients;
- locations for treatment;
- requirements for clinical evaluations; and
- the maintenance of a sick call log.

Timeline for Completion:

Policies: 07/01/07

Implementation: 10/30/07

19e. Treatment in Response to Sick Call Request in a Clinical Setting

- A policy will be developed and/or revised providing that all sick call visits will take place in an appropriate, private setting conducive to the activity.
- In some areas this will be difficult without the physical plant changes noted in ¶¶ 11 and 18.
- The DOC will work to assure that, in the meantime and to the extent possible, the clinical setting is appropriate for the service to be provided.

Timeline for Completion:

Policies: 07/01/07

20. Isolation Rounds

The DOC will be responsible for drafting appropriate policies, and the medical vendor is responsible for actually performing in compliance with this provision.

- The DOC will develop or revise and implement a policy to assure that medical staff make daily sick call rounds in isolation areas and nursing staff make rounds at least three times a week.
- The policy will indicate that the intent is to provide an opportunity for inmates in isolation adequate opportunity to contact and discuss health/mental health concerns with appropriate medical/mental health staff in a setting that affords as much privacy as the security concerns allow.

Timeline for Completion:

Policies: 07/01/07

Implementation date: 10/30/07

21. Grievances

The Office of Health Services, Quality Improvement Administrator, and medical vendor will share responsibility for assuring compliance with this provision.

21a. Develop and Implement Medical Grievance System

- The DOC will develop or revise and implement an improved grievance system.
- That system will ensure that medical grievances are processed and addressed in a timely manner. The Office of Health Services, along with the Bureau of Prisons, is the responsible party for assuring that grievances are handled in an efficient and effective fashion. The contract audit nurses are part of the team that will work to evaluate the effectiveness of the system, and make suggestions for improvement.

Timeline for Completion: 12/30/07

21b. Medical Grievances and Responses Placed in Inmate Files

- Medical issues raised by the grievance process will be addressed and actions taken will be noted in the progress notes of the inmates' medical record.
- The actual grievance is maintained electronically, under each inmate's name, in DACS as described in ¶ 21c below.

Timeline for Completion: 12/30/07

21c. Log, Review, and Analyze Grievance Outcomes

- Grievances, along with all updates, appeals, responses, and outcomes are, and will continue to be, logged in the DACS system, which can be reviewed by all parties.
- The Office of Health Services will review and analyze the grievances on a monthly basis to identify and note any systemic issues raised by the grievances.

Timeline for Completion: 12/30/07

21d. Develop and Implement Procedure for Addressing Systemic Problems

- The DOC will develop and implement a comprehensive system for understanding and addressing all systemic problems discovered through the analysis conducted in ¶ 21c, above.
- On a monthly basis, the Office of Health Services will be responsible for reviewing systemic problems and making recommendations for systemic responses.

Timeline for Completion: 12/30/07

Chronic Disease Care

22. Chronic Disease Management Program

The Health Services Director, the Quality Improvement Administrator, the audit nurses, and the medical vendor staff will share responsibility for assuring compliance with this provision.

22a. Develop and Implement Chronic Care Disease Management Program

- The DOC will develop or revise and implement a Chronic Care Disease Management Program to identify and track inmates with chronic conditions.
- The DOC plans to implement a Chronic Care Disease Management Program that is driven by the level of control achieved for any given chronic condition.
 - For example, the frequency of chronic care appointments will be based on degree of control of the illness.
 - Each chronic care patient will be seen at least quarterly.
 - Those under poor control will have more frequent visits to the provider for appropriate evaluation and treatment.
- Appropriate diagnosis, treatment, monitoring and continuity of care are important components of the Chronic Care Disease Management Program and will be tracked accordingly.
- Quality improvement audits will be conducted using the DOC audit tool every two months for the first two quarters beginning July 2007 and every three months for the following quarters.

Timeline for Completion: 12/30/07

22b. Maintain Registry of Inmates with Chronic Disease

- DOC will use the DACS system and a manual registry to track those inmates who at intake, or on subsequent occasions, are identified as having a chronic condition.
- Compliance with this requirement will be audited every two months for the first two quarters beginning July 2007 and every three months for the following quarters.

Timeline for Completion: 12/30/07

23. Immunizations

The DOC Office of Health Services, and the medical vendor will share responsibility for assuring compliance with this provision.

23a. Obtain Immunization Records for Juveniles

- The DOC plans to work with the Division of Public Health Immunization program to obtain records, if available, of those juveniles who are in the custody of the DOC.
- Records obtained will become a part of the unified patient chart.

Timeline for Completion:

Policies: 07/01/07

23b. Update Juvenile Immunizations

- The DOC plans to develop or revise immunization policy consistent with current immunization standards.
- The DOC plans to implement standards that are consistent with current nationally recognized guidelines, adolescent immunization standards, and Delaware School Admission requirements.

Timeline for Completion: 10/30/07

23c. Develop Policies and Procedures for Influenza, Pneumonia, and Hepatitis A and B Vaccines

- The DOC plans to develop or revise and implement immunization policies, which will include policies for identifying inmates who require immunizations.
- DOC policies will address immunizations that may be indicated in connection with certain chronic diseases or other conditions, as well as immunization schedules that are appropriate for certain categories of inmates.
- Patients will be evaluated for the following immunizations: pneumonia, influenza, Hepatitis A and B.
- Inmates will be offered immunization based on the criteria established by the policy.
- Medical staff and physician extenders will be trained on immunization protocols
- The medical vendor's Quality Assurance/Control of Infectious Disease ("QA/CID") nurse will be required to monitor compliance with these policies

Timeline for Completion:

Policies: 07/01/07

Implementation start date for immunizations: 10/01/07

Medication

24. Medication Administration

The medical vendor, DOC security staff, and Quality Improvement Administrator will share responsibility for assuring compliance with this requirement.

24a. Appropriately Prescribe and Administer Medications in Timely Manner

- The DOC plans to develop or revise and implement policies that are consistent with NCCHC standards for the prescription and delivery of appropriate medications, based on an assessment and clinically indicated by symptomatology.
- The current formulary will be assessed for appropriateness.
- The DOC intends to draft policies that will require prescribing practitioners to note in the medical record if an alternative medication is indicated and the reason for prescribing the alternative medication. The alternative medication will be made available within 72 hours.

Timeline for Completion:

Policies: 07/01/07

Training: 08/01/07

Implementation date: 10/30/07

24b. Appropriate Access to Medications

- The DOC will develop or revise and implement policies to assure that inmates who are prescribed medications receive those medications on a schedule consistent with clinical practice guidelines and the instructions of the prescribing practitioner.
- A formulary committee was established in February 2007, and is scheduled to meet on at least a quarterly basis.
- The formulary committee will include the Medical Director, Director of Nursing, Director of Psychiatry, one staff clinician, one advanced practice nurse, the DOC Director of Health Services, the DOC Mental Health Treatment Services Administrator and one other DOC professional employee.
- Minutes of the formulary committee meetings will be available for review and examination.

Timeline for Completion:

Policies: 07/01/07

Implementation date: 08/01/07

24c. Policies and Procedures Regarding Missed Doses

- DOC will develop or revise and implement policies to ensure that the prescribing practitioner is notified if a patient misses doses of a particular medication on three consecutive days.
- Notice to the provider shall be documented, according to policy, in the medical chart.
- Compliance with this requirement will be audited every two months for the first two quarters beginning July 2007 and every three months for the following quarters.

Timeline for Completion:

Policy development: 07/01/07

Implementation date: 08/01/07

24d. Formulary Shall Not Unduly Restrict Medications

- The DOC will develop or revise formulary policies which reflect the understanding that the formulary developed will not unduly restrict medications.
- Additions and deletions from the formulary will be made by vote of the committee and reasons for the addition or deletion of any particular medication will be noted in the minutes of the committee.
- Non-formulary requests must be submitted to the vendor's medical director for approval.
- Reasons for denial must be documented and alternatives noted on request forms.

Timeline for Completion:

Policies: 07/01/07

Training: 08/01/07

Implementation date: 10/30/07

24e. MARs Appropriately Completed and Maintained

- The DOC is currently using a MAR in the unified chart.
- The DOC will develop or revise policies to require that medications prescribed are noted in a MAR, which will be a part of each inmate's medical file.
- DOC policies will require documentation in the MAR that is consistent with standard practices.
- Compliance with DOC policy will be audited every two months for the first two quarters beginning July 2007 and every three subsequently.

Timeline for Completion:

Finalization of policy: 07/01/07

Total implementation and completion of first Quality Improvement Audit: 10/30/07

25. Continuity of Medication

- The DOC will develop or revise policy to assure that on intake each entering inmate is screened for medications currently prescribed and those medications are noted on the intake form.
- That list will be forwarded to the prescribing practitioner, who will determine the medical appropriateness of any medications and note any changes to the medication regimen in the progress notes.
- A face-to-face encounter will be conducted when the medical condition so dictates.
- The medication prescribed will be ordered and administered consistent with the medication policy noted above.
- The DOC will implement changes to the DACS medical module to streamline this process.

Timeline for Completion

Policy: 07/01/07

Intake changes to the DACS system: 10/30/07

26. Medication Management

- The DOC will develop or revise policies and procedures consistent with standard practice for the access to, storage of, and safe and proper disposal of medications and medical waste.
- The medical vendor and the Substance Abuse Treatment Services Administrator will be the responsible parties for compliance with this item.

Timeline for Completion:

Policy: 07/01/07

Training: 08/01/07

Implementation: 09/01/07

Emergency Care

27. Access to Emergency Care

The Director of Health Services, Mental Health Treatment Program Administrator, EDC and the medical vendor will share responsibility for assuring compliance with this provision.

27a. Train to Recognize and Respond to Medical and Mental Health Emergencies

- As noted in ¶¶ 8 and 9 of this document, the DOC will assure appropriate training of staff who may respond to emergency situations.

Timeline for Completion: 01/01/08

27b. Timely and Appropriate Care of Medical and Mental Health Emergencies

- The DOC will develop or revise policies requiring medical personnel to use appropriate clinical judgment to determine whether the inmate must be transported to an outside facility for emergency treatment.
- If medical staff are not available, the policy will require transportation of the patient to an appropriate facility for evaluation.

Timeline for Completion:

Policy: 07/01/07

Implementation: 01/01/08

28. First Responder Assistance

28a. First Responder Training

As noted in ¶¶ 8 and 9 of this Action Plan, the DOC will continue to conduct training sessions for all employees. Training materials and schedules will be available to the monitor for inspection.

Timeline for Completion: 01/01/08

28b. Emergency Response Protective Gear

Consistent with the training noted above, protective gear will continue to be made available. Protective gear includes items such as masks, gloves, etc.

Timeline for Completion:

Training: 10/30/07

Full implementation: 01/01/08

Mental Health Care

29. Treatment

Mental Health Treatment Program Administrator, the Clinical Director of Mental Health, and the medical vendor will share responsibility for assuring compliance with this provision.

- The DOC will develop policies to address the provision of mental health services by qualified mental health professionals.
- The policy will address timely, adequate, and appropriate screening, assessment, evaluation, treatment and structured therapeutic activities for inmates who are diagnosed with a mental health illness.
- The policy will also address the need for specific observation of and assessment of those inmates who are identified as suicidal, and those who enter DOC with a serious mental health condition or need, or who develop such a need after incarceration.

Timeline for Completion:

Policy: 07/01/07

Full implementation: 10/30/07

30. Psychiatrist Staffing

The Office of Health Services will work with the medical vendor to identify qualified psychiatrists to meet the psychiatrist staffing needs in the DOC system.

30a. Psychiatrist Staffing

- Additional psychiatric staff are scheduled to be hired because of staffing increases negotiated in April 2007 with the current medical vendor.
- The DOC will assist the medical vendor in recruiting and retaining qualified psychiatrists to meet the mental health needs of inmates housed in the Facilities.
 - The DOC plans to work with the Medical Society of Delaware to identify qualified candidates.
 - The DOC also plans to contact regional medical schools to identify recruiting opportunities.
- The DOC will work with the Clinical Director of Mental Health and the medical vendor to identify the appropriate number of psychiatrist hours required to participate in individualized treatment plans, prescribe and adequately monitor

psychotropic medications, review charts, and respond to diagnostic and laboratory tests.

- As noted in ¶ 5, the DOC will ensure that psychiatrists hired by the medical vendor have appropriate licenses and certifications.
- The DOC will maintain a roster of all professionals providing this service, including the sites they are assigned to and the number of hours provided.

Timeline for Completion: Continuing

30b. Psychiatrist Duties and Responsibilities

- The DOC will work with the Clinical Director of Mental Health to assure that all psychiatric staff:
 - collaborate with mental health staff to identify the resources needed to care for those with serious mental health illness; and
 - communicate those needs to the warden of the particular Facility, while maintaining autonomy regarding clinical decisions.
- Psychiatrists assigned to a Facility will oversee the Facility's mental health treatment team.

Timeline for Completion: 10/30/07

31. Administration of Mental Health Medications

Responsibility for compliance with this provision will be shared by the medical vendor, Mental Health Treatment Program Administrator, nursing supervisors, and the Quality Improvement Administrator.

31a. Policies, Procedures, and Practices Regarding Prescribing, Distributing, and Monitoring Psychotropic Medications

- As noted in ¶ 24 of this Action Plan, the DOC will develop or revise and implement medication prescribing, ordering, distribution and reordering policies consistent with professional standards.
- This procedure will apply to all medications, including those prescribed for psychiatric conditions.

Timeline for Completion:

Policy: 07/01/07

Implementation: 10/30/07

31b. MAR Documentation

- As noted in ¶24 of this Action Plan, the MAR will be used to document the time and amount of medication given and any refusal by the inmate.

- Only registered and licensed practical nurses will be allowed to administer medications to inmates in the Facilities, in accordance with Delaware law.
- Compliance with existing policies requiring nurses to perform mouth checks will be monitored.
- Compliance with policies requiring nurses to note any adverse effects of medications in the patient record will be audited at each Facility with the DOC audit tool every two months for the first two quarters beginning 10/30/07, and every three months for the following quarters.

Timeline for Completion:

Policies: 07/01/07

Total implementation and completion of first Quality Improvement audit: 10/30/07

31c. MAR Review

- MARs will be reviewed on a regular basis by the nursing supervisor assigned to the particular clinical area.
- This review will be to assure that policies and procedures are being followed consistently and thoroughly.
- Notations in the progress notes of the medical chart will also be reviewed for appropriate documentation.

Timeline for Completion:

Policy: 07/01/07

Training: 08/01/07

Total implementation and completion of first review by nurse supervisor: 10/30/07

32. Mental Illness Training

As noted in ¶¶ 8 and 9 of this Action Plan, mental illness training will be conducted consistent with this portion of the MOA.

- Security personnel who are assigned to the special needs units will have training designed for their job locations.
- Qualified mental health professionals will provide training through on-site or via interactive Internet.

Timeline for Completion: 01/01/08

33. Mental Health Screening

33a. Screening within 24 Hours

- As noted in ¶¶ 10 and 12 of this Action Plan, the DOC plans to use the updated DACS module for the initial intake process.
- This intake system is designed to be consistent with generally accepted mental health screens conducted according to NCCHC standards.
- The DOC expects that mental health screening performed with this tool will identify any history of mental illness, current psychiatric medications, potential for suicide ideation, past suicide attempts, or suicidal tendencies.

Timeline for Completion:

Policy development: 07/01/07
 Screening tool on line: 10/30/07

33b. Psychiatric Assessment

- The DOC will develop or revise policies to require a face-to-face encounter with a psychiatrist before any changes are made to psychotropic medications.
- The DOC expects that this assessment will take place no later than 10 days after the intake is completed.
- Inmates who require resumption of psychotropic medications are expected to be seen as soon as clinically appropriate, but no later than 10 days after intake.

Timeline for Completion:

Policy development: 07/01/07
 Full implementation of policy due to lag time in hiring psychiatrists: 01/01/08

33c. Medication Continuation

- The DOC will develop or revise policies intended to assure that generally accepted professional standards are met in identifying whether an inmate was prescribed psychotropic medications at the time of intake and that orders for the continuation of psychotropic medications are written in accordance with the provisions of the MOA.

Timeline for Completion:

Policy development: 07/01/07
 Full implementation of policy: 10/30/07

33d. Emergency Mental Health Referral

- The DOC will develop or revise its policies to require direct communication, either in-person or via telephone, with a qualified mental health professional when an immediate referral to a qualified mental health professional is clinically indicated, based on the inmate's responses to the intake screening.

- Quality Improvement systems developed for mental health referrals will be used to assure adherence to this policy.

Timeline for Completion:

Policy development: 07/01/07

Implementation of updated DACS module and Quality Improvement activities: 10/30/07

34. Mental Health Assessment and Referral

The Clinical Director of Mental Health, the medical vendor, and DOC mental health personnel share responsibility for assuring compliance with this provision. DOC personnel will also assist with updates to the DACS mental health modules.

34a. Mental Health Assessment

- When the updated DACS module is completed, it will automatically refer any inmate identified during the intake process as requiring an assessment by a qualified mental health professional.
- Inmates referred for routine mental health referrals are to be seen by a mental health professional within 72 hours.
- The vendor has been instructed that it must make direct contact with a qualified mental health professional when an urgent referral is needed for an urgent problem.

Timeline for Completion:

Policy development: 07/01/07

Full implementation: 10/30/07

34b. Confidential Self-Referral

- The DOC will develop or revise policies to assure that each inmate will have access, regardless of institutional setting, to a confidential self-referral system without the need to reveal the substance of the request to security staff.
- The DOC will work to assure that written requests will be evaluated daily and triaged by qualified mental health professionals for immediate and routine evaluation.
- DOC policies will require the medical vendor to arrange for a face-to-face encounter with a qualified mental health professional within 72 hours of the request.

Timeline for Completion:

Policy development: 07/01/07

Implementation: 10/30/07

34c. Referral for Specialty Care

- The DOC will develop or revise policies regarding referrals to specialty psychiatric care, if such a need is identified based on the face-to-face clinical evaluation of a psychiatrist.
- All patients identified with a serious mental health condition will have routine mental health visits scheduled.
- The referral process will be monitored via regular compliance audits.

Timeline for Completion:

Policy development: 07/01/07

Full implementation of policy due to unavoidable lag time in hiring psychiatrists:
01/01/08

35. Mental Health Treatment Plans

- The DOC will develop or revise policies to assure that patients requiring ongoing mental health services have a treatment plan based on diagnosis and individual clinical needs.
- DOC policies will require treatment plans to be prepared at the time of the initial assessment and updated at a minimum of quarterly.
- DOC policies will also require that changes to a treatment plan be documented in the unified medical record.

Timeline for Completion:

Policy development: 07/01/07

Implementation: 10/30/07

36. Crisis Services

Responsibility for assuring compliance with this requirement will be shared by the Commissioner of Correction, Deputy Attorney General assigned to the DOC, Mental Health Treatment Program Administrator, and the medical vendor.

36a. Adequate Array of Crisis Services

- The DOC will develop or revise policies assuring that appropriate services are available in the event of a psychiatric crisis.

- Transfer to the Delaware Psychiatric Center (“DPC”) will be used when it is determined that in-patient psychiatric care is necessary to stabilize the patient.
- It is currently, and will continue to be, the policy of the DOC that administrative/disciplinary isolation or observation status is not a substitute for in-patient psychiatric care.

Timeline for Completion:

Policy development: 07/01/07

Full implementation of referral to DPC: 01/01/08. (Additional time is required for full implementation of referral policies because Department of Health and Social Services policies regarding the availability of beds may also have to be revised.)

36b. In-Patient Psychiatric Care

- The Delaware Psychiatric Center will be used for in-patient psychiatric services.
- The DOC, Deputy Attorney General, and medical vendor will work together to assure that transfers to DPC occur as expeditiously as possible.
- The DOC also plans to develop strategies for assuring that adequate space is available for psychiatric care at each Facility.

Timeline for Completion:

Full implementation of referral to DPC: 01/01/08. (Additional time is required for full implementation of referral policies because Department of Health and Social Services policies regarding the availability of beds may also have to be revised.)

37. Treatment for Seriously Mentally Ill Inmates

37a. Space for Treatment

- The DOC will continue working to assure that space is available for the treatment of inmates with a mental health diagnosis.
- The DOC is currently reviewing potential expansion options at the Facilities.
- Because capital improvements are long range solutions to space issues, the Facilities will continue reviewing opportunities for short-term modifications to existing resources in an effort to improve space available for mental health treatment.

Timeline for Completion:

Site evaluations: 07/01/07

Minor changes: 12/30/07

Capital improvements plan to be presented to the bond bill committee in June 2007.

37b. Staffing

Recruitment of qualified mental health professional staff has been initiated, and will continue on an as-needed basis

Timeline for Completion:

Continuing

37c. Adequate Array of Therapeutic Programming

- Because the availability of therapeutic programming depends significantly on the mental health staffing levels, the DOC and medical vendor plan to continue recruiting efforts.
- The DOC will develop or revise policies on the appropriate use of therapeutic programming for those inmates identified as seriously mentally ill.

Timeline for Completion:

Policy development: 07/01/07

Implementation based on hiring appropriate qualified mental health professionals:
10/30/07

37d. Regular Physician Visits for Inmates on Psychotropic Medications

- The DOC will develop or revise and implement policies to assure that patients who are being treated with psychotropic medications are seen routinely by a physician to monitor responses and potential reactions to the medications.
- The DOC will conduct audits to ensure compliance.
- The DOC will work with the medical vendor to ensure the relevant health care staff receive training on new policies.

Timeline for Completion:

Policy development: 07/01/07

Implementation of regular visits by physicians: 01/01/2008

38. Review of Disciplinary Charges for Mental Illness Symptoms

Responsibility for compliance with this provision will be shared by Facility wardens, the Mental Health Treatment Program Administrator, Clinical Director of Mental Health, and medical vendor.

- The DOC will develop or revise and implement policies to assure that when any inmate identified as seriously mentally ill has a disciplinary charge resulting in

transfer to isolated status, the charge will be reviewed by a qualified mental health professional, who will evaluate the inmate, on the time schedule outlined in ¶ 39b below, to determine if there are mitigating factors related to the serious mental illness of the inmate.

- If the qualified mental health professional determines that such mitigating factors exist, this will be considered when punishment is imposed on that particular inmate with a serious mental illness.
- When serious security concerns exist that contraindicate the recommend remedy made by the mental health staff, a multidisciplinary case conference, including at a minimum security and mental health staff, will be held and an appropriate alternative will be identified.

Timeline for Completion:

Policy development: 07/01/07

Implementation based on the hiring of qualified mental health professional staff: 10/30/07.

39. Procedures for Mentally Ill Inmates in Isolation or Observation Status

The Commissioner of Correction, Mental Health Treatment Program Administrator, and medical vendor will share responsibility for assuring compliance with this provision.

39a. Policies, Procedures, and Practices Regarding Treatment of Inmates Housed in Isolation

- The DOC will develop or revise and implement policies, procedures, and practices to ensure appropriate treatment of inmates housed in isolation, including isolation rounds one time per week by qualified mental health professionals.
- The DOC will conduct audits to ensure compliance.

Timeline for Completion:

Policy development: 07/01/07

Full implementation (depending on ability to hire qualified mental health professional staff): 10/30/07.

39b. Evaluation of Mentally Ill Inmates Placed in Isolation

- The DOC will develop or revise and implement policies to ensure initial evaluation by a qualified mental health professional within 24 hours for inmates with serious mental illness who are placed in isolation.
- After the initial evaluation, these inmates will be reevaluated for any psychological decompensation by a qualified mental health professional a minimum of three times per week.

- The DOC will evaluate whether continued isolation is appropriate, based upon the evaluation of a qualified mental health professional, or whether the inmate would be appropriate for graduated alternatives.

Timeline for Completion:

Policy development: 07/01/07

Implementation based on the hiring of a sufficient number of qualified mental health professional staff: 10/30/07

39c. Documentation and Treatment Review by Psychiatrist

- The DOC will develop or revise and implement its policies, procedures, and practices to ensure adequate documentation by medical/mental health staff for all admissions to and discharges from isolation.
- Such documentation shall include a review of treatment by a psychiatrist.
- The DOC will work with the medical vendor to ensure the relevant health care staff receive training on new policies.
- The DOC will conduct audits to ensure compliance.

Timeline for Completion:

Policy development: 07/01/07

Implementation based on the hiring of qualified mental health professional and psychiatric staff: 10/30/07

39d. Adequate Observation Facilities

- The DOC will provide adequate facilities for observation, with no more than two inmates per room.
- Evaluations of each site are taking place to identify potential options for complying with this requirement utilizing existing resources.
- Full compliance with this requirement will be accomplished as outlined in ¶ 18 above.

Timeline for Completion:

Evaluations: 07/01/07

Initial modifications/changes due: 12/30/07

Capitol improvements as outlined in ¶ 18 above

40. Mental Health Services Logs and Documentation

Responsibility for assuring continuing compliance with this provision will be shared by the DOC Quality Improvement Administrator and the medical vendor.

40a. Mental Health Log

- The DOC will continue maintaining a log of inmates receiving mental health services, listing all inmates receiving mental health treatment regardless of medication status.
- The log will continue to include the following information:
 - name;
 - diagnosis or complaint;
 - next scheduled appointment;
 - and medications and dosages.
- The log will continue to be maintained and made available to each clinician.

Timeline for Completion:

Log is currently available and will be maintained on a continuing basis. Log is available on request for inspection.

40b. Updated and Accurate Medical Records

- Inmate medical records shall contain current and accurate information regarding any medication changes ordered in at least the past year.
- The DOC will continue to conduct quality assurance reviews of medical records to identify deficiencies and training needs.

Timeline for Completion:

Medical records are currently available; quality assurance monitoring will be continuing.

IV. Suicide Prevention

41. Suicide Prevention Policy

The Mental Health Treatment Program Administrator and the Quality Improvement Administrator will be responsible for assuring compliance with this provision.

- The DOC will develop or revise a suicide prevention policy to ensure training, intake screening/assessment, communication, housing, observation, intervention, and morbidity and mortality review.

Timeline for Completion:

Policy development: 07/01/07

42. Suicide Prevention Training Curriculum

The Mental Health Treatment Program Administrator and EDC share responsibility for developing the suicide prevention training curriculum.

- The DOC will develop or revise a suicide prevention training curriculum, which will include the following information:
 - the DOC suicide prevention policy;
 - the ways in which facility environments contribute to suicidal behavior;
 - potential predisposing factors to suicide;
 - high risk suicide periods;
 - warning signs and symptoms;
 - case studies of recent suicides and serious suicide attempts;
 - mock demonstrations regarding the proper response to a suicide attempt;
 - and the proper use of emergency equipment.

Timeline for Completion:

Training curriculum development: 06/15/07

43. Staff Training

Mental Health Treatment Program Administrator, the Director of Health Services, the medical vendor, and EDC will share responsibility for compliance with requirements in this provision.

43a. Initial Training

- Consistent with ¶ 8b above, the DOC will ensure that training on suicide prevention for all existing and newly hired correctional, medical, and mental health staff will be provided using a monitor-approved curriculum as described in ¶ 42.

Timeline for Completion:

Curriculum available for DOJ review by 06/15/07

Training will commence upon DOJ approval of the curriculum, and is expected to be completed by 01/01/08.

43b. Refresher Training

- After initial training is completed, the DOC will ensure that all correctional, medical, and mental health staff receive an annual two-hour refresher training on the suicide prevention curriculum, described in ¶ 42 above, each year.

Timeline for Completion:

Policy development by 07/01/07

Refresher training is scheduled to begin one year after initial training is completed (this date will be driven by the date on which DOC receives approval of the curriculum from DOJ and begins the initial training).

44. Intake Screening/Assessment

Responsibility for assuring compliance with this section is being shared by Mental Health Treatment Program Administrator, the DOC Quality Improvement Administrator, DOC Management Information Systems, and CMS

- The DOC will develop or revise and implement policies and procedures pertaining to intake screening in order to identify newly arrived inmates who may be at risk for suicide.
- The screening will include inquiry regarding past suicide ideation and/or attempts, current ideation, threat, plan, prior mental health treatment/hospitalization, recent significant loss (job, relationship, death of a family member/close friend, etc.), history of suicidal behavior by a family member/close friend, suicide risk during prior confinement in a state facility, and the arresting or transporting officer(s) belief that the inmate is currently at risk.
- The updated DACS system will be used to track and identify if the inmate has any of the above factors noted on intake.
- Under the current intake system, these factors are noted and referrals are made via telephone to the qualified mental health professional.

Timeline for Completion:

Policy development: 07/01/07

DACS changes: 10/30/07

45. Mental Health Records

Health Services Director and the medical vendor are responsible for assuring compliance with this provision.

- The DOC will develop or revise and implement policies that require medical staff to immediately request all pertinent mental health records, regarding an inmate's prior hospitalization, court-ordered evaluations, medication and other treatment, upon admission.
- The DOC Office of Health Services will work with local providers to facilitate compliance.

Timeline for Completion:

Policy development: 07/01/07

Coordination with external agencies and education of intake medical staff: 10/30/07

46. Identification of Inmates at Risk of Suicide

Policy development will be the responsibility of the DOC; the medical vendor will be responsible for implementing the policies as written.

- The DOC will develop or revise and implement policies that require medical staff place inmates identified as at risk for suicide on suicide precautions until they can be assessed by a qualified mental health professional.
 - Inmates identified as “at risk” include those who actively suicidal (i.e. threatening or engaging in suicidal behavior), those expressing suicidal ideation, (i.e. a vague wish to die without a plan), or those with a recent history of self-destructive behavior, and/or those who deny suicidal ideation and do not threaten suicide, but whose behavior indicates the potential for self-injury.
- The assessment is to occur according to the time limit stated below in ¶ 47.

Timeline for Completion:

Policy development : 07/01/07

Implementation based on the hiring of a sufficient number of qualified mental health professional staff: 10/30/07

47. Suicide Risk Assessment

The Mental Health Treatment Program Administrator, DOC Quality Improvement Administrator, and the medical vendor will share responsibility for compliance with this provision.

- The DOC will develop or revise and implement policies that require a formalized risk assessment to be conducted by a qualified mental health professional within the appropriate time frame, not to exceed 24 hours from the initiation of suicide precautions.
- The assessment shall include, but not be limited to, description of antecedent events and precipitating factors, suicidal indicators, mental status examination, previous psychiatric and suicide risk history, level of lethality, current medication, diagnosis, and recommendations/treatment plan.
- The assessment will be documented in the treatment record.

Timeline for Completion:

Policy development: 07/01/07

Training of existing staff by 08/01/07

Timing of full implementation will be governed partly by the medical vendor’s ability to hire a sufficient number of qualified mental health professional staff, but the DOC’s goal is to have this task accomplished by 10/30/07.

48. Communication

The Mental Health Treatment Program Administrator and medical vendor share responsibility for this provision.

48a. Documentation for Inmates on Suicide Precautions

- The DOC will develop or revise and implement policies that require mental health or medical staff placing an inmate on suicide precautions to document the initiation of the precautions, level of observation, housing location, and conditions of the precautions.

Timeline for Completion:

Policy development: 07/01/07

Implementation: 08/01/07

48b. Notification of Mental Health Staff

- The DOC will develop or revise and implement policies requiring mental health staff to be provided with all of the documentation described in ¶ 48a (above).
- These policies will also require that in-person contact be made with mental health staff to alert them of placement of an inmate on suicide precautions.

Timeline for Completion:

Policy development: 07/01/07

Implementation: 08/01/07

48c. Medical Record Review

- The DOC will develop or revise and implement policies that require that mental health staff thoroughly review the health care record for documentation of any prior suicidal behavior.

Timeline for Completion:

Policy development: 07/01/07

Implementation: 08/01/07

48d. Medical Record Documentation

- The DOC will develop or revise and implement policies requiring that mental health staff document each interaction with and/or assessment of a suicidal inmate in the health care record, including full justification of any decision to upgrade, downgrade, discharge, or maintain an inmate on suicide precautions.

Timeline for Completion:

Policy development: 07/01/07

Implementation: 08/01/07

48e. Downgrade / Discharge Suicide Precautions

- The DOC will develop or revise and implement policies stating that no inmate is downgraded or discharged from suicide precautions until the responsible mental and health care staff has thoroughly reviewed the inmate's health care record and conferred with correctional personnel regarding the inmate's stability.

Timeline for Completion:

Policy development: 07/01/07

Implementation: 08/01/07

48f. Multidisciplinary Case Management

- The DOC will develop or revise and implement policies requiring multidisciplinary case management team meetings (to include correctional, medical, and mental health staff) to occur on a weekly basis in order to discuss the status of inmates on suicide precautions.

Timeline for Completion:

Policy development: 07/01/07

Implementation: 08/01/07

49. Housing

The Mental Health Treatment Program Administrator, DOC Maintenance Department, DOC Wardens, and medical vendor will all share responsibility for assuring compliance with this provision.

49a. Suicide Resistant Cells

The DOC will ensure that all inmates on suicide precautions are housed in suicide resistant cells (i.e. cells without protrusions that would provide easy access for hanging attempts), which provide full visibility to staff.

Cells used for suicide precautions are being or have been evaluated for suicide resistance at each of the facilities. At HRYCI, identified cells have been retrofitted with breakaway sprinkler heads. Suicide resistant air vents have been installed, and openings in window frames, which could have been used for hanging, have been sealed.

Timeline for Completion:

Facility improvements are either under way or being evaluated
Full compliance is expected to occur by 01/01/08

49b. Mental Health Staff to Stipulate Conditions

- The DOC will develop or revise and implement policies requiring that the appropriate medical or mental health staff write orders in the health care record setting forth the conditions for the observation.
- Such orders will take into consideration all relevant security concerns.
- The Warden and or his or her designee will work with the mental health provider to resolve any dispute between custody and mental health/medical staff over which privileges are appropriate in a particular instance.

Timeline for Completion:

Policy development: 07/01/07

Implementation: 08/01/07

50. Observation

The Mental Health Treatment Program Administrator is responsible for drafting the policies required under this section, and, along with the medical vendor, will oversee training on the policies. The medical vendor and DOC security staff will share responsibility for implementing the policies.

50a. Policies and Procedures Pertaining to Suicidal Inmates

- The DOC will develop or revise and implement policies and procedures relating to the observation of inmates who are suicidal or at risk for suicide under the criteria identified in ¶ 50 of the MOA.
- These policies will provide that such inmates are to be placed on close observation status and observed by staff at staggered intervals, not to exceed every 15 minutes.
- The DOC policy will provide that any inmate who is actively suicidal, i.e. threatening or engaging in suicidal behavior, will be placed on constant observation and observed by staff on a continuous, uninterrupted basis.

Timeline for Completion:

Policy development: 07/01/07

Implementation: 08/01/07

50b. Daily Mental Health Assessment of Suicidal Inmates

- The DOC will develop or revise and implement policies and procedures requiring that mental health staff interact with inmates on suicide precautions on a daily basis, rather than just observing the inmates.

Timeline for Completion:

Policy development: 07/01/07

Full implementation depends on the vendor's ability to hire a sufficient number of qualified mental health professionals, but the DOC's goal is to accomplish full implementation by 10/30/07

51. Step-Down Observation

The Mental Health Treatment Program Administrator is responsible for drafting the policies required under this section, and, along with the medical vendor, will oversee training on the policies. The medical vendor and DOC security staff will share responsibility for implementing the policies.

51a. Step-Down Level of Observation

- The DOC will develop or revise and implement policies and procedures requiring that inmates released from suicide precautions are gradually released via a "step-down," from a more restrictive level of observation to less restrictive levels, for an appropriate period of time prior to their discharge from suicide precautions.

Timeline for Completion:

Develop policy by 07/01/07

Train existing staff by 10/30/07

Full implementation will be contingent on the medical vendor's ability to hire a sufficient number of qualified mental health professionals, but the DOC's goal is for this to be accomplished by 01/01/08.

51b. Follow-Up Assessment

- The DOC will develop or revise and implement policies and procedures requiring that inmates discharged from suicide precautions receive follow up assessment in accordance with a treatment plan developed by a qualified mental health professional.

Timeline for Completion:

Develop policy by 07/01/07

Train existing staff by 10/30/07

Full implementation will be contingent on the medical vendor's ability to hire a sufficient number of qualified mental health professionals, but the DOC's goal is for this to be accomplished by 10/30/07.

52. Intervention

The Mental Health Treatment Program Administrator, Director of Health Services, medical vendor, and EDC will share responsibility for compliance with requirements in this provision.

52a. First Aid and CPR Training

- The DOC will develop or revise and implement policies and procedures ensuring that all staff who come into contact with inmates receive training in CPR and First Aid on a biennial basis.

Timeline for Completion:

Currently up to date; training will be continuing.

52b. Annual Mock Drill

Mock drill/demonstration will be a part of the initial and annual suicide trainings as outlined in ¶¶ 42 and 43 above.

Timeline for Completion: 01/01/08

52c. Response Equipment

The DOC will ensure that emergency response equipment is available within close proximity to each housing unit, including a first aid kit and an emergency rescue (cut down knife) tool, and that all staff who come into contact with inmates know the location and proper use of the equipment.

Timeline for Completion:

Completed; compliance will be continuing.

53. Mortality and Morbidity Review

The DOC Quality Improvement Administrator, Mental Health Treatment Program Administrator, and medical vendor share responsibility for assuring compliance with this provision.

- The DOC will develop or revise and implement policies and procedures ensuring that a multidisciplinary review is conducted to review all suicides and serious suicide attempts (e.g., those requiring hospitalization for medical treatment).
- The review will include an inquiry of:
 - the circumstances surrounding the incident;
 - facility procedures relevant to the incident;
 - relevant training received by staff involved;
 - pertinent medical and mental health reports involving the victim;
 - possible precipitating factors; and
 - recommendations, if any, that are made.
- A written plan will be developed to address any identified areas requiring corrective action.

Timeline for Completion:

Policy development: 07/01/07

Implementation: 08/01/07

V. Quality Assurance

54. Policies and Procedures

The DOC Quality Improvement Administrator, Director of Health Services, Mental Health Treatment Program Administrator, BOP Chief Richard Kearney, and the Deputy Attorney General assigned to the DOC share responsibility for assuring compliance with this provision.

- The DOC will develop or revise quality assurance polices and procedures that address each of the substantive provisions noted above.
- The DOC Quality Assurance Program will involve:
 - the creation of a multidisciplinary team;
 - morbidity and mortality reviews with root cause analysis;
 - periodic review of emergency room visits and hospitalizations for ambulatory-sensitive conditions.
- The DOC Quality Assurance program will be designed to assure that the DOC is able to regularly assess and address identified deficiencies.
- An assessment tool is currently being used for DOC Quality Improvement audits.
- This assessment tool permits data tracking and analysis of trends, and can be easily modified to address new issues.

Timeline for Completion:

Polices and procedure: 07/01/07

First Quality Assurance report: 10/30/07

55. Corrective Action Plans

55a. Policies and Procedures to Address Identified Problems

- The DOC will develop or revise policies and procedures as needed to address issues that arise during the Quality Assurance activities described in this Action Plan.

Timeline for Completion: 10/30/07 and continuing as needed

55b. Corrective Action Plan

- When indicated by the results of a quality assurance review, the DOC will develop corrective action plans to address identified issues.
- The purpose of the corrective action plan will be to prevent future occurrences of identified issues.

Timeline for Completion:

As needed

APPENDIX III

IMMUNIZATION SCHEDULES

Recommended Immunization Schedule for Persons Aged 7–18 Years—UNITED STATES • 2008

For those who fall behind or start late, see the green bars and the catch-up schedule

Vaccine ▼	Age ►	7-10 years	11-12 years	13-18 years
Diphtheria, Tetanus, Pertussis ¹		see footnote 1	Tdap	Tdap
Human Papillomavirus ²		see footnote 2	HPV (3 doses)	HPV Series
Meningococcal ³		MCV4	MCV4	MCV4
Pneumococcal ⁴		PPV		
Influenza ⁵		Influenza (Yearly)		
Hepatitis A ⁶		HepA Series		
Hepatitis B ⁷		HepB Series		
Inactivated Poliovirus ⁸		IPV Series		
Measles, Mumps, Rubella ⁹		MMR Series		
Varicella ¹⁰		Varicella Series		

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2007, for children aged 7–18 years. Additional information is available at www.cdc.gov/vaccines/recs/schedules. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not

contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations, including for **high risk conditions**: <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). (Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™)

- Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoids (Td) booster dose.
- 13–18 year olds who missed the 11–12 year Tdap or received Td only, are encouraged to receive one dose of Tdap 5 years after the last Td/DTaP dose.

2. Human papillomavirus vaccine (HPV). (Minimum age: 9 years)

- Administer the first dose of the HPV vaccine series to females at age 11–12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine.

- Administer MCV4 at age 11–12 years and at age 13–18 years if not previously vaccinated. MPSV4 is an acceptable alternative.
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories.
- MCV4 is recommended for children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups.
- Persons who received MPSV4 3 or more years prior and remain at increased risk for meningococcal disease should be vaccinated with MCV4.

4. Pneumococcal polysaccharide vaccine (PPV).

- Administer PPV to certain high-risk groups.

5. Influenza vaccine.

- Administer annually to all close contacts of children aged 0–59 months.
- Administer annually to persons with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at higher risk.

- Administer 2 doses (separated by 4 weeks or longer) to children younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time last season, but only received one dose.
- For healthy nonpregnant persons (those who do not have underlying medical conditions that predispose them to influenza complications) ages 2–49 years, either LAIV or TIV may be used.

6. Hepatitis A vaccine (HepA).

- The 2 doses in the series should be administered at least 6 months apart.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children.

7. Hepatitis B vaccine (HepB).

- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

8. Inactivated poliovirus vaccine (IPV).

- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age 4 years or older.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR).

- If not previously vaccinated, administer 2 doses of MMR during any visit, with 4 or more weeks between the doses.

10. Varicella vaccine.

- Administer 2 doses of varicella vaccine to persons younger than 13 years of age at least 3 months apart. Do not repeat the second dose, if administered 28 or more days following the first dose.
- Administer 2 doses of varicella vaccine to persons aged 13 years or older at least 4 weeks apart.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

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Recommended Adult Immunization Schedule

Note: These recommendations must be read with the footnotes that follow.

Figure 1 Recommended adult immunization schedule, by vaccine and age group United States, October 2007 - September 2008

VACCINE ▼	AGE GROUP ▶	19–49 years	50–64 years	≥65 years
Tetanus, diphtheria, pertussis (Td/Tdap) ^{1,*}		1 dose Td booster every 10 yrs Substitute 1 dose of Tdap for Td	1 dose Td booster every 10 yrs	1 dose
Human papillomavirus (HPV) ^{2,*}		3 doses females (0, 2, 6 mos)		
Measles, mumps, rubella (MMR) ^{3,*}		1 or 2 doses	1 dose	1 dose
Varicella ^{4,*}			2 doses (0, 4–8 wks)	1 dose
Influenza ^{5,*}			1 dose annually	1 dose
Pneumococcal (polysaccharide) ^{6,7}			1–2 doses	1 dose
Hepatitis A ^{8,*}			2 doses (0, 6–12 mos or 0, 6–18 mos)	
Hepatitis B ^{9,*}			3 doses (0, 1–2, 4–6 mos)	
Meningococcal ^{10,*}			1 or more doses	
Zoster ¹¹				1 dose

*Covered by the Vaccine Injury Compensation Program.

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 24 hours a day, 7 days a week.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

Figure 2. Vaccines that might be indicated for adults based on medical and other indications United States October 2007 – September 2008

VACCINE ▼	INDICATION ▶	Pregnancy	Immuno-compromising conditions (excluding human immunodeficiency virus (HIV), medications, radiation) ¹	HIV infection ^{1,11} CD4 + T lymphocyte count <small><200 cells/μL</small> <small>≥200 cells/μL</small>	Diabetes, heart disease, chronic pulmonary disease, chronic alcoholism	Asplenia ¹² (including splenectomy and terminal complement deficiencies)	Chronic liver disease	Kidney failure, end-stage renal disease, receipt of hemodialysis	Health-care personnel
Tetanus, diphtheria, pertussis (Td/Tdap) ^{1,13} *				1 dose Td booster every 10 yrs					
Human papillomavirus (HPV) ^{1,14} *				Substitute 1 dose of Tdap for Td					
Measles, mumps, rubella (MMR) ^{1,15} *		Contraindicated		3 doses for females through age 26 yrs (0, 2, 6 mos)		1 or 2 doses			
Varicella ^{1,16} *		Contraindicated				2 doses (0, 4–8 wks)			1 dose TIV or LAIV annually
Influenza ^{1,17} *				1 dose TIV annually					
Pneumococcal (polysaccharide) ^{1,18} *				1–2 doses					
Hepatitis A ^{1,19} *				2 doses (0, 6–12 mos, or 0, 6–18 mos)					
Hepatitis B ^{1,20} *				3 doses (0, 1–2, 4–6 mos)					
Meningococcal ^{1,21} *				1 or more doses					
Zoster ^{1,22}		Contraindicated					1 dose		

*Covered by the Vaccine Injury Compensation Program.

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly indicated for adults ages 19 years and older, as of October 1, 2007. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/pubs/acip-list.htm).

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Physicians (ACP).



Recommended Adult Immunization Schedule • United States, October 2007 – September 2008

For complete statements by the Advisory Committee on Immunization Practices (ACIP), visit www.cdc.gov/vaccines/pubs/ACIP-list.htm.

1. Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination

Tdap should replace a single dose of Td for adults aged <65 years who have not previously received a dose of Tdap. Only one of two Tdap products (Adacel[®][sanofi pasteur]) is licensed for use in adults.

Adults with uncertain histories of a complete primary vaccination series with tetanus and diphtheria toxoid-containing vaccines should begin or complete a primary vaccination series. A primary series for adults is 3 doses of tetanus and diphtheria toxoid-containing vaccines; administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second. However, Tdap can substitute for any one of the doses of Td in the 3-dose primary series. The booster dose of tetanus and diphtheria toxoid-containing vaccine should be administered to adults who have completed a primary series and if the last vaccination was received ≥ 10 years previously. Tdap or Td vaccine may be used, as indicated.

If the person is pregnant and received the last Td vaccination ≥ 10 years previously, administer Td during the second or third trimester; if the person received the last Td vaccination in <10 years, administer Tdap during the immediate postpartum period. A one-time administration of 1 dose of Tdap with an interval as short as 2 years from a previous Td vaccination is recommended for postpartum women, close contacts of infants aged <12 months, and all health-care workers with direct patient contact. In certain situations, Td can be deferred during pregnancy and Tdap substituted in the immediate postpartum period, or Tdap can be administered instead of Td to a pregnant woman after an informed discussion with the woman.

Consult the ACIP statement for recommendations for administering Td as prophylaxis in wound management.

2. Human papillomavirus (HPV) vaccination

HPV vaccination is recommended for all females aged ≤ 26 years who have not completed the vaccine series. History of genital warts, abnormal Papanicolaou test, or positive HPV DNA test is not evidence of prior infection with all vaccine HPV types; HPV vaccination is still recommended for these persons.

Ideally, vaccine should be administered before potential exposure to HPV through sexual activity; however, females who are sexually active should still be vaccinated. Sexually active females who have not been infected with any of the HPV vaccine types receive the full benefit of the vaccination. Vaccination is less beneficial for females who have already been infected with one or more of the HPV vaccine types.

A complete series consists of 3 doses. The second dose should be administered 2 months after the first dose; the third dose should be administered 6 months after the first dose.

Although HPV vaccination is not specifically recommended for females with the medical indications described in Figure 2, "Vaccines that might be indicated for adults based on medical and other indications," it is not a live-virus vaccine and can be administered. However, immune response and vaccine efficacy might be less than in persons who do not have the medical indications described or who are immunocompetent.

3. Measles, mumps, rubella (MMR) vaccination

Measles component: Adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive ≥ 1 dose of MMR unless they have a medical contraindication, documentation of ≥ 1 dose, history of measles based on health-care provider diagnosis, or laboratory evidence of immunity.

A second dose of MMR is recommended for adults who 1) have been recently exposed to measles or are in an outbreak setting; 2) have been previously vaccinated with killed measles vaccine; 3) have been vaccinated with an unknown type of measles vaccine during 1963–1967; 4) are students in postsecondary educational institutions; 5) work in a health-care facility; or 6) plan to travel internationally.

Mumps component: Adults born before 1957 can generally be considered immune to mumps. Adults born during or after 1957 should receive 1 dose of MMR unless they have a medical contraindication, history of mumps based on health-care provider diagnosis, or laboratory evidence of immunity.

A second dose of MMR is recommended for adults who 1) are in an age group that is affected during a mumps outbreak; 2) are students in postsecondary educational institutions; 3) work in a health-care facility; or 4) plan to travel internationally. For unvaccinated health-care workers born before 1957 who do not have other evidence of mumps immunity, consider administering 1 dose on a routine basis and strongly consider administering a second dose during an outbreak.

Rubella component: Administer 1 dose of MMR vaccine to women whose rubella vaccination history is unreliable or who lack laboratory evidence of immunity. For women of childbearing age, regardless of birth year, routinely determine rubella immunity and counsel women regarding congenital rubella syndrome. Women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the health-care facility.

4. Varicella vaccination

All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine unless they have a medical contraindication. Special consideration should be given to those who 1) have close contact with persons at high risk for severe disease (e.g., health-care personnel and family contacts of immunocompromised persons) or 2) are at high risk for exposure or transmission (e.g., teachers; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).

Evidence of immunity to varicella in adults includes any of the following: 1) documentation of 2 doses of varicella vaccine at least 4 weeks apart; 2) U.S.-born before 1980 (although for health-care personnel and pregnant women birth before 1980 should not be considered evidence of immunity); 3) history of varicella based on diagnosis or verification of varicella by a health-care provider (for a patient reporting a history of or presenting with an atypical case, a mild case, or both, health-care providers should seek either an epidemiologic link with a typical varicella case or to a laboratory-confirmed case or evidence of laboratory confirmation, if it was performed at the time of acute disease); 4) history of herpes zoster based on health-care provider diagnosis; or 5) laboratory evidence of immunity or laboratory confirmation of disease.

Assess pregnant women for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health-care facility. The second dose should be administered 4–8 weeks after the first dose.

5. Influenza vaccination

Medical indications: Chronic disorders of the cardiovascular or pulmonary systems, including asthma; chronic metabolic diseases, including diabetes mellitus, renal or hepatic dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or human immunodeficiency virus [HIV]); any condition that compromises respiratory function or the handling of respiratory secretions or that can increase the risk of aspiration (e.g., cognitive dysfunction, spinal cord injury, or seizure disorder or other neuromuscular disorder); and pregnancy during the influenza season. No data exist on the risk for severe or complicated influenza disease among persons with asplenia; however, influenza is a risk factor for secondary bacterial infections that can cause severe disease among persons with asplenia.

Occupational indications: Health-care personnel and employees of long-term care and assisted-living facilities.

Other indications: Residents of nursing homes and other long-term care and assisted-living facilities; persons likely to transmit influenza to persons at high risk (e.g., in-home household contacts and caregivers of children aged 0–59 months, or persons of all ages with high-risk conditions); and anyone who would like to be vaccinated. Healthy, nonpregnant adults aged ≤ 49 years without high-risk medical conditions who are not contacts of severely immunocompromised persons in special care units can receive either intranasally administered live, attenuated influenza vaccine (FluMist[®]) or inactivated vaccine. Other persons should receive the inactivated vaccine.

6. Pneumococcal polysaccharide vaccination

Medical indications: Chronic pulmonary disease (excluding asthma); chronic cardiovascular diseases; diabetes mellitus; chronic liver diseases, including liver disease as a result of alcohol abuse (e.g., cirrhosis); chronic alcoholism, chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]); immunosuppressive conditions; and cochlear implants and cerebrospinal fluid leaks. Vaccinate as close to HIV diagnosis as possible.

Other indications: Alaska Natives and certain American Indian populations and residents of nursing homes or other long-term care facilities.

7. Revaccination with pneumococcal polysaccharide vaccine

One-time revaccination after 5 years for persons with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); or immunosuppressive conditions. For persons aged ≥ 65 years, one-time revaccination if they were vaccinated ≥ 5 years previously and were aged < 65 years at the time of primary vaccination.

8. Hepatitis A vaccination

Medical indications: Persons with chronic liver disease and persons who receive clotting factor concentrates.

Behavioral indications: Men who have sex with men and persons who use illegal drugs.

Occupational indications: Persons working with hepatitis A virus (HAV)-infected primates or with HAV in a research laboratory setting.

Other indications: Persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A (a list of countries is available at www.cdc.gov/travel/content/diseases.aspx) and any person seeking protection from HAV infection.

Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6–12 months (Havrix[®]), or 0 and 6–18 months (Vaqta[®]). If the combined hepatitis A and hepatitis B vaccine (Twinrix[®]) is used, administer 3 doses at 0, 1, and 6 months.

9. Hepatitis B vaccination

Medical indications: Persons with end-stage renal disease, including patients receiving hemodialysis; persons seeking evaluation or treatment for a sexually transmitted disease (STD); persons with HIV infection; and persons with chronic liver disease.

Occupational indications: Health-care personnel and public-safety workers who are exposed to blood or other potentially infectious body fluids.

Behavioral indications: Sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than 1 sex partner during the previous 6 months); current or recent injection-drug users; and men who have sex with men.

Other indications: Household contacts and sex partners of persons with chronic hepatitis B virus (HBV) infection; clients and staff members of institutions for persons with developmental disabilities; international travelers to countries with high or intermediate prevalence of chronic HBV infection (a list of countries is available at www.cdc.gov/travel/content/diseases.aspx); and any adult seeking protection from HBV infection.

Settings where hepatitis B vaccination is recommended for all adults: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug-abuse treatment and prevention services; health-care settings targeting services to injection-drug users or men who have sex with men; correctional facilities; end-stage renal disease programs and facilities for chronic hemodialysis patients; and institutions and nonresidential daycare facilities for persons with developmental disabilities.

Special formulation indications: For adult patients receiving hemodialysis and other immunocompromised adults, 1 dose of 40 $\mu\text{g}/\text{mL}$ (Recombivax HB[®]), or 2 doses of 20 $\mu\text{g}/\text{mL}$ (Engerix-B[®]) administered simultaneously.

10. Meningococcal vaccination

Medical indications: Adults with anatomic or functional asplenia, or terminal complement component deficiencies.

Other indications: First-year college students living in dormitories; microbiologists who are routinely exposed to isolates of *Neisseria meningitidis*; military recruits; and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic (e.g., the “meningitis belt” of sub-Saharan Africa during the dry season [December–June]), particularly if their contact with local populations will be prolonged. Vaccination is required by the government of Saudi Arabia for all travelers to Mecca during the annual Hajj.

Meningococcal conjugate vaccine is preferred for adults with any of the preceding indications who are aged ≤ 55 years, although meningococcal polysaccharide vaccine (MPSV4) is an acceptable alternative. Revaccination after 3–5 years might be indicated for adults previously vaccinated with MPSV4 who remain at increased risk for infection (e.g., persons residing in areas in which disease is epidemic).

11. Herpes zoster vaccination

A single dose of zoster vaccine is recommended for adults aged ≥ 60 years regardless of whether they report a prior episode of herpes zoster. Persons with chronic medical conditions may be vaccinated unless a contraindication or precaution exists for their condition.

12. Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccine may be used

Hib conjugate vaccines are licensed for children aged 6 weeks–71 months. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults with the chronic conditions associated with an increased risk for Hib disease. However, studies suggest good immunogenicity in patients who have sickle cell disease, leukemia, or HIV infection or who have had splenectomies; administering vaccine to these patients is not contraindicated.

13. Immunocompromising conditions

Inactivated vaccines are generally acceptable (e.g., pneumococcal, meningococcal, and influenza [trivalent inactivated influenza vaccine]), and live vaccines generally are avoided in persons with immune deficiencies or immune suppressive conditions. Information on specific conditions is available at www.cdc.gov/vaccines/pubs/acip-list.htm.

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**TITLE 14 EDUCATION
DELAWARE ADMINISTRATIVE CODE**

800 Health and Safety

804 Immunizations

1.0 Definition

"School Enterer" means any child between birth and twenty (20) years inclusive entering or being admitted to a Delaware school district for the first time, including but not limited to, foreign exchange students, immigrants, students from other states and territories and children entering from nonpublic schools.

10 DE Reg. 1807 (06/01/07)

2.0 Minimum Immunizations Required for All School Enterers

2.1 All School Enterers shall have immunizations given up to four days prior to the minimum interval or age and shall include:

2.1.1 Four or more doses of diphtheria, tetanus, pertussis (DTaP, DTP, or other approved vaccine) or a combination of these vaccines. A booster dose of Td or Tdap (adult) is recommended by the Division of Public Health for all students at age 11 or five years after the last DTaP, DTP or DT dose was administered whichever is later. Notwithstanding this requirement:

2.1.1.1 A child who received a fourth dose prior to his or her fourth birthday shall have a fifth dose;

2.1.1.2 A child who received the first dose of Td (adult) at or after age seven may meet this requirement with only three doses of Td or Tdap (adult).

2.1.2 Three or more doses of inactivated polio virus (IPV), oral polio vaccine (OPV), or a combination of these vaccines with the following exception: a child who received a third dose prior to the fourth birthday shall have a fourth dose.

2.1.3 Two doses of measles, mumps and rubella (MMR) vaccine. The first dose should be administered on or after the age of 12 months. The second dose should be administered after the fourth birthday. Individual combination vaccines of measles, mumps, rubella (MMR) may be used to meet this requirement.

2.1.3.1 Disease histories for measles, rubella and mumps shall not be accepted unless serologically confirmed.

2.1.4 Three doses of Hepatitis B vaccine.

2.1.4.1 For children 11 to 15 years old age, two doses of a vaccine approved by the Center for Disease Control (CDC) may be used.

2.1.4.2 Titers are not acceptable in lieu of completing the vaccine series and a disease history for Hepatitis B shall not be accepted unless serologically confirmed.

2.1.5 Varicella vaccine is required beginning in the 2003-2004 school year with kindergarten. One grade shall be added each year thereafter so that by the 2015-2016 school year all children in grades kindergarten through 12 shall have received the vaccination. Beginning in the 2008-2009 school year new enterers into the affected grades shall be required to have two doses of the Varicella vaccine. The first dose shall be administered on or after the age of twelve (12) months and the second at kindergarten entry into a Delaware public school. A written disease history, provided by the health care provider, parent, legal guardian, Relative

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Caregiver or School Enterer who has reached the statutory age of majority (18), 14 Del.C. §131(a)(9), will be accepted in lieu of the Varicella vaccination. Beginning in the 2008-2009 school year, a disease history for the Varicella vaccination must be verified by a health care provider to be exempted from the vaccination.

2.2 Children who enter school prior to age four (4) shall follow current Delaware Division of Public Health recommendations.

10 DE Reg. 1807 (06/01/07)

11 DE Reg. 666 (11/01/07)

3.0 Certification of Immunization

3.1 The parent, legal guardian, Relative Caregiver or a School Enterer who has reached the statutory age of majority (18), 14 Del.C. §131(a)(9), shall present a certificate specifying the month, day, and year that the immunizations were administered by a licensed health care practitioner.

3.2 According to 14 Del.C. §131, a principal or person in charge of a school shall not permit a child to enter into school without acceptable evidence of immunization. The parent, legal guardian, Relative Caregiver or a School Enterer who has reached the statutory age of majority (18), 14 Del.C. §131(a)(9), shall be notified of this requirement in writing. Within 14 calendar days after notification, evidence must be presented to the school that the basic series of immunizations has been initiated or has been completed.

3.3 A school enterer may be conditionally admitted to a Delaware school district by presenting a statement from a licensed health care practitioner who specifies that the School Enterer has received at least:

3.3.1 One dose of DTaP, or DTP, or DT; and

3.3.2 One dose of IPV or OPV; and

3.3.3 One dose of measles, mumps and rubella (MMR) vaccine; and

3.3.4 The first dose of the Hepatitis B series; and

3.3.5 One dose of Varicella vaccine as per 2.5.

3.4 14 DE Admin. Code 901 Education of Homeless Children and Youth 6.0 states that "School districts shall ensure that policies concerning immunization, guardianship and birth certificates do not create barriers to the school enrollment of homeless children and youth". To that end, school districts shall as stated in 14 DE Admin. Code "assist homeless children and youth in meeting the immunization requirements".

3.5 If the school enterer fails to complete the series of required immunizations the parent, legal guardian, Relative Caregiver or a school enterer who has reached the statutory age of majority (18), 14 Del.C. §131(a)(9), shall be notified that the School Enterer will be excluded according to 14 Del.C. §131.

10 DE Reg. 1807 (06/01/07)

4.0 Lost or Destroyed Immunization Record

When a student's immunization record has been lost or destroyed by the medical provider who administered the vaccine, the parent, legal guardian, Relative Caregiver or a school enterer who has reached the statutory age of majority (18), 14 Del.C. §131(a)(9), shall sign a written statement to this effect and must obtain at least one dose of each of the

immunizations as identified in 3.3. Evidence that the vaccines were administered shall be presented to the superintendent or his or her designee.

10 DE Reg. 18707 (06/01/07)

5.0 Exemption from Immunization

5.1 Exemption from this requirement may be granted in accordance with 14 Del.C. §131 which permits approved medical and notarized religious exemptions.

5.2 Alternative dosages or immunization schedules may be accepted with the written approval of the Delaware Division of Public Health.

10 DE Reg. 1807 (06/01/07)

6.0 Verification of School Records

The Delaware Division of Public Health shall have the right to audit and verify school immunization records to determine compliance with the law.

1 DE Reg. 1808 (05/01/98)

4 DE Reg. 1515 (03/01/01)

5 DE Reg. 2295 (06/01/02)

10 DE Reg. 1807 (06/01/07)

7.0 Documentation

7.1 School nurses shall record and maintain documentation of each student's immunization status.

7.2 Each student's immunization record shall be included in the Delaware Immunization Registry.

1 DE Reg. 1808 (05/01/98)

4 DE Reg. 1515 (03/01/01)

5 DE Reg. 2295 (06/01/02)

10 DE Reg. 1807 (06/01/07)