South Carolina Department of Corrections
Implementation Panel Report of Compliance
December 2017

Executive Summary

This fifth report of the Implementation Panel (IP) is provided as stipulated in the Settlement Agreement in the above referenced matter, and it is based on the fifth site visit to the South Carolina Department of Corrections (SCDC) facilities and our review and analysis of SCDC's compliance with the settlement agreement criteria. To date the IP has conducted site visits to SCDC on May 2-5, 2016; October 31-November 4, 2016; February 27-March 3, 2017; July 10-14; and December 4-8, 2017. Despite the IP's request that important documents needed to assess compliance/non-compliance with the Settlement Criteria be provided two weeks prior to each site visit, we did not receive all of the requested documents within that time frame. The IP has been asked to consider documents/information provided to us during the site visits and up to the Exit Conference on the last day of the site visits. The IP visits are scheduled and requests for documents have been consistently provided well in advance of the visits; however, our requirement for documents has never been met by SCDC. Regardless of the lateness of receipt of those documents, the IP has considered the information provided prior to and during the site visits in our assessment of compliance/non-compliance with the Settlement Agreement Criteria. The IP has also participated in conference calls at the requests of both plaintiffs and defendants, and held meetings during this visit with Mr. Westbrook and Director Stirling. Deputy Director [redacted] Assistant Director [redacted], and SCDC administrative staff have attended site visits and provided very valuable input to the discussions. Finally, the wardens of each institution site visited as well as the Regional Directors have assisted this process and provided their input. Dr. Sally Johnson and Ms. Terre Marshall, consultants to SCDC, accompanied the IP to the facilities during this site visit. On December 8, 2017 the IP held an Exit Briefing attended by Director Stirling, attorney Roy Laney and SCDC staff, and plaintiff's counsel Daniel Westbrook to apprise the parties of our preliminary findings and encouraged feedback and discussion. Judge William Howard was not able to attend but was apprised of the IP's preliminary findings.

This Executive Summary presents an overview of the SCDC analysis and the Implementation Panel's findings regarding SCDC's compliance with the Settlement Agreement. During each site visit, the IP has provided onsite technical assistance, presented its findings, and when indicated have acknowledged the positive efforts and findings made in specific programs and/or facilities.

The IP review has focused on the Settlement Agreement criteria components and SCDC's own findings and analyses as presented to the IP. The Settlement Agreement compliance levels are reported as "noncompliance", "partial compliance", or "substantial compliance" in each of the elements which are provided along with the basis for the particular/specific findings and recommendations. The IP provided direct feedback during the Exit Briefings at each facility and with SCDC central office staff. The IP also included in this report additional information related to each facility visited during this tour to illustrate both positive and negative aspects of their performance that impacted compliance, partial compliance, or noncompliance.

Included in this report is Exhibit B, and appended are Attachments 1-5. Exhibit B is the summary of the IP's assessment of compliance with the remedial guidelines. The IP acknowledges the work of SCDC in the development and revision of policies and procedures, as well as the development of a preliminary "Master Plan" for mental health services to address the mental health needs of inmates living in the SCDC and to meet the requirements of the Settlement Agreement. As Exhibit B illustrates, the Implementation Panel determined the following levels of compliance:

1. Substantial Compliance--- 14 components

2. Partial Compliance--- 38 components

3. Noncompliance--- 6 components

While the Implementation Panel acknowledges the efforts by SCDC to improve mental health care, particularly considering the conditions at the time of the inception of the Settlement Agreement, SCDC continues to struggle mightily in their attempts to achieve compliance with the necessary requirements of the Settlement Agreement in various programs and facilities. The IP has identified multiple factors of serious concern from past site visits and noted in previous reports, including the following:

1. Staffing - including clinical (mental health, medical and nursing), operations, administration and support staff.

2. Conditions of confinement - including Restrictive Housing Units (RHU), and segregation of any type. The IP was made aware that SCDC administrative staff "reinterpreted" the policy on Suicide Prevention and Management to allow for up to 120 hours for transfer to the Crisis Stabilization Unit from safety cells in other facilities. Further, the safety cells at Gilliam Psychiatric Hospital were found to be less suicide resistant than in the past, which requires immediate attention.

3. Prolonged stays in Reception and Evaluation at both Kirkland C.I. and Graham C.I. with very minimal mental health services and structured and unstructured out of cell time and activities. The timeliness of assessments, referrals and treatment continue to impede these processes, largely impacted by staffing deficiencies.

4. Lack of timely assessments by multidisciplinary treatment teams at the mental health programmatic levels.

5. Operations and clinical staff adherence to policies and procedures and lack of appropriate supervision.

6. Access to all higher levels of care for male and female inmates - The CSU has not yet operationalized its role in the overall mental health system to determine both level of care needs and assistance to operations for management of inmates who require alternative

treatment and housing. The BMU's are not functioning at their planned levels. GPH is basically a lockdown program with very limited programming. A noted positive improvement is the pending contract for hospital level services for women.

7. Future planning for a comprehensive mental health services delivery system including staffing, beds and programs. The current Master Plan is largely a plan to develop a plan.

8. Medication management, particularly at Graham CI and Leath CI with reported audits that do not appear to adequately address medication administration and documentation. Of critical concern is the practice at several male facilities to administer medications by staff placing the medications on the food slot and/or sliding medications under the cell door which are both major clinical and security risks;

9. Substantial progress in the Quality Management Program, specifically by the development and efforts by the Quality Improvement Risk Management Program (QIRM) including necessary increases in staffing, training, audits and review of documents/information. Additional support has been suggested via the Behavioral Health Division and the developing electronic medical record; however, the interface will require improvements in collaboration, methodology, reliability, and timeliness of reporting information. The IP has repeatedly emphasized the necessity to provide pre-site visit information as requested, and SCDC has yet to provide information in a timely manner;

10. The implementation of the EHR, including eZmar, and interface with the pharmacy system (CIPS) continues to be piloted at Graham C.I. and Leath C.I. with extension of the timeframe for implementation system-wide as difficulties have been identified. More available mining of information/data and utilization of this process should facilitate and support systems development provided the methodologies and reliability of the information is sound.

In addition, the following issues regarding custody operations should be addressed and recommendations for addressing them follow each area of concern:

1. Inmates held in Short Term and Disciplinary Detention Status

Assessment: A high number of inmates are being held in Short Term and Disciplinary Detention Status over 60 days (per the provided SCDC Weekly Report Listing of Inmates by Institution in SD, DD, MX, ST, and AP Status). Over 80 inmates were identified in RHU over 60 days in Short Term, Disciplinary Detention and Awaiting Placement Status in the December 7, 2017, Weekly Report.

Recommendation: SCDC needs to develop a corrective action plan within 30 days to prevent inmates in ST, DD and AP Status from exceeding 60 days in RHU.

2. Inmate Disciplinary

Assessment: SCDC OP 22.14 only allows visitation and telephone restrictions to be imposed up to 20 days if an inmate does not have a MH classification regardless of the disciplinary offense. If an inmate has a MH classification, visitation and telephone restrictions can be imposed only if the charge involved visitation or telephone disciplinary offenses. A review of SCDC-produced records for the IP December 2017 Site visit revealed inmates without a MH classification receive restrictions of greater than 20 days for disciplinary offenses and inmates with a MH classification are receiving visitation and telephone restrictions for disciplinary offenses that are not visitation or telephone offenses.

Recommendation: SCDC needs to provide additional training to staff responsible for OP 22.14 to ensure:

- Visitation and telephone restrictions imposed do not exceed 20 days if an inmate does not have a MH classification regardless of the disciplinary offense.
- If an inmate has a MH classification, visitation and telephone restrictions are imposed only if the charge involved visitation or telephone disciplinary offenses.

SCDC officials should review both inmates without a MH designation and those with a MH designation with existing visitation and telephone restrictions and modify any restrictions that do not comply with OP 22.14 and provide the IP documentation of compliance as soon as possible.

3. RHU Population

Assessment: Per SCDC officials a high number inmates are being held in RHU because the inmate has a safety concern and refuses to return to the general population (possibly 20 or more inmates per institution with an RHU). Inmates being held in RHU for safety concerns limits cells for inmates that are identified as a risk to harm staff and/or inmates. An inmate eligible for time credits while in RHU cannot earn the credits to reduce the length of their prison sentence. Inmates held in RHU for safety concerns and eligible to earn time credits are most likely serving longer prison sentences draining valuable resources and increasing the SCDC budget.

Recommendation: SCDC should expand existing RHU alternatives to significantly reduce the number of inmates held in RHU for safety concerns.

4. RHU Behavior Levels for ST, DD, and SD

Assessment: SCDC has not fully implemented the RHU Behavior Levels for inmates in ST, DD, and SD status. OP 22.38 B Intensive Management and Restrictive Management Step Down Programs for High Risk Inmates was finalized and signed by the Director in November 2017. A review of the existing OP 22.38 Restrictive Housing Units (RHU) identified policy inconsistencies with intended SCDC Behavior Level practices.

Recommendation: SCDC Operations should review the OP 22.38 RHU and identify any inconsistencies and request revisions to the policy where necessary to the IP and Plaintiffs. QIRM should begin conducting QI studies regarding progress to implement the OP 22.28 RHU Behavior Levels and OP 22.38B Intensive Management and Restrictive Management Step Down Programs for High Risk Inmates.

5. **Tablets to Electronically Record Inmate Activities in RHU and CSU**

Assessments: SCDC Operations is pilot testing correctional officers utilizing computer tablets to record inmate activities (shower, welfare checks, and recreation, etc.) in RHU and CSU. Broad River CI CSU was selected as the site for the pilot. SCDC Operations and IT officials provided a demonstration of the new program to an IP Member at Broad River CI CSU the afternoon of December 5, 2017. It appears electronically recording inmate activities in RHU and CSU has promise to enhance recording quality and staff efficiency.

Recommendation: Continue the Broad River CI CSU Pilot electronically recording Institution RHUs.

Below are summaries of the IP's visits at each of the institutions during the week of December 4-8, 2017:

Kirkland Correctional Institution

During December 4 and 5, 2017, we site visited Kirkland CI. The inmate count on November 27, 2017 was 1523 inmates which included 270 inmates on the mental health caseload including approximately 80 Level 1 inmates (GPH), 139 Level 2 inmates (ICS), 14 Level 3 inmates (Area Mental Health), 96 Level 4 inmates (Outpatients) and 2 Level 5 inmates (stable and monitored). The mental health staffing allocations and filled positions were as follows based on pre-site information provided:

QMHPs:	25 FTEs allocated
	10 FTEs vacant
GPH Bay Area Staff:	7 FTEs allocated
	0 FTEs vacant
MH Techs:	17 FTEs allocated
	5 FTEs vacant
Activity Therapists:	3.5 FTEs allocated
	1.0 FTEs vacant

We conducted a community meeting of approximately 25 inmates who described minimal programmatic activities and out of cell time at GPH. Only 3 of 25 inmates reported attending 3 groups per week. The newly installed spider table for group therapies had not been used. Discussions with staff indicated requests for additional staff, however implementation of therapeutic activities could not occur without increases. Tours of the units indicated the nurses stations are near completion, however serious nursing shortages, and the majority of staff vacancies are covered by registry nurses. Further, the suicide resistant cells are no longer suicide resistant and are in need of repairs.

We toured the ICS programs, attended a treatment team meeting and held a Community meeting with inmates. The IP was favorably impressed by the team meeting, including participation by inmates and the inmates reported significant out of cell time for structured therapy groups.
We toured the HLBMU and met with inmates. While the inmates reported efforts by staff to have programmatic activities, their impressions, consistent with staff reports, are that there is insufficient staff for programs, out of cell time on weekends, and family visits.

Broad River Correctional Institution

The IP site visited Broad River CI on December 5, 2017. Broad River continues to experience staff shortages that impede the implementation of the CSU and HLBMU programs. The CSU has only limited telepsychiatry services and no psychiatric participation at treatment team meetings. The CSU is the central receiving for inmates from other facilities who have reported or demonstrated increased risk of self-harm and/or suicide. There is limited participation by psychology, and no presence of classification at the treatment team meetings, where recommendations and decisions are made regarding inmate placement in mental health programs. The role of the CSU in the overall system should be reviewed in this context. We were provided with two psychological autopsies of inmates who died by suicide, and both had multiple admissions to the CSU. The autopsies were incomplete and while on site, the IP recommended the outsourcing of psychological autopsies to clinicians more experienced with the appropriate process.
The HLBMU remains at KCI based on lack of staffing resources.
Of critical concern is the decision and movement of Level 3 inmates (Area Mental Health/Enhanced Outpatient) to the Marion dorm at BRCI. This movement did not go smoothly and our Community meeting with these inmates revealed their very serious concerns regarding treatment, medication administration, safety and property issues, as well as extended lockdown of the units for inmates who had been involved in active programming prior to the moves. The mental health staff indicated they are in the process of reviewing and reclassification of these inmates, reporting 14 of 22 inmates had been reclassified to Level 4 AFTER transfer to BRCI as Level 3. There was [redacted] by an inmate on this unit during the site visit.

Lieber Correctional Institution

During December 6, 2017, we site visited the Lieber CI. The inmate count at the Lieber CI during December 4, 2017 was 1092 inmates, which included 233 inmates on the mental health caseload (12 L3 inmates and 221 L4 inmates).
Lieber CI averages ~ 14 hours per week of coverage by a psychiatrist. Additional mental health staff included the following:

QMHPs: 4.0 FTE allocated positions
2.0 FTE vacancies
4.0 FTE positions designated in the staffing plan
MHTs: 2.0 FTE allocated positions
1.0 FTE vacancies

Nursing staff: 13.0 FTE positions filled
32.0 FTE positions designated in the staffing plan

We observed an outpatient treatment team meeting during the afternoon of December 6, 2017, where we observed the treatment team planning process for four inmates.
There were four safety cells in the RHU at the Lieber CI, which still needed further renovations in order to be suicide resistant.
We discussed transfer timeframes specific to inmates placed on either suicide watch or on observation status. There appeared to have been a misunderstanding among the mental health staff in the context of the policy and procedures specific to suicide watch and observational status. We clarified that regardless of which status applied to a given inmate, the 60 hours principle still applied.
We met with 11 general population mental health caseload inmates in a group setting. These inmates indicated that their housing units were, more often than not, locked down due to a variety of reasons, including custody staff shortages and/or disruptive behaviors by one of more inmates on the unit. They stated that the whole housing unit would be locked down if one or more inmates were disruptive. When a housing unit was on lockdown status for any reason, medications would be delivered under the cell door if there was not a food port. Cell doors in general population housing units did not have food ports. It was not uncommon for correctional officers to assist in this process of medication administration. This method of medication administration was confirmed by nursing staff.
These inmates indicated that they generally met with the psychiatrist on an every 90 day basis. However, these sessions were not confidential because the door was left open with a correctional officer within hearing distance. Custody staff stated that the door was left open at the request of the psychiatrist. In general, sessions with their mental health counselors generally occur every 90 days with similar issues relevant to lack of privacy from a sound perspective. None of the inmates interviewed were aware of the recent initiation of two group therapies (anger management classes) being offered to general population inmates. Staff reported there was a waiting list for these four-week groups.

Inmates described the shower stalls within the mental health housing unit to be filthy and fecal stained. Observation of these shower stalls by the monitors was consistent with the inmates' descriptions.
The inmates interviewed were aware of treatment plans with a minority of them indicating that they found knowledge of their treatment plans to be useful to them. None of these inmates remembered attending a treatment team meeting specific to development of the treatment plans. We observed a treatment plan meeting that involved reviewing treatment plans of four inmates, which was attended by two QMHP's and one nurse. The treatment planning meeting process was very brief.

Assessment: The mental health staff and custody staff shortages clearly have a negative impact on the delivery of outpatient mental health services to inmates. The manner of medication administration in housing units that are locked down for any reason is unacceptable and below the standard of correctional mental health care. Individual sessions with a QMHP and/or a psychiatrist lacked adequate privacy from a sound perspective. The treatment planning process, in part related to the minimal staffing resources, does not currently appear to be very meaningful. The excessive lockdown of general population housing units, which is certainly reflective of significant staff shortages, remains very problematic for many different reasons. The shower stalls are hygienically very problematic. The method of food delivery results in food being too cold upon delivery to the inmate.

Recommendations:

1. As summarized in an earlier subsection, remedy the staffing issues.
2. Medications need to be administered in a clinically appropriate manner and not under the cell door.
3. Clinical contact with the psychiatrist and primary mental health clinician should be done in an office setting that allows for adequate sound confidentiality and safety.
4. Once staffing allocations/vacancy issues have been improved, staff should become more focused on treatment plans and treatment team meetings for treatment planning purposes.
5. The shower stall areas should be cleaned on a regular basis.
6. The practice of group punishment related to disruptive behavior by one of more inmates needs to be changed.
7. The food delivery system needs to be revised in order to serve food at an appropriate temperature.

Kershaw Correctional Institution

During the morning of December 7, 2017, we site visited Kershaw CI. The inmate count was 1361, which included 214 inmates on the mental health caseload (2 L3, 204 L4, and 8 L5 level of care mental health inmates). Of the approximate 80 RHU inmates, a total of 41 inmates were on the mental health caseload (27 SD, 10 ST and 4 inmates awaiting placement).

Staffing data was as follows:

Kershaw CI averages about eight hours per week of coverage by psychiatrist either on-site or via telepsychiatry.

1.0 FTE QMHP positions were filled with a 1.0 FTE vacancy being present.

1.0 FTE lead QMHP position was vacant.

1.0 FTE MHT position was filled.

6.0 FTE nursing positions of the 10. FTE allocated positions were filled with the staffing plan designating 15.67 FTE positions.

The correctional officer staff vacancy rate was 46.5%.

We observed 3 inmates receiving an assessment by the psychiatrist via telepsychiatry, which was performed in a very competent manner.

We interviewed 9 mental health caseload inmates in a group setting. They indicated significant medication administration problems related to the medications being administered to them in a small envelope under their cell door, which reportedly contributed to them not receiving their medications or receiving the wrong medications. The last "pill call" was at 2:30 pm. General population housing units were very often locked down related to correctional officer shortages and various disturbances.

These inmates reported generally seeing their psychiatrist every 3 months. Very few of these inmates reported meeting with their primary mental health clinician on a regular basis. When available, individual treatment was often not done in a confidential setting. Group therapy was not available to these inmates. In general, they reported much dissatisfaction with access to mental

health treatment.
Assessment: Related in large part to the mental health staffing vacancies, significant problems existed in mental health caseload inmates accessing adequate mental health services. Medication administration issues were present as summarized above.

Lee Correctional Institution

During the afternoon of December 7, 2017, we site visited the Lee Correctional Institution. The inmate count was 1510 inmates, which included 309 mental health caseload inmates (20.5% of the total inmate population). There were 239 L4, 28 L3, and 42 L5 mental health level of care inmates. 75 inmates were in the RHU which included 42 mental health caseload inmates (5 DD, 22 SD and 13 ST).
The step-down unit previously located at the McCormick CI moved several months ago to Lee CI. The current count was 46 inmates with 22 inmates in the RHU track and 24 inmates in the IMU track.
A Better Living Incentive Community (BLIC) has been established in at least two different housing units with one of the housing units being designated for mental health caseload inmates.
Staffing data was as follows:

5.0 allocated QMHP positions with 2.0 vacancies. 1.0 FTE QMHP was on medical leave with coverage being provided on a 3 day per week basis for this person.

13 hours per week psychiatric coverage is provided by three providers with a minority of these hours being provided via telepsychiatry.

2.0 FTE MHT positions allocated with both positions being vacant.

14 FTE nursing positions were filled out of the 36 FTE positions allocated. Registry nurses are also used to mitigate the vacancies.

We interviewed 11 mental health caseload inmates from the BLIC in a group setting. Medication continuity issues were not common. Lockdowns in general population housing units related to systemwide lockdowns were reported to not be uncommon. Medication administration during such lockdowns occurs under the cell door. Reasonable access to the psychiatrist appeared to be present. Inmates described mixed perceptions concerning access to their mental health counselors. However, all the inmates in the BLIC participate in at least two classes per week. In general, these inmates were very complementary of the BLIC.

Assessment: As compared to other SCDC correctional institutions we have assessed, the satisfaction regarding mental health services on an outpatient basis described by mental health caseload inmates was significantly higher, which is likely related to the programming and therapeutic milieu established in the BLIC. We did not interview mental health caseload inmates who were not in the BLIC. Medication administration issues remain very problematic during lockdowns.
Accordingly, the following description and appendices are reflective of the Implementation Panel's findings based on the specific facilities inspected during this site visit, namely Kirkland CI, Broad River CI, Lieber CI, Lee CI, Kershaw CI and Graham CI. As noted previously, Policies and Procedures are in partial compliance and the Implementation Panel has very strongly recommended

further review of the Policies and Procedures, as well as the Master Plan given changes within the system and the critical needs for staffing and other resources.

Camille Graham Correctional Institution

The IP visited Camille Graham CI on December 8, 2017. The IP was very positively impressed by the efforts demonstrated at CGCI during the last site visits, despite continuing staff shortages. We also identified concerns at both CGCI and Leath CI regarding the piloting of the EHR, particularly concerning medication administration. We were assured by staff that there had been significant improvement with only 4% refusals based on audits done by IT and nursing; however we were subsequently informed there were an additional 7% of "missed" doses, and the audit only looked at a sample of inmate records from the ICS and RHU programs. We were also told of multiple groups for caseload inmates in ICS, RHU and outpatients, as well as 6-8 hrs. of out of cell time for women in R & E.
We held two Community meetings in the ICS programs and toured R & E and RHU; the feedback we received from inmates, as well as ongoing concerns by psychiatry and nursing, indicate the information we were provided was inconsistent, at best. CGCI continues to not meet the requirements of the Settlement Agreement largely based on inadequate staffing. It is essential that the information and methodologies for collection and analysis be clear and accurately presented.

Below are the specific findings followed by the attachments that provide overview information on the system as a whole as well as the individual facilities within the system.

The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:

1.a. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs.

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
A QI study was completed to determine if the timeframes for the initial screening and follow up evaluations outlined by policy were being met, to identify root causes of any deficiencies, and to provide action plans to correct any identified deficiencies. In contrast to previous tracking results, during this study, R&E staff at Camille Graham differentiated between level urgency of assessment needed, identifying 41 inmates in need of urgent evaluations and 17 in need of emergent evaluations. Kirkland R&E staff identified 19 urgent referrals but no emergent referrals. Both programs continue to face challenges in completing required screenings and follow up evaluations within the timeframes outline in policy though, Kirkland QMHPs showed major improvement assessing routine referrals within the required timeframe for the months of August and September. Both institutions continue to struggle with completing psychiatric follow ups within the required timeframe, but stabilization of QMHP staffing at Kirkland has improved compliance with the meeting the secondary evaluation deadline.

The results are below:

Camille Graham

July	August	September
MH screening (n=28) Percentage completed within mandated timeframe= 71% Average # of days from intake to screening =3.04	**MH screening** (n=29) Percentage completed within mandated timeframe = 69% Average # of days from intake to screening = 2.6	**MH screening** (n=36) Percentage completed within mandated timeframe = 69% Average # of days from intake to screening = 2.74
Routine referrals completed within mandated timeframe QMHP= 66% (n=15) Psychiatry= 36% (n=11)	**Routine referrals** completed within mandated timeframe QMHP= 96% (n=27) Psychiatry= 0% (n=19)	**Routine referrals** completed within mandated timeframe QMHP-31% (n=13) Psychiatry= 0% (n=10)
Urgent referrals completed within mandated timeframe QMHP=0% (n=9) Psychiatry= 0% (n=8)	**Urgent referrals** completed within mandated timeframe QMHP=6% (n=17) Psychiatry= 0% (n=17)	**Urgent referrals** completed within mandated timeframe QMHP= 0% (n=15) Psychiatry= 0% (n=15)
Emergent referrals completed within mandated timeframe QMHP= 0% (n=4) Psychiatry=0% (n=4)	**Emergent referrals** completed within mandated timeframe QMHP= 0% (n=5) Psychiatry=0% (n=5)	**Emergent referrals** completed within mandated timeframe QMHP= 0% (n=8) Psychiatry=0% (n=8)

Kirkland

July	August	September
MH screening (n=46) Percentage completed within mandated timeframe = 76% Average # of days from intake to screening =3.46	**MH screening** (n=54) Percentage completed within mandated timeframe = 80% Average # of days from intake to screening = 3.9	**MH screening** (n=43) Percentage completed within mandated timeframe = 65% Average # of days from intake to screening = 3.37
Routine referrals completed within mandated timeframe QMHP= 80% (n=41) Psychiatry= 68% (n=31)	**Routine referrals** completed within mandated timeframe QMHP= 84% (n=51) Psychiatry= 27% (n=26)	**Routine referrals** completed within mandated timeframe QMHP=91% (n=32) Psychiatry=47% (n=15)
Urgent referrals completed within mandated timeframe QMHP=100% (n=5) Psychiatry= 20% (n=5)	**Urgent referrals** completed within mandated timeframe QMHP=33% (n=3) Psychiatry= 33% (n=3)	**Urgent referrals** completed within mandated timeframe QMHP=82% (n=11) Psychiatry= 27% (n=11)
Emergent referrals completed within mandated timeframe No emergent referrals.	**Emergent referrals** completed within mandated timeframe No emergent referrals.	**Emergent referrals** completed within mandated timeframe No emergent referrals.

The full QI study with planned actions is included as Appendix A.

December 2017 Implementation Panel findings: As per SCDC status update section. Improvement is noted with meeting policy and procedures' timeframes as compared to the prior site visit. As with previous site assessments, it appeared that the partial compliance was related to inadequate mental health and custodial staffing allocations, which are exacerbated by lockdowns and staff being pulled elsewhere.

Average length of stays in the R&E units were as follows:

Removals from Kirkland R&E (Average Time to Assignment, excludes releases from R&E):
Jul17 removals average days in R&E: 72 days
Aug17 removals average days in R&E: 66 days
Sep17 removals average days in R&E: 69 days

Removals from Graham R&E (Average Time to Assignment, excludes releases from R&E):
Jul17 removals average days in R&E: 39 days
Aug17 removals average days in R&E: 47 days
Sep17 removals average days in R&E: 43 days

Staff at Camille Griffin Graham CI reported that newly admitted R&E inmates were offered a coping skills group during the first week following admission and a character building group during the second week until they were transferred from the R&E unit. They estimated that such inmates also received out of cell dayroom time as well. However, information obtained from inmates in the R & E indicated that they were not receiving out of cell time.

It was also brought to our attention, and confirmed by staff, that R&E inmates, who are placed on the mental health caseload as a result of the screening process, are not assigned a mental health clinician regardless of their length of stay in R&E. An inmate complained that she was notified that her mother had died during the second month of her stay in R&E and was unable to meet with a mental health counselor to discuss relevant issues until she was transferred to Blue Ridge C Wing about 68 days later.

December 2017 Recommendations:

1. Continue to QI the relevant timeframes.
2. Adequately address the mental health and correctional staffing vacancies.
3. Accurately track the out of cell time offered to R&E inmates on a weekly basis.
4. Please provide average and median LOS data in the future for inmates in the R&E upon transfer from the R&E.
5. R&E inmates need reasonable access to mental health services for both medication purposes and crisis intervention.

1a.i. Accurately determine and track the percentage of the SCDC population that is mentally ill.

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
To track the percentage of mentally ill inmates, the Division of Resources and Information Management (RIM) generates s report entitled *Mental Health Classifications for the Mentally Ill Institutional Population*. This report includes

- the numbers of mentally ill inmates by classification,
- the percentage of mentally ill by classification as a percent of the mentally ill population, and the percent of mentally ill inmates as a percentage of the total population.

An important part of our ongoing effort to accurately identify and track inmates within the SCDC population that are mentally is through annual screenings.

As of October 2, 2017, the following institutions have implemented this annual screening process:

Month	Institution(s)
February	Camille Graham
March	Lee
April	Perry
May	McCormick
June	Lieber
July	Broad River
September	MacDougall
October	Allendale /Evans
November	Tuberville/Kershaw
December	Leath/Tyer River
January 2018	Ridgeland/Kirkland
February 2018	Livesay/Catwaba
March 2018	Palmer/Goodman

The full QI study with planned actions and protocols for screenings are attached as Appendix B. and Appendix B1, respectively. Assessment of the results was as follows:

In this data set, 68.8% of inmates eligible for their annual mental health screening were actually screened. Only 1.5% of those eligible for screening actually ended up added to the mental health caseload. This low number seems to be largely due to two factors. First, inmates who are eligible to be screened and receive an Order to Report for the screening do not always show up. Second, follow up evaluations must be completed before an inmate is actually placed on the mental health caseload and these are not being completed within policy timeframes. Thus, it is possible that some inmates in this data set who did receive their annual screening were eventually added to the mental health caseload but their addition is not reflected in this data because it happened after the data for this study was gathered.

Planned actions:
On October 2, 2017, The Division of BMHSAS implemented a new statewide protocol (see attachment) following the guidance provided by the IP during their last site visit. This protocol requires that the wellness checks account for all inmates eligible for them in any given month. In order to accomplish this, mental health staff will seek out inmates who fail to report for their

appointments for face to face contact. Additionally, mental health staff will follow up on inmates who refuse to attend their appointment by completing a records review (AMR and medical chart) and talking with security staff. No inmate will be noted to have "refused services" until all of this has been done. Supervisory staff were trained on this protocol in October. Continued monitoring and oversight will occur to determine if current procedures are adequate based on time/effort built into the process. Since the completion of this study, Camille Griffin Graham CI's Psychiatry hours have doubled. They increased by 32 hours per month and now have 64 hours per month between three part time psychiatrists.

December 2017 Implementation Panel findings: As per SCDC update.

December 2017 Recommendations: Implement and QI the above referenced plan.

1.b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 Update:
The Division of BMHSAS conducted a QI study to review triage decisions made by Qualified Mental Health professionals (QMHPs) to determine if screening/assessment practices are accurate for the diagnosing of inmates with serious mental illness for referral to appropriate treatment programs.

The full study is attached as Appendix C. Results were as follows:

Assessment of Results
As noted in previous studies, staff meeting timeframes for triaging referrals continue to be outside of policy guidelines. The data entry of medclass information after inmates have seen the QMHP and Psychiatrist also appears to be an issue.

Plan Actions
1. Psychiatry time for both programs has increased to address timely follow-up of referrals. Camille Graham has approximately 64 Psychiatry hours a month between three part time psychiatrists. In October 2017, Kirkland began Saturday Psych clinics, which will increase their psychiatry coverage by an additional 12 hours a month.
2. Camille's Mental Health Supervisor will provide additional oversight and coordination to subordinate staff to improve compliance percentages for routine, urgent, and emergent referrals to the QMHP.
3. Pursue the hiring of a pink-slip/temporary position to assist with data entry requirements at Kirkland R&E.

December 2017 Implementation Panel findings: The QI referenced in the status update focused on compliance with relevant timeframes in contrast to assessing the accuracy of the mental health screening and/or assessment processes.

December 2017 Recommendations:

Perform a QI specific to assessing the quality of the mental health screening/assessment processes. Target populations can include an appropriate sample of inmates admitted to SCDC within the past six months with negative R&E assessments from a mental health perspective who were subsequently placed on the mental health caseload within six months of admission to the SCDC. Another QI could focus on a sample of R&E mental health screening/assessments performed by a QMHP and reviewed by a supervisor to determine percentage of agreement or disagreement with the QMHP assessments.

1.c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 Update:

The R&E Committee established in November 2016 continues to meet and discusses R&E data for Kirkland and Camille Correctional Institutions. The July 2017 meeting was cancelled due to scheduling conflicts. The August 2017 meeting focused on completion of mental health evaluations and ensuring that MEDCLASS and mental health evaluation were reviewed. Detailed minutes for August and September are included as Appendix D.

1. To ensure that policies relating to the timeliness of assessment and treatment for incoming inmates are enforced:
2. Psychiatry coverage at R&E for Kirkland and Camille Graham has increased to address timely follow-up of referrals.
    a. Camille Graham has approximately 64 psychiatry hours per month from three part-time psychiatrists. This has increased from 36 hours per month
    b. In October 2017, Kirkland initiated Saturday psychiatric clinics, which has increased their psychiatry coverage by an additional 12 hours per month.
3. Camille Graham's Mental Health Supervisor will provide additional oversight and coordination to subordinate staff to improve compliance percentages for routine, urgent, and emergent referrals to the QMHP. A part of the problem has been coordination and supervision. Therefore, the MH Supervisor will be more directly involved with monitoring the data regarding timeframes and ensuring that staff are productive. Coordination has also been worked out with Dr[redacted] to ensure Camille and Kirkland staff will have access to a Psychiatric provider daily to handle urgent/emergent referrals.
4. Health Services has identified that a temporary pink slip position will be filled to ensure mental MEDCLASS data is entered timely.

December 2017 Implementation Panel findings: As per status update section. The increased staffing allocations described in the status update section are encouraging, which should facilitate better compliance with relevant timeframes.

This provision has not yet been directly monitored specific to timeliness of inmates receiving treatment once they have been placed on the mental health caseload. However, based on data relevant to other provisions, many inmates are not receiving timely treatment related to custody and mental health staff allocations and/or vacancy issues.

December 2017 Recommendations: continue to closely monitor via QI.

1.d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
See report and QI study for 1a.i..

The South Carolina Department of Corrections (SCDC) has established a mental health screening process which all inmates go through during intake at the Reception & Evaluation center (R&E). The goal of this screening process it to identify mild, moderate, and serious mental illness and/or crisis intervention needs that may be associated with psychiatric and psychological problems. As a result of the screening, inmates are classified either as needing no mental health services or as needing a routine, urgent, or emergent mental health follow up evaluation. Policy provides timeframes for the completion of each category of follow up evaluation: routine, urgent, or emergent. Follow up evaluations are then conducted by Qualified Mental Health Professionals (QMHP) or Psychiatrists. If this first follow up evaluation is completed by a QMHP, the QMHP can refer the inmate for an additional follow up with a Psychiatrist if necessary. The purpose of this study was to determine if the timeframes for the initial screening and follow up evaluations outlined by policy were being met, to identify root causes of any deficiencies, and to provide action plans to correct any identified deficiencies.

December 2017 Implementation Panel findings: As per 1a.i.

December 2017 Recommendations: As per 1a.i.

2. The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates, and substantially improves/increases mental health care facilities within SCDC.

2.a. Access to Higher Levels of Care

2.a.i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
The Division of BMHSAS completed a QI study to review and assess processes that may contribute to an increase in number of male and female inmates receiving Area Mental Health care services.

The goal of the study was to measure whether SCDC had more accurately identified inmates needing a higher level of outpatient mental health care.

Results of the study revealed an increased number of inmates added to the L3 classification from April to May followed by a slight decrease in June. In comparison, there was a significant increase in the numbers for July; however, August and September numbers present a decline with September having the lowest of all 6 months.

The CQI study is attached as Appendix E

Mental Health's Plans for Area Mental Health

1. The decision has been made to create an area mental health unit to centralize delivery of area mental health services to higher security inmates currently house at Lee, Lieber, and Perry. Approximately 239 area mental health inmates will be relocated to designated Mental Health dorms at to BRCI;
2. The Area Mental Health (L3 classified) inmates will be housed in Marion dorm as current non-mental health inmates housed at Marion will be moved:
3. The move will be complete by December 1;
4. 2 QMHPs and 1 mental health tech will have offices at Marion;
5. 2 group rooms will be used on each side of the Marion dorm for a total of 4 rooms;
6. 2 QMHPs will be on the yard and 1 supervisor will be located at Moultrie
7. 1 MH tech will be located at RHU.
8. Adequate supplies will be obtained.
9. Repairs to the dorm will be completed;
10. The mental health counselor requested CIT officers and wants to use the positive experiences at CSU to model Area Mental Health program and services.
11. A unit manager has been assigned to the new area mental health dorm.

December 2017 Implementation Panel findings: See SCDC status update section.

During the afternoon of December 5, 2017, we interviewed inmates in a community - like setting in one of the Marion housing unit wings at the Broad River Correctional Institution that was occupied by inmates with an L3 mental health classification. These inmates were very upset, angry and vocal regarding their dissatisfaction with the transfer process from their home institutions to the Marion housing unit at BRCI. There complaints included the following:

1. Significant problems with the medication administration process such as nursing staff administering the medicines under the cell door, leaving medications on the food port, not delivering medications and/or administering medications to the wrong inmate.
2. Poor access to the mental health counselor due to the large caseload of the assigned mental health counselor to the housing unit.
3. Inadequate access to commissary.
4. Not obtaining property from the sending institution.
5. Lack of access to the law library.
6. Inadequate access to religious services.
7. Lack of access to educational activities, jobs and/or other programs.
8. Lack of access to outdoor yard.
9. Significant laundry issues.
10. Essentially being locked down for the first four weeks following transfer to this unit.

After talking with key administrative clinical and custody staff, it was apparent that many of the above allegations were at least partially, if not completely, accurate. We met with key leadership staff to discuss recommended interventions such as frequent community meetings with custodial decision-makers to address these issues until they were adequately resolved. Leadership staff had made a decision to transfer these L3 classified inmates in the near future to the Murray housing unit due to its better physical plant. Leadership staff appeared to be very open to our recommendations. Lessons learned from the above transfer of inmates process were also discussed with key staff.

We had been informed by mental health staff that these inmates were receiving mental health screenings with a significant number of such inmates having their mental health classification changed from a L3 to L4 designation. We recommended that mental health staff stop this screening process at the present time and focus on crisis management and supportive therapy interventions.

[redacted]

December 2017 Recommendations:

1. Implement the above recommendations.
2. There remain L3 inmates in other CI's that have not yet been transferred to the BRCI. We recommend that these inmates be screened at the sending institution as part of the decision whether to transfer the inmate to BRCI. Some of the L3 inmates' mental health level of care may no longer require an L3 LOC and for some it may be beneficial to not be transferred based on their level of functioning and programming, especially those inmates housed in various character dorms.

2. a.ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
The Division of BMHSAS completed a QI study to review and assess processes that may contribute to an increase in number of male and female inmates receiving intermediate care services.

A CQI study was completed to measure whether SCDC had more accurately identified inmates needing this level of care.

The results of the study revealed that the number of MEDCLASS changes to L2 from lower levels of care were low. However, 22 referrals were made to the ICS program, staffed by the treatment team, which were ultimately not deemed appropriate for ICS. Reasons for the denials included: not suitable due to behavioral issues, does not have SMI warranting L2 services, no treatable psychiatric disorder, not suitable due to manipulative behavior, and not suitable due to extensive disciplinary history. All but one of those denials were upheld in the review phase. This indicates that the QMHPs making the initial referrals to the L2/ICS level of care are not referring the appropriate inmates.

The CQI study is attached as Appendix F.

Community Meetings

- The Program Manager reported that Community Meetings are held on Fridays in the Blue Ridge Unit (C & D). Source documentation (signed attendance rosters) were received which indicates the following:
- Three community meetings were held in July 2017; July 7, 14, and 21, 2017.
- The meeting scheduled for the 28th was cancelled due to agency cleaning day.
- Four community meeting were held in August 2017; August 4, 11, 18 and 25 2017.
- Four community meeting were held in September; September 1, 8, 15, 22 & 29, 2017.
- Due to a late submission of documentation, the sing-in sheets are out of order in the appendix references; however, the sign-in sheets are attached as Appendix R.

MAR-specific considerations:

- After the July 2017 IP visit, more consistent collaboration began between RIM, nursing, MH and pharmacy staff to address any medication issues. Several enhancements have been added to the system:
- The external vendor/Medicalistics has activated the capability for eZmar to automatically send notifications to the prescribing provider when an inmate misses three consecutive doses. This capability was not functional until recently. The provider should have the ability to address the medication non-compliance issues of the inmates in a timely manner.
- Due to the continuing issue of psychiatry coverage at the two female facilities, nursing and MH staff have been proactive in addressing medications that are due to expire. They have been contacting the prescribing psychiatrist and SCDC full-time psychiatrists by email in order to call attention to those medications and receive the renewals that are needed.
- We have had our software vendor amend coding in the eZmar system to allow for improved medication check-in processes.
- Some of the issues with eZmar functionality still exist due to workflow tasks not being completed appropriately by the medical staff. SCDC has coordinated an extra week of

training time with our software vendors. Those re-training classes are scheduled for December 12-14. Correcting these issues will allow staff to request medication refills through eZmar, whereas the current lack of completing workflow tasks are preventing them from being able to request electronically.

- The classes will focus primarily on:
- Consistently checking the "Map Meds" screen to appropriately map new prescriptions to the pill calls.
- Enhanced technology and the ability to electronically check in medications upon arrival from the pharmacy.
- Electronically checking in medications when they arrive from the pharmacy.
- Appropriately selecting "Start New Package" when one is available during a pill call.
- Reviewing the "Medication Change" tasks in the Inbox before preparing medications for an upcoming call to ensure discontinued meds are removed and dose changes are taken into account.
- Preparing the pill calls according to the pill call created in eZmar rather than preparing a pill call based on what the medication bags say for each inmate. The medication information in eZmar will always be more current and accurate than what is shown on a pharmacy label that has perhaps not yet been updated and delivered.

Refresher material has also been made available to all the prescribing providers at Graham and Leath for physicians to prescribe in a manner that reduces the burden of work put on the nursing staff.

December 2017 Implementation Panel findings:

Kirkland Correctional Institution

Nursing staff continues to not be housed within the male ICS unit related to safety issues. Very little has changed from a custody staffing perspective in the male ICS since the April 2017 homicides other than assigning a unit manager and correctional counselor to the male ICS unit. Following the homicides, the male ICS unit was reorganized as follows: Unit F1, which is a 64 bed ICS housing unit, was established for ICS inmates who were considered a high risk of harming vulnerable inmates from the perspective of their functioning level. Unit F2, which is a 128-room ICS housing unit with a capacity of 256 inmates, was designated to treat inmates with a lower level of functioning as compared to F1 inmates. The count during the site visit of unit F2 was 97 inmates as compared to the count of 40 inmates in Unit F1.

At the time of the site visit the total male ICS count was 137 inmates.

The lack of medication administration at KCI being available on a HS basis (i.e., at night) continues to be very problematic. Long acting injectable medications are available but are administered off the housing unit because nursing staff have been removed from ICS related to perceived safety issues.

During the morning of December 5, 2017, we observed a treatment team meeting in the male ICS at KCI. The appropriate staff were present, inmates were interviewed by the team and a reasonable multidisciplinary discussion occurred during the meeting. Specific inmate referrals to the ICS were reviewed during the treatment team meeting. It appeared that acceptance or rejection of such referrals was a team decision, which is problematic from a number of perspectives.

We also met with ICS inmates in one of the F2 wings in a community-like setting. These inmates described satisfaction with the ICS program. Most inmates reported receiving 3 to 5 groups per week, which they described as being very helpful. They were complimentary towards both the custody and mental health staffs. Medication continuity issues were not present. Reasonable access to both individual counseling and the psychiatrist was described. A therapeutic milieu was clearly present on this unit. Suggestions for improvement in the program included access to more therapeutic groups and a wider variety of such groups.

We also met with ICS inmates in housing unit F1 in a community - like setting. These inmates were described as "higher functioning" as compared to ICS inmates in housing unit F2. A therapeutic environment also had been established in this unit. A larger number of inmates, but still a significant minority of inmates, expressed dissatisfaction with certain aspects of this program. Most inmates reported access to 3-4 groups per week, which were generally described as being helpful. Medication continuity issues were not present. Reasonable access to a psychiatrist and assigned mental health clinicians was described.

Assessment: We were very encouraged by the therapeutic milieu established in the ICS units at Kirkland CI. We remain very concerned regarding safety issues, which have resulted in the lack of nursing staff having a significant presence within the ICS. Increased out of cell structured therapeutic activities need to be implemented and tracked.

We do not think that acceptance or rejection of inmates referred to the ICS should be a team decision, although in many cases it may be appropriate for the decision-maker to seek input from the treatment team.

Recommendations:

1. A plan needs to be developed and implemented specific to a custody staffing analysis specific to the male ICS as soon as possible due to obvious safety concerns.
2. Provide accurate information regarding the number of hours of out of cell structured therapeutic activities both offered and received by individual ICS inmates, on average, on a weekly basis.
3. The lack of medication administration on a HS basis needs to be remedied.
4. Safety issues related to the absence of nursing staff having offices within the ICS need to be resolved

Camille Griffin Graham Correctional Institution

The inmate count during November 27, 2017 was 719 inmates. During December 8, 2017 there were 380 mental health caseload inmates (~59% of the population), which included 23 L2, 55 L3, 204 L4, and 25 L5 mental health caseload inmates.

The RHU count was 18 inmates, which included 13 mental health caseload inmates.

There were 12 CSU beds and 4 safety cells in RHU. The number of inmates on CI status generally ranged from 0-3 per day with length of stay less than 10 days. The 4 safety cells in the RHU were not suicide resistant.

The female ICS count was 23 inmates with three ICS level of care female inmates in the RHU and one ICS female inmate on security detention status.

Staffing data included the following:

> Psychiatric coverage is provided by three psychiatrists that involves up to 16 hours per week, which included 4 hours of telepsychiatry. Additional psychiatric coverage was available on an as needed basis during weekends.
>
> A psychologist provides on-site coverage two days per week for an average of 15 hours per week.
>
> 7.0 FTE QMHP positions are allocated with 6.0 FTE positions filled.
> 4.0 FTE MHT positions are allocated with 3.0 FTE positions filled.
>
> 20.0 FTE nursing staff positions are allocated with 2.0 FTE RN FTE positions filled and 5.0 FTE LPN positions being filled. Registry nurses provided the equivalent of 2.5 FTE nursing positions.

Staff reported that the number of groups being offered to inmates had increased related to the collaborative training project and decreased staffing vacancies.

We observed a treatment team meeting during the afternoon of December 8, 2017. We were again impressed by the multidisciplinary discussion and the presence of a psychiatrist, Dr. [redacted]

ICS

Staff reported that ICS inmates in D Wing were being offered group therapies on a weekly basis although they could not quantify the number of hours of out of cell structured therapeutic activity, on average, being offered to these inmates. A lesser number of group therapies were being offered to mental health caseload inmates who were housed in C Wing. Fifteen group therapies were being offered in the general population mental health caseload inmates, which included those inmates

housed in C Wing. L2 inmates housed in C Wing were offered group therapies being provided to D Wing ICS inmates.

Fourteen ICS inmates in D Wing were interviewed following our observation of a community meeting, which was conducted in a very reasonable manner. The majority of the inmates interviewed indicated that they participated in less than two groups per week with a high refusal rate noted re: other groups offered to them.

We also observed part of a community meeting in C Wing, which was attended by many inmates who had many medication management complaints as referenced in the next subsection. These inmates also complained that until very recently a significant number of non-mental health caseload inmates were housed in this dorm, which caused numerous problems including acting out behaviors by some of those inmates. Several inmates also expressed concern about an inmate in the general population who they described as being psychotic and eating poorly.

Medication Management

Staff reported minimal continuity of medication issues based on an audit that used a sample population of ICS and RHU inmates. However, information obtained from many inmates in the ICS directly contradicted the reported audit results. Medication management issues described by many inmates included the following:

1. Waits up to one hour for the morning medication pass, which involves going to a general population pill call line beginning around 4:45 AM
2. The pharmacy running out of certain prescribed medications, which resulted in significant delay in receiving prescribed medications despite the staff's report that many medications were available via a stock supply.
3. About 4-6 weeks ago, the medication administration process changed from a three per day to a two per day pill call line process due to nursing staff shortages. Nursing staff reported that a psychiatrist had adjusted patients prescribed medications on a t.i.d. scheduled basis to a b.i.d. schedule as a result but many inmates denied that their medications had been changed in that fashion.
4. The lack of medication administration not being available on a HS basis (i.e., at night) continues to be problematic.

R&E

Staff also reported that newly admitted R&E inmates were offered a coping skills group during the first week following admission and a character building group during the second week until they were transferred from R&E. They estimated that such inmates also received out of cell dayroom time as well. However, information obtained from inmates in the R & E indicated that they were not receiving out of cell time.

It was also brought to our attention, and confirmed by staff, that R&E inmates, who are placed on the mental health caseload as result of the screening process, are not assigned a mental health

clinician despite the length of stay in R&E. An inmate complained that she was notified that her mother had died during the second month of her stay in R&E and was unable to meet with a mental health counselor to discuss relevant issues until she was transferred to C Wing about 68 days later.

Assessment: We clearly expressed our dismay regarding the discrepancies in information obtained from staff as compared to inmates specific to medication management issues, participation in out of cell structured therapeutic activities, and the amount of out of cell time offered to inmates in R & E.

Recommendations:

1. The medication management issues need to be remedied and studied via a QI process.
2. Adequate tracking of the out of cell structured therapeutic hours and unstructured out of cell time offered to each mental health caseload inmate, on average, each week as well as the actual number of hours participated in such activities by each inmate, on average, each week needs to occur. This tracking should differentiate between out of cell structured therapeutic time and out of cell unstructured time. This tracking process should occur for mental health caseload inmates in the RHU and for mental health caseload inmates in the R & E.
3. A similar tracking process should occur for ICS inmates.

December 2017 Recommendations:
See Attachment 1. Although the accuracy of the data summarized in Attachment 1 was questionable, there was no disagreement that both male and female ICS inmates were not receiving minimal out of cell structured therapeutic activities. This issue was described as being predominantly related to staffing allocation and/or vacancy issues.

Refer to the previous assessment and recommendations section specific to Kirkland CI and Camille Griffin Graham CI for specific assessments and opinions relevant to each program.

2.a.iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
Status of GPH Renovations as of 10/30/2017
The renovations to turn two cells on each wing of the GPH housing unit to a nurse station is on-going. Most of the renovation is complete except for the electrical upgrades, security camera system, patching of walls/ceilings and painting.

Substantial Completion is anticipated by December 31, 2017. SCDC will then request inspection by SC DHEC for operational permit.

Inpatient psychiatric beds

To increase access to inpatient housing for female inmates, SCDC has successfully executed an amended contract with Correct Care for 10 beds dedicated to SCDC use. This separate unit for SCDC is currently undergoing renovations with an anticipated completion by February 1, 2018. The amended contract has been signed by both parties. A copy has been provided to the Implementation Panel.

Gilliam Psychiatric Hospital (GPH) is the inpatient facility for all males requiring this level of care. During the months of July-October 2017, GPH averaged a census of 79 mentally inmates.

During the months of July – October 2017 there was one (1) female inpatient at Correct Care. She was there for 3 weeks during the month of October.

GPH Treatment Chairs

- Treatment chairs have been removed and replaced with a spider table that can sit six inmates comfortably.
- Provide training/supervision to mental health staff regarding court orders relevant to involuntary medications.

GPH Low Admissions Rate

- Camille Graham has increased Psychiatry at Camille Graham to provide psychiatric care, medication assessment and management.
- Camille is averaging approximately 64 hours of psychiatry services monthly which allows appropriate interventions, preventing hospitalizations.
- **Training on court-ordered involuntary medications**
- On October 25, 2017, a training on Involuntary Medications was taught by the Division Director and Assistant Division Director of BMHSAS. This training was attended by twenty-nine MH staff. The content of this training is attached as Appendix G.
- **Supervision of mental health staff for court-ordered involuntary medications**
- Supervision will be provided by keeping a database of all inmates with court orders for involuntary medications. Clinical Supervisors will be required to review all cases quarterly with subordinate staff to ensure continuity of mental health care.

- Attachment 1 summarize at a cell time offered to GPH inmates.

December 2017 Implementation Panel findings:

The amount of out of cell time, both structured and unstructured, actually used by GPH inmates remains alarmingly small. This issue is predominantly related to inadequate staffing allocations (both correctional and mental health staff) although institutional cultural issues likely contribute.

Renovations at GPH are not yet completed with specific reference to the nursing stations although significant progress has been made as summarized in the SCDC status update section.

Since the last site visit, training has been provided to mental health staff regarding court orders relevant to involuntary medication. In addition, the "treatment" chairs have been replaced by a spider table in one of the group therapy rooms.

Clinical staffing for GPH was reported as follows:

Psychiatrists: 2.1 FTE positions filled with 4.0 FTE positions designated in the staffing plan.

Psychologist: .60 FTE position filled with 1.50 FTE positions designated in the staffing plan.

QMHPs: 4.0 FTE positions filled out of the 8.0 FTE allocated positions with 9.0 FTE positions designated in the staffing plan.

MHTs: 15.0 FTE positions filled out of the 16.0 designated positions in the staffing plan.
Nursing (R.N./LPN): 7.0 FTE positions were filled out of the 22 FTE allocated positions with 27.0 FTE positions designated in the staffing plan. Registry nurses are used to cover many of the vacant positions.

Activity therapists: .42 FTE positions were filled out of the 1.0 FTE positions designated in the staffing plan.

During the afternoon of December 4, 2017, we met with 22 inmates at GPH in a community meeting like-setting. The inmates were attentive and generally socially appropriate throughout the 30-40 minute meeting. Inmates reported that they received 0-2 hours per day of out of cell activity, which was mainly unstructured recreational activity in either the dayroom or outdoor recreational cages. Very few inmates were offered out of cell structured therapeutic activities in a group setting. Individual out of cell counseling was offered to many inmates but on an infrequent basis. These inmates described the housing unit at GPH to essentially be a locked down housing unit. Inmates who had been at GPH many years ago described the current conditions of confinement initiated to have improved. Inmates also reported that the groups offered to them were helpful but too few in numbers.

Several inmates reported that they had witnessed inappropriate use of force by staff against inmates.

We discussed with staff issues relevant to the minimal out of cell time offered to inmates in GPH. We were informed that medication administration generally occurs around the time that meals are being delivered, which meant that on a daily basis there was only about a five-hour window of opportunity for GPH inmates to be out of their cell. The default principal for GPH inmates is that they are locked in their cell unless there is a specific reason for them to come out of their cells.

December 2017 Recommendations:

1. Focus on providing more out of cell structured therapeutic and unstructured time to inmates in GPH. We strongly recommend at least several community meetings be conducted per week with both mental health and correctional staff in attendance and actively participating.

2. Further explore the reasons for the low admission rate of female inmates to an inpatient psychiatric unit.

3. Complete the renovations.

4. Fill the mental health staffing vacancies and perform a needs analysis for custody staffing in GPH.

5. Provide information relevant to the number of hours received, on average, to each GPH inmate on a weekly basis both in terms of out of cell structured therapeutic time and out of cell unstructured time. Please provide this data as part of the pre-site document requests prior to our March 2018 site assessment.

2.a.iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
The strategies summarized in Attachment 1 outline SCDC's plan to decrease vacancy rates of clinical positions. This plan includes salary increases to a more competitive rate, hiring additional staff to decrease workloads and developing a plan to consolidate and centralize some of the mental health services.

New mental health staffing allocations have been approved as follows:

NEW POSITIONS REQUESTED				
Position	**# of FTE's**	**Base pay**	**Total**	**Total W/Benefits**
QMHP	9	$ 50,000.00	$ 450,000.00	$ 653,535.0000
MH Techs	6	$ 37,000.00	$ 222,000.00	$ 322,410.6000
Psychiatrist	2	$ 206,000.00	$ 412,000.00	$ 598,347.6000
Psychologist	2	$ 90,000.00	$ 180,000.00	$ 261,414.0000

Total	**19**	**$ 383,000.00**	**$ 1,264,000.00**	**$ 1,835,707.20**

December 2017 Implementation Panel findings: As per SCDC status update section.

Our July 2017 recommendations included the following:

> A staffing needs analysis for all aspects of the mental health system throughout the SCDC, which should include both mental health and custodial staff, is needed. This analysis should be completed in a timeframe that would permit the Director to request additional FTE positions, if needed, for the next fiscal year.
>
> In addition, a salary analysis should be completed specific to mental health staff positions to determine the level of salary that is needed to be competitive for hiring purposes.

The salary analysis was completed, which has contributed to restructuring the salaries for various mental health disciplines as summarized in Attachment 2. An aggressive hiring recruitment plan was developed and implemented as summarized in that attachment, which is beginning to demonstrate positive results.

A staffing needs analysis has not yet occurred although it is clearly recognized that more staffing allocations are needed as evidenced by new positions being requested by the Director as summarized in the SCDC status update section. It is encouraging that an outside correctional consultant is doing a staffing analysis for SCDC in the context of correctional officers. It is expected that a report will be finalized in March 2018.

The current mental health staffing vacancy rate is 26.78%, which is a significant improvement as compared to the 37% to 40% mental health staffing vacancy rates noted during site visits since November 2016.

December 2017 Recommendations: Continue to implement the recruitment and retention plan as outlined in attachment 2.

2.a.v.The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.

Implementation Panel December 2017 Assessment: **compliance (07/17)**

November 2017 SCDC Status Update:

LLBMU Denials

Mental Health continues to review denials to the BMU programs. Training was provided to staff on the BMU policy on 10/25/17; therefore, the decrease in denials cannot be directly attributed to the

training. The staffing pattern for LLBMU has remained consistent throughout last reporting period. The training content is included as Appendix I.

Inmates not accepted were reviewed by Dr. [redacted] committee and if overturned are currently awaiting to transfer in to the program. Inmates remain in RHU until transferred to either LLBMU or HLBMU. LLBMU has capacity for 24 inmates based on current staffing.

December 2017 Implementation Panel findings:

During our prior site visit, SCDC provided a description of the QI committee that meets to review denials of referrals of inmates to higher levels of care. The description included the following:

1. This committee has met three times (20 Apr 17, 17 May 17, 21 Jun 17). There are four members: [redacted] meets w/us via VTC.

2. Prior to each meeting, Dr. [redacted] eceives reports from the six (five as of June) residential/inpatient programs (SIB, ICS, HAB, LLBMU, HLBMU, GPH) which reflect the number of requests for admission, the number of inmates accepted, the number wait-listed, the number removed by the referral source before they were admitted/denied and the number denied. These reports also contain a section in which all inmates who are denied admission/acceptance are identified along with the date they were denied and an explanation of why they were denied.

3. During the meeting, all inmates denied are reviewed. Their AMR and their relevant OMS data is reviewed. The committee decides to either concur or not concur with the denial. The names of those inmates whom we believe were denied inappropriately, along with the reasons we believe the denial was inappropriate, are forwarded to Mr. [redacted] for further action.

4. Mr. [redacted] replies to Dr. [redacted] regarding his decision to agree or disagree with or not concur in the finding.

This review process has continued.

Some issues described during the prior site visit relevant to denials specific to the HLBMU appeared to have been adequately addressed via this review process.

As summarized in the SCDC status update section, training has been provided to mental health staff relevant to criteria for referral to the BMUs.

December 2017 Recommendations: Continue with the described review process.

2.b. Segregation:
2.b.i. Provide access for segregated inmates to group and individual therapy services

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:

HLBMU

The attachment at Appendix J outlines progression of inmates through the three phases of the HLMBU from July- September 2017. The mission of the HLBMU is to provide programming, treatment and structure to inmates whose mental health needs likely contribute to their segregation status.

The HLBMU's serves as an alternative to long-term placement in restrictive housing. For some inmates, the program will facilitate reentry to the community at the completion of their sentence. HLBMU services include: crisis intervention, individual & group treatment, and daily rounds.

The program is designed to provide inmates ten (10) hours of out-of-cell activities structured by their mental health treatment plans, including group activities, and ten (10) hours of unstructured, out-of-cell activities time each week.

HLBMU has not moved from KCI to Broad River due to staffing and the relocation of Death Row to the SSR building at KCI. Timelines and program expansion dates are outlined and explained in the Master Plan.

The SDP program Managers are actively involved in the selection of officers assigned to the SDP.

The SDP policy addressing inmates released from Security Detention has been written and in the signature stage.

HLBMU Staffing & Program Capacity

Staffing

Position	Positions Allotted	Positions Filled	Current Vacancies
Program Manager	1	1	0
QMHP	4	1	3
Mental Health Techs	4	1*	3

*1 Mental Health Tech was hired for this area but had to be reassigned to GPH as a Bay Counselor as a result of failing the required officer certification.

Program Capacity

Program Capacity	24	
Number of Admissions	3	
Number served this quarter (July- September 2017)	18	
Number dismissed	4^	

^ Inmates dismissed due to staff assault & building destruction

December 2017 Implementation Panel findings:

During the afternoon of December 4, 2017, we interviewed level 2 and level 3 HLBMU inmates in the HLBMU at the KCI. The inmate census in this unit was 19 with a current capacity of 24. The planned expansion and move of the HLBMU at KCI to the Broad River CI did not occur for reasons summarized in the SCDC status update section. Our prior site assessment report included the following:

> The HLBMU program has essentially never been appropriately implemented due to the custody staffing shortages (average about two officers per day with only one officer assigned at times) and inadequate mental health staffing (1.0 FTE QMHP and 1.0 FTE mental health technician, both of whom provide coverage to the SSR) within the unit.

For somewhat different reasons as referenced in the SCDC status update section, the mental health and custody staffing shortages have persisted. Level 2 inmates remained very upset that their visitations did not include weekend visits. HLBMU inmates continued to complain about lack of structured programming within the HLBMU and inconsistency among correctional staff due to regularly assigned staff being frequently pulled to other units. Our prior site assessment report included the following:

> The HLBMU is currently not a treatment program although the physical plant is certainly better than what was available within the SSR and, at least some, RIIUs. It is clear that many of the problems are related to inadequate mental health and custody staffing. Unfortunately, inmates are not being provided with many privileges that could at least mitigate the lack of programming such as reasonable access to the yard, increased out of cell time within the dayrooms, at least intermittent visitation during weekends, and/or permission to have pictures of their families within their cells.

Our opinion is essentially unchanged.

Inmates also complained about work orders not being completed in a timely fashion in the context of a broken phone within the unit and various plumbing issues.

We did not evaluate the LLBMU during this site assessment.

December 2017 Recommendations:

We discussed with key clinical and administrative staff various ways of mitigating the lack of programming, with an emphasis on increasing out of cell time and providing, at least intermittently, access to weekend visitation. It appeared that weekend visitation on a monthly basis for these inmates would be implemented in the very near future.

2.b.ii. Provide more out-of-cell time for segregated mentally ill inmates;

Implementation Panel December 2017 Assessment: **noncompliance**

November 2017 SCDC Status Update:

To determine the average number of SCDC Mentally Ill Inmates in RHU and Total Institutional Population for the months of July, August and September of 2017 the RIM reports provided were utilized. The RIM reports would provide the institution's RHU census for each Thursday of the week. Each week was then utilized to determine the average. Refer to attachment 3 for a summary of the RHU population from a mental health classification perspective.

Suring September 14, 2017, QIRM hosted the first of four-learning session of the Mental Health Care Improvement Collaborative. This purpose of the collaborative was to work with seven institutions selected jointly by Mental Health and Operations leaders to individually test system changes focused on improving the care provided to their mental health inmates.

This Breakthrough Series (BTS) Collaborative is a systematic approach to healthcare quality improvement in which organizations and providers test and measure practice innovations and then share their experiences to accelerate learning and widespread implementation of best practices.

The objectives of the collaborative were:

- to increase collaboration among institutions to address components of the Mental Health Lawsuit.
- provide evidence-based information on mental health subject matter, application of that subject matter, and methods for measurement and process improvement, both during and between collaborative learning sessions.
- provide coaching and training to teams on continuous quality improvement.

- During the learning sessions participating institutions, through plenary sessions, small group discussions, and team meetings, attendees have the opportunity to:
- Learn from content experts and colleagues;
- Receive individual coaching;
- Gather knowledge on clinical topics and on process improvement;
- Share experiences and collaborate on improvement plans; and
- Problem-solve barriers to improve care.

Action periods are the times between learning sessions. During action periods, teams work within their institutions to test and implement changes using small tests of change know as Plan-Do-Study-Act or PDSA cycles. Teams share the results of their improvement efforts in monthly senior leader reports and also participate in shared learning through an electronic mailing list and scheduled conference calls.

A major focus of the Collaborative encouraged institutions to closely assess out-of-cell time for segregated mentally ill inmates. A measure was created that required teams to evaluate the time mentally ill inmates in segregation spend out of their cells. The mental health settlement agreement requires 10 OOC hours structured by the inmate's MH treatment plan and 10 unstructured OOC hours.

There continues to be limited data on the amount of out-of-cell structured and unstructured time for segregated mentally ill inmates; however, institutions have identified this as problematic and are currently taking some steps to identified opportunities for improvement.

As a part of the collaborative, seven team were encouraged to selected one area to focus on improving upon return to their institutions. Camille Graham, Broad River, McCormick, Leath and Lee CIs focused on increasing OOC time for inmates in RHUs. Perry and Broad River focused on increasing the percentage of inmates on CI seen in a confidential setting.

A summary of reported barriers, successes, and lessons learned as reported by each team is outlined in the CQI update attached as Appendix K.

December 2017 Implementation Panel findings: Data relevant to structured and unstructured out-of-cell time for institutions participating in the learning collaborative was presented and reviewed by the IP. Based on the data presented, it was clear that inmates with mental illness in the RHUs received very little, if any, out of cell therapeutic activities on a monthly basis.

Medication administration in all the RHU's we reviewed, except for the Camille Griffin Graham CI, involved administering the medications under the cell door.

Broad River Correctional Institution

During the afternoon of December 5, 2107, we obtained information relevant to the RHU at the Broad River CI. Thirty-nine (39) of the 65 RHU inmates were on the mental health caseload. Staff confirmed that prior to August 2017 inmates were not receiving out of cell recreational time. They have been receiving minimal out of cell time since that time but the frequency was nowhere close to occurring on a daily basis. There were at least one or two inmates in the RHU that were reported to be extremely disruptive, which caused significant problems in the operation of the RHU. The conditions of confinement within the RHU, based on information obtained from staff, appeared to have changed little since our last site visit.

Lieber Correctional Institution

The RHU count at the Lieber CI during December 6, 2017 was 66 inmates. Forty of these inmates were on the mental health caseload (14 (L3) and 26 (L4)). We observed the mental health rounding process in the RHU during the morning of December 6, 2017, which was done in a competent manner. Recently, RHU inmates were being offered access to the recreational cages, reportedly on a three times per week basis in the mornings. Showers were reportedly offered on a three times per

week basis. Inmates described being offered access to the yard cages 1-3 times per week. Many inmates complained about the filthy conditions of confinement within the RHU.

A group therapy, in the visitation room, has just been initiated for a small number of RHU inmates. "Therapy" chairs were to be installed on December 7, 2017 and will be used for group therapy purposes for some RHU inmates.

Four safety cells in the RHU were not suicide resistant.

Kershaw Correctional Institution

During the morning of December 7, 2017, we site visited Kershaw CI. Of the approximately 80 RHU inmates, a total of 41 inmates were on the mental health caseload (27 SD, 10 ST and 4 inmates awaiting placement). The two safety cells located in the RHU were suicide resistant. Related in large part to the 46.5% correctional officer vacancy rate, RHU inmates for the past month had access to the outdoor recreational cages on only one day. Inmates were reported to have access to showers on a three times per week basis.

We observed the mental health rounding process in the RHU, which was performed by the MHT in a competent manner.

Not surprisingly, many inmates had numerous complaints regarding the conditions of confinement within the RHU.

We observed cell searches occurring while inmates were in the shower. Correctional officers, which included the captain, were involved in the cell search which resulted in some inmates' property being thrown out of the cell into the dayroom in a disrespectful manner while the inmates were watching, for reasons that included having more socks and/or boxer shorts than was allowed by policy. Family pictures and a Christmas card were also removed from an inmate's cell walls due to violation of policy. Inmates observing these cell searches became understandably agitated.

Lee Correctional Institution

During the afternoon of December 7, 2017, we site visited the Lee Correctional Institution. Seventy-five inmates were in the RHU, which included 42 mental health caseload inmates (5 DD, 22 SD and 13 ST). RHU inmates were reported to be out of their cells for at least 10 hours per week for purposes of showers, outdoor recreation, various medical and mental health appointments, etc. In addition, a program has recently been initiated to provide out of cell structured therapeutic activities for two or three RHU caseload mental health inmates. The increased out of cell time for all RHU inmates was initiated by staff as a result of the recent mental health collaborative training project.

Despite the presence of a large number of central office staff, monitors, and "brass" from Lee CI, RHU inmates remained quiet and respectful throughout the review process. Inmates confirmed their access to increased out of cell time although they indicated they generally had to choose on a daily

basis between access to a shower or access to the outdoor recreational cages. They also complained that they did not have access to warm outerwear (i.e., jackets) during their time in the outdoor recreational cages.

Camille Griffin Graham RHU

Staff reported that 5 RHU groups per week were provided to mental health caseload inmates in the RHU. These groups were started as result of the collaborative training project. Staff estimated that RHU caseload inmates were being offered 6 to 8 hours per week of out of cell time. However, we were unable to confirm this report due to lack of time, which resulted in us being unable to interview inmates in the RHU.

December 2017 Recommendations:

1. The manner of medication administration within the RHU's is unacceptable and below the standard of healthcare. This needs to be remedied immediately.

2. We remain very concerned about the conditions of confinement within the RHU at the Broad River Correctional Institution. The conditions of confinement should be changed to include at least one hour per day of out of cell recreational time in addition to access to showers on a three times per week basis.

3. The conditions of confinement at the Lieber CI RHU are also very problematic from a physical plant perspective and are exacerbated by the very limited out of cell time offered to RHU inmates. The conditions of confinement should be changed to include at least one hour per day of out of cell recreational time in addition to access to showers on a three times per week basis.

4. The conditions of confinement at the Kershaw CI RHU are very problematic from a physical plant perspective and are exacerbated by the lack of out of cell time offered to RHU inmates and the selective enforcement of policies. Specifically, policies and procedures specific to inmates such as property restrictions appear to be enforced in contrast to policies and procedures specific to inmates' access to outdoor recreation. The conditions of confinement should be changed to include at least one hour per day of out of cell recreational time in addition to access to showers on a three times per week basis.

5. The conditions of confinement in the Lee CI RHU were impressive in the context of any other male RHU we have visited within the SCDC. Specifically, correctional staff make extra efforts to provide inmates with what is due to them (e.g., property, (especially out of cell time) and clearly demonstrated a respectful attitude towards inmates.

   It should be noted that the Lee CI RHU appears to be a model RHU within SCDC due to the abysmal conditions of confinement and other RHU's within SCDC that we have site visited. In that context, other wardens and RHU captains could benefit from visiting this RHU. However, compared to many RHU's in other prison systems across the country, the Lee RHU would be far from a model and would be considered very problematic. However, the

progress made at Lee CI in improving the RHU and the vision demonstrated by Lee CI leadership staff should facilitate continued progress toward more acceptable conditions of confinement.

Inmates should have access to jackets while in the outdoor recreational cages.

6. The safety cells in the Camille Griffin Graham CI RHU need to meet criteria for being a safety cell. We assume that RHU safety cells are not used unless there were no vacant CSU cells.

7. The safety cells in the Lieber CI RHU need to be made suicide resistant.

8. As part of our pre-site document request, please provide data relevant to the number of hours of outdoor recreational cage time, on average, offered to each RHU inmate at each institution on a weekly basis as well as the number of showers, on average, offered to each inmate on a weekly basis by institution.

9. We understand that the major reason for the very limited out of cell recreational time offered to RHU inmates in most SCDC prisons is directly related to correctional officer shortages. We also understand that these shortages will not be corrected quickly. Much stronger efforts should be made to provide RHU inmates with increased privileges within their cells in order to mitigate not providing them with the out of cell time required by policy and procedures.

   Access to tablets (e.g. iPads) have been successfully implemented by other correctional systems in RHU environments. It was our understanding that crank radios will be increasingly available to RHU inmates as will TVs in the dayroom-like areas. Ensuring that inmates receive timely laundry exchanges and that shower areas are kept clean are other common sense interventions.

2.b.iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:

See below:

	% Timeliness of QMHP Sessions		% Timeliness of Psychiatry Sessions	
RHU	Median	Range	Median	Range
Allendale	66.7	62.5 - 100	33.3	25 - 66.7
Camille Graham	62.5	62.5 - 70	20	12.5 - 50
Evans	60	53.8 - 61.5	53.8	46.7 - 53.8
Broad River	64.7	52.4 - 82.4	61.9	56.3 - 70.6
Kershaw	72	50 - 84	50	44 - 56

Kirkland	94.1	81.8 -100	72.7	70.6 - 78.6
Kirkland GPH	88.9	77.8 - 88.9	100	77.8 - 100
Leath	70	40 - 100	47	27.3 - 66.7
Lee	80	76.7 - 87.5	63.3	60 - 68.8
Lieber	65.2	57.1 - 71.4	53.6	52.2 - 66.7
McCormick	77.8	68.8 - 96.0	68	44.4 - 68.75
Perry	53.8	50 - 58.8	53.1*	20.5* - 85.7
Ridgeland	90	66.7 - 100	50	25 - 50
Turbeville	90.9	80 - 100	45.5	20 - 75
Tyger River	31.3	30 - 33.3	61.1	60 - 75
Agency Wide	70	30 - 100	56.2*	12.5* - 100

December 2017 Implementation Panel findings: See SCDC status update section. Partial compliance was due to a combination of custody and mental health staffing allocation/vacancies.

December 2017 Recommendations: Remedy the above .

2.b.iv. Provide access for segregated inmates to higher levels of mental health services when needed;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
See response provided at 2.a.v. (click here)

December 2017 Implementation Panel findings: See 2.b.i.

December 2017 Recommendations: See 2.b.i.

1. Implement the LLBMU and HLBMU as per policies and procedures.
2. Consider options for developing a female BMU.

2.b.v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;

Implementation Panel December 2017 Assessment: **compliance (11/2016)**

November 2017 SCDC Status Update:
RIM compiles and distributes the report, *Weekly Mentally ill Report for Institutional and Female GEO Care Population.* This report includes by institution:

- Total number of inmates
- Total number of mentally ill inmates

- Total number of mentally ill inmates by mental health classification*
- Mentally ill inmates as a percent of:
- The location's population
- Total mentally ill population
- Total SCDC population

The following is an example of this weekly report.

Mental Health Classifications for Mentally Ill Institutional and Female GEO Care Population on September 25, 2017

SCDC Institutional and Female GEO Care Population = 20,109

SCDC Mentally Ill Population = 3,524

Mental Health Classification	Female	Male	Total	Percent of Mentally Ill Population	Percent of Total Population
Missing	82	492	574	N/A	2.85%
BL	0	14	14	.397%	.070%
BU	0	19	19	.539%	.094%
L1	0	81	81	2.30%	.403%
L2	27	148	175	4.97%	.870%
L3	61	227	288	8.17%	1.43%
L4	631	2,190	2,821	80.1%	14.0%
L5	2	101	103	2.92%	.512%
LC	0	1	1	.028%	.005%
MR	1	21	22	.624%	.109%

Explanation of Mental Health Classifications

(Code table pulled in directly from system and includes Non-Mentally Ill and retired codes. When an inmate returns, their previous Mental Health Classification is used until a new review is performed.)

CODE	DESCRIPTION
BL	BL (BEHAV MANAGEMENT LOWE
BU	BU (BEHAV MANAGEMENT UPPE
L1	MH-1 (HOSPITALIZATION)
L2	MH-2 (INTERMEDIATE CARE S
L3	MH-3 (AREA MENTAL HEALTH)
L4	MH-4 (OUTPATIENT)
L5	MH-5 (STABLE)
LC	SELF-INJURIOUS BEHAVIOR
MH	NMH (NO MENTAL HEALTH TRE
MI	MH-I (MENTALLY ILL)
MR	MH-R (DEVELOPMENTALLY DIS
OK	MH-S (MENTALLY STABLE)
RA	RA (REFUSED ASSESSMENT)
RT	RT (REFUSED TREATMENT)
SA	SUBSTANCE ABUSE TREATMENT

Distribution by Location

												Location Counts		Mentally Ill Inmates as Percent of		
Location	L1	L2	L3	L4	L5	LC	BL	BU	RT	MI	MR	Mentally Ill Inmates	Loc Total	Loc's Pop.	Total Mentally Ill Pop.	Total Pop.
ALLENDALE	0	0	2	159	5	0	14	0	0	0	0	180	1,048	17.2%	5.11%	.895%
BROAD RIVER	0	2	5	284	8	1	0	2	0	0	20	322	1,380	23.3%	9.14%	1.60%
CATAWBA	0	0	0	0	0	0	0	0	0	0	0	0	125	.000%	.000%	.000%
EVANS	0	1	0	115	18	0	0	0	0	0	0	134	1,322	10.1%	3.80%	.666%
GILLIAM PSY	78	2	0	1	0	0	0	1	0	0	0	82	90	91.1%	2.33%	.408%
GOODMAN	0	0	0	0	0	0	0	0	0	0	0	0	522	.000%	.000%	.000%
GRAHAM	0	22	50	229	2	0	0	0	0	0	1	304	596	51.0%	8.63%	1.51%
GRAHAM R&E	0	5	11	37	0	0	0	0	0	0	0	53	187	28.3%	1.50%	.264%
KERSHAW	0	0	2	196	8	0	0	0	0	0	0	206	1,293	15.9%	5.85%	1.02%
KIRKLAND	3	142	6	125	1	0	0	12	0	0	1	290	1,814	16.0%	8.23%	1.44%
KIRKLAND INFRM	0	0	0	0	0	0	0	0	0	0	0	0	18	.000%	.000%	.000%
KIRKLAND MAX	0	0	2	2	0	0	0	1	0	0	0	5	5	100%	.142%	.025%
LEATH	0	0	0	365	0	0	0	0	0	0	0	365	680	53.7%	10.4%	1.82%
LEE	0	0	81	174	41	0	0	1	0	0	0	297	1,332	22.3%	8.43%	1.48%
LIEBER	0	1	86	189	4	0	0	2	0	0	0	282	1,167	24.2%	8.00%	1.40%
LIVESAY	0	0	0	0	0	0	0	0	0	0	0	0	497	.000%	.000%	.000%
MACDOUGALL	0	0	0	120	1	0	0	0	0	0	0	121	669	18.1%	3.43%	.602%
MANNING	0	0	0	8	0	0	0	0	0	0	0	8	554	1.44%	.227%	.040%
MCCORMICK	0	0	0	176	5	0	0	0	0	0	0	181	1,085	16.7%	5.14%	.900%
PALMER	0	0	0	0	0	0	0	0	0	0	0	0	232	.000%	.000%	.000%
PERRY	0	0	41	229	4	0	0	0	0	0	0	274	855	32.0%	7.78%	1.36%
RIDGELAND	0	0	0	114	0	0	0	0	0	0	0	114	988	11.5%	3.23%	.567%
TRENTON	0	0	0	6	0	0	0	0	0	0	0	6	558	1.08%	.170%	.030%
TURBEVILLE	0	0	1	100	4	0	0	0	0	0	0	105	1,030	10.2%	2.98%	.522%
TYGER RIVER	0	0	1	191	2	0	0	0	0	0	0	194	1,251	15.5%	5.51%	.965%
WATEREE RIVER	0	0	0	1	0	0	0	0	0	0	0	1	811	.123%	.028%	.005%
TOTAL	**81**	**175**	**288**	**2,821**	**103**	**1**	**14**	**19**	**0**	**0**	**22**	**3,524**	**20,109**	**17.5%**	**100%**	**17.5%**

December 2017 Implementation Panel findings: As per SCDC status update section. Average lengths of stay in RHU were as follows:

Length of Stay (in days) for Inmates in
Short Term RHU Custody (DD and ST) on Dec. 6, 2017

	Number of DD/ST Short Term RHU Inmates	Average (Mean) Days Spent in RHU	Median Days Spent in RHU
All Inmates	517	30	20
Non-Mentally Ill Inmates	361	31	20
Mentally Ill Inmates	156	29	20

Length of Stay (in days) for Inmates with
Long Term RHU Custody (SD, MX, AP) on Dec. 6, 2017

	Number of SD/MX/AP Long Term RHU Inmates	Average (Mean) Days Spent in RHU	Median Days Spent in RHU
All Inmates	355	335	242
Non-Mentally Ill Inmates	203	320	216
Mentally Ill Inmates	152	354	280

Note: Inmates serving long durations in RHU can skew the "average", therefore the "median" days spent in RHU reflects the "middle" value for the group and may better represent a "typical" value for days spent in RHU.

December 2017 Recommendations: Compliance continues.

2.b.vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:

- As a part of the Mental Health Collaborative, QIRM Analysts compiled baseline reports for participating institutions from the cell and temperature logs. Operations maintains a shared folder or institutions to upload daily cell and temperature logs. Analysts assessed the data to determine:

- -the percent of days with logs uploaded as required. This measure was used to determine if at least one log was uploaded daily. Other measures included:
- -the percentage of cells with a daily temperature log completed and uploaded to the system. One log includes a total of eight cells per day: four from the morning and four from the evening shift.
- -the percent of cells with identified cleanliness issues with documentation that issues were addressed. If a cell had a cleanliness deficiency, a response indicating what was done to correct the deficiency, with documentation was required. If the information was not included, it was identified as noncompliance.
- The percent of cells with identified temperature issues with documentation that issues were addressed. If a cell had a temperate out of the range of 68-78 degrees, a response indicating what was done to correct the deficiency, with documentation was required. If the information was not included, it was identified as noncompliance.

The following chart include baseline data for participating collaborative institutions and those included for the current IP site visit.

July 2017

	KCI - RHU	KCI - SSR	KCI - GPH	Leath	BRCI C SU	Camille RHU	Lieber	Kershaw	Average
% of days with logs uploaded as required	56%	90%	23%	100%	35%	100%	100%	87%	74%
% of cells with a daily temperature log completed and uploaded to the system	52%	77%	19%	100%	27%	98%	95%	84%	69%
% of cells with identified cleanliness issues with documentation that issues were addressed	0%	6%	0%	0%	0%	0%	0%	0%	1%
% of cells with identified temperature issues with documentation that issues were addressed	0%	0%	0%	5%	0%	0%	0%	0%	1%

Operations Management has developed a form for daily inspections for cleanliness and for recoding temperatures of random cells. As a part of the MH Learning Collaborative, institutional

teams were provided with baseline data, to include a summary for the month of July, for the following:

- Percentage of cells with a daily temperature log completed and uploaded to the system
- Percent of uploaded logs with identified cleanliness issues that included documentation that issues were addressed
- Percent of uploaded logs with identified temperature issues that included documentation that issues were addressed
- Percentage of days with logs uploaded as required

To ensure staff respond to sanitation deficiencies and temperate outside of the acceptable range of 68-78 degrees, QIRM recommended that the form used to collect and submit daily checks be revised to allow staff to provide specific responses when temperatures were found to be out-of-range or when sanitation issues were identified. When the temperatures are out of range, the form provides a space to report how it was addressed, with examples provided. When sanitation issues are identified, the form provides a space for staff to address how sanitation issues are addressed, with specific examples provided.

Before making this a system-wide change, Camille Graham pilot-tested the revised form for five days (October 18-22, 2017).

Pilot results

- CGCI increased to 100% for 98% in the July 2017 98% for uploading the appropriate forms to the system. (It should be noted, for the pilot test, the requirement was to submit the forms directly to QIRM staff upon completion. If this pilot form is adopted, institutions would continue the current practice of submitting the completed forms to a shared Operations folder.)
- CGCI identified two sanitation issues during the pilot test but did not respond appropriately to either resulting in 0% compliance. This remained the same as the July 2017 baseline.
- CGCI identified no out-of-range temperatures during the pilot test. There were 20 cells with temperature that were out-of-range during for the July 2017 baseline; however, none were addressed, resulting in 0% compliance.
- Based on the results of the first pilot-test, QIRM developed a following step-by-step guide to provide additional instructions on completing the Temperature and Sanitation Log and requested that Camille conduct another five-day pilot test, October 27-31, 2017.
- In this second pilot test, CGCI demonstrated improvement in documentation when deficiencies were identified.
- CGCI submission of documentation remained at 100%
- There were no sanitation issues identified
- One cell was identified to have temperature out of range. CGCI reported that a maintenance request was submitted to address the deficiency; however, supporting documentation, although requested, was not submitted.

These results were forwarded to Operations with the recommendation of providing an instruction sheet for each area within the institutions responsible for uploading temperature and sanitation logs.

December 2017 Implementation Panel findings:
Operations maintains a shared folder for institutions to upload daily cell and temperature logs. SCDC provided Cell Temperature and Cleanliness Logs for selected institutions. Overall the provided logs had missing dates as well as incomplete and blank forms.

QIRM Analysts compiled baseline reports for participating institutions from the cell and temperature logs for the month of July identifying the following:

- Percentage of cells with a daily temperature log completed and uploaded to the system
- Percent of uploaded logs with identified cleanliness issues that included documentation that issues were addressed
- Percent of uploaded logs with identified temperature issues that included documentation that issues were addressed
- Percentage of days with logs uploaded as required

Based on the findings, a revised Operations Cell Temperature and Sanitation Form was implemented and pilot tested at Camille Graham CI in October 2017. The Camille Graham CI pilots continued to identify that necessary responses were not being provided for deficiencies.

On-site observations revealed Lieber CI, and Kershaw CI cell sanitation levels were at unacceptable levels. Kirkland CI and Lee CI sanitation levels had improved since previous site visits. The sanitation levels at the Camille Graham CI RHU remained high; however, preventive maintenance remains a concern. An in-operable toilet was identified in one of the un-occupied crisis cells. Management and on duty staff did not appear aware the toilet was non-operational.

December 2017 Recommendations:

1. Operations Management ensure all prisons are performing daily inspections for cleanliness and taking temperatures of random cells;
2. Ensure deficiencies identified in the cell inspections for cleanliness and temperature checks are followed up on and the action taken is documented on the Cell Temperature and Cleanliness Logs;
3. SCDC QIRM continue to perform QI Studies regarding Correctional Staff performing daily, random cell temperatures and cleanliness inspections.

2.b.vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
A report of QIRM CQI activities, and progress towards the implementation of policy GA 06.06, is attached as Appendix K. Institution-specific data related to this component will be presented in the ICQMC meetings. Information regarding inmates impacted by decisions made during the Segregation Committee's meetings will be discussed at the institutional and agency level meetings and included in the report to the Senior Management Board.

December 2017 Implementation Panel findings:
Appendix K provides a report on the QIRM CQI activities and progress towards implementation of SCDC Quality Improvement Plan. Implementation of the quality management program will begin in January 2018 with the goal of full implementation by December 2018.

December 2017 Recommendations:
Begin rollout of quality management program in January 2018.

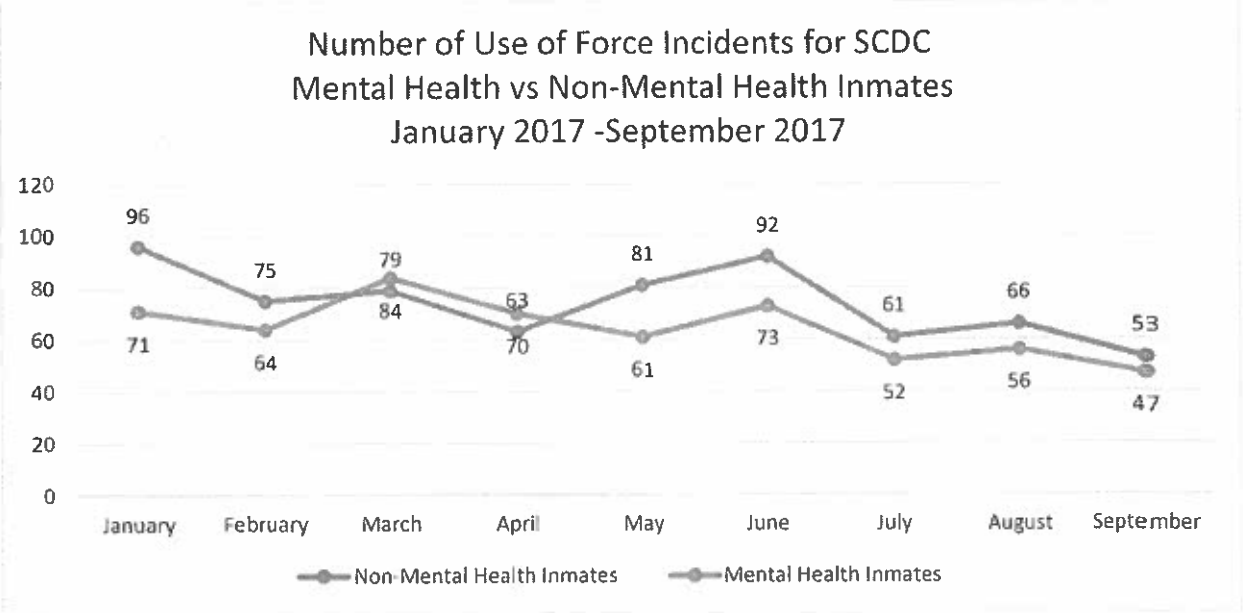
2.c. Use of Force:

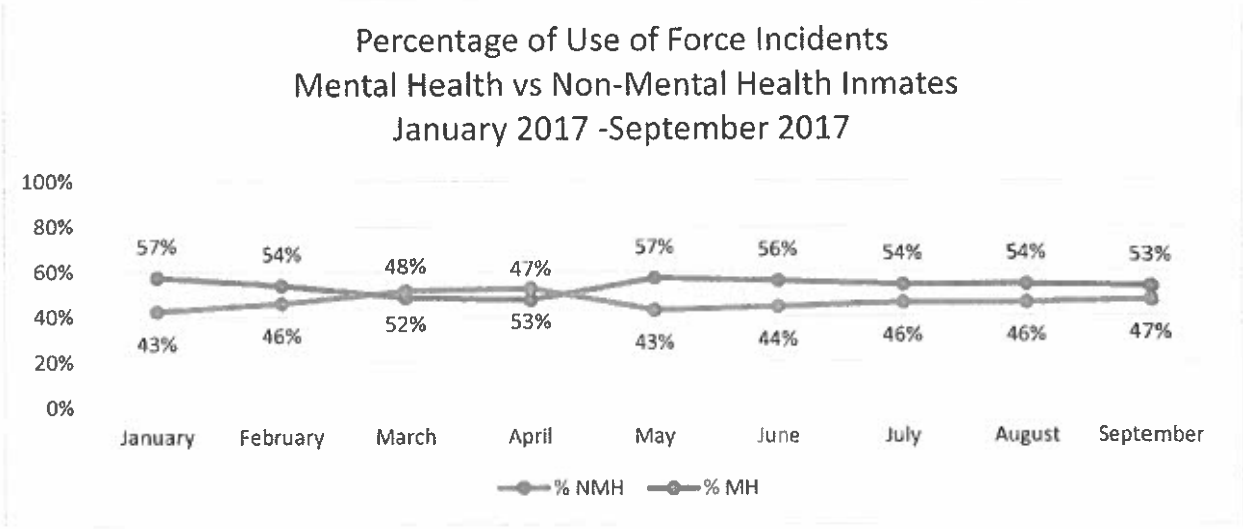
2.c.i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

1. Use of Force Reviewers continue to track use of force. This includes comparing uses of force for inmates with a mental health classification to uses of force for those inmates without a mental health classification. The following chart compares this information from January-September 2017. The data for October is still being compiled and assessed. This chart has been shared with the Division of Operations.
2. The Division of Operations continues to monitor use of force reports as a part of their strategy to reduce use of force against inmates with mental illness and non- mentally ill inmates. The Assistant Deputy Director of Operations ADDO requires that the Regional Directors meet with their wardens to discuss their UOF reports and address any issues.





Use of Force Training

Overall SCDC has twenty seven (27) Use of Force Classes scheduled for various dates in October through December 2017. The current schedule will allow 1,336 employees to complete their training. The classes have been scheduled across the state at different times to accommodate the needs of the institutions and employees. Forty-four (44%) percent, or 2,682 of the 6,108 employees in the agency have completed this class.

December 2017 Implementation Panel findings:

SCDC continues disproportionate use of force against inmates with mental illness. Approximately 17.5 percent (as of 9/25/17) of the SCDC inmate population is on the mental health caseload;

however, use of force against inmates with a mental illness accounts for 54.6 percent of total incidents for the time period of June 2017 through September 2017.

SCDC has trained forty-four (44%) percent, or 2,682 of the 6,108 employees on the revised use of force policy. It is unlikely that SCDC employees will complete the revised Use of Force training by December 31, 2017.

December 2017 Recommendations:

1. SCDC continue to monitor all Use of Force incidents to identify and address the reasons for disproportionate Use of Force against inmates with mental illness;
2. Identify strategies to reduce use of force against inmates with mental illness and non-mentally ill inmates;
3. All staff complete the revised March 2017 Use of Force Training.

2.c.ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

1. QIRM's UOF Reviewers continue to review use of force incidents through the automated system and institutional MINS daily. This report included a summary of MINS relative to the types of forces used during the week, use of control cells, planned versus immediate use of force, use of force in the general population vs RHU, and UOF with MH versus NMH inmates.
2. When reviewing Institutional MINs and reports from the automated system the following issues specific to use of force are included: presence of a reasonably perceived threat; UOF appropriate based on Time/Place/Distance; was UOF planned or unplanned; was conflict resolution used prior to planned UOF; was conflict resolution conducted by CIT, SITCON or mental health employee; was mental health contacted prior to UOF regarding inmates with a mental health classification; was inmate provided with blanket or smock post UOF for inmates placed in crisis status; were chemical munitions used within policy guidelines; did report justify use of chemicals that exceeded the guidelines; was inmate afforded opportunity to decontamination, provided clean clothes and cell decontamination if necessary after use of chemical munitions, and was inmate afforded post UOF medical treatment. Reports are maintained on QIRM's shared drive.
3. QIRM staff continues to meet weekly with Operations leadership to discuss UOF and other relevant issues;
4. 6,108 staff are required to complete the revised Use-of-Force Training by December 31, 2017. As of October 23, 2017, 2,682 have completed the revised training. There are currently 1,336 slots remaining to allow staff to complete the training by the deadline.

December 2017 Implementation Panel findings: SCDC continues implementation of the revised OP 22.01 Use of Force Policy requiring instruments of force are employed in a manner consistent with manufacturer's instructions. IP review of monthly UOF MINS narratives reveals a marked improvement in employees following SCDC guidelines on the amount of chemical agents deployed for each application and restraint chair use. SCDC has agreed to revise Housing Unit Post Orders as it applies to *Cover Teams* to achieve compliance that MK 9 use is consistent with manufacturer's instructions.

SCDC used the restraint chair on two (2) occasions during the relevant period; one incident involved a mentally ill inmate and the other a non-mentally ill inmate. QIRM review of the restraint chair incidents revealed use involving the mentally ill inmate was appropriate and it was not appropriate for the incident involving the non-mentally ill inmate.

SCDC has trained forty-four (44%) percent, or 2,682 of the 6,108 employees on the revised use of force policy. It is unlikely that SCDC employees will complete the revised Use of Force training by December 31, 2017.

December 2017 Recommendations:

1. Operations and QIRM continue to review use of force incidents through the automated system to ensure instruments of force are fully consistent with the manufacturer's instructions;
2. QIRM continue to meet weekly with Operations leadership to discuss UOF and other relevant issues;
3. Revise Housing Unit Post Orders as they pertain to *Cover Teams* to require that MK 9 use will be consistent with manufacturer's instructions;
3. All staff complete the revised March 2017 Use of Force Training.

2.c.iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;

Implementation Panel December 2017 Assessment: **compliance (3/2017)**

Operations and QIRM staff continue to review and monitor use of force incidents through the automated systems and in a daily review of MINS. There have been no documented reports from July–October, 2017 of inmates being placed the crucifix or other positions that do not conform to generally accepted correctional standards.

December 2017 Implementation Panel findings: SCDC remains in compliance. Neither SCDC nor the IP identified any incident where an inmate was placed in the crucifix or other position that did not conform to generally accepted correctional standards.

December 2017 Recommendations: Operations and QIRM staff continue to review and monitor use of force incidents through the automated system to ensure restraints are not used to place inmates in

the crucifix or other positions that do not conform to generally accepted correctional standards. Pursue corrective action when violations and/or issues are identified.

2.c.iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

SCDC policies prohibit the use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance. After an inmate is secured in a restraint chair, policy requires that the inmate will be examined by a qualified medical staff member. In the event it is necessary that the inmate needs to be secured in a restraint chair for up to two (2) hours, a qualified medical staff member is required to examine the inmate to assess his/her condition and approve continued placement which cannot exceed a total maximum of three (3) hours in the restraint chair.

According to Policy 22.01, Use of Fore, section 13.11, the restraint chair is to be used for control purposes only and will not be used for any longer than the conditions warrant. However, if a decision is made by the Shift Supervisor or higher authority to continue restraint of the inmate longer than two hours, medical staff will be notified by the Shift Supervisor of the extended use of the restraint chair, and the qualified medical staff member on duty will be required to conduct a documented physical check of the inmate to determine if a medical reason exists that would prohibit the continued use of the chair. The inmate may not be restrained in the chair for more than a three hour period.

December 2017 Implementation Panel findings: Restraint Chair use continues to occur infrequently. SCDC reported the Restraint Chair was used for two (2) incidents. Per SCDC Update for 2.c.v:

MIN #	Date	Location	Inmate	Mental Health Status	Time in Chair
[redacted]	6/28/2017	RIDGELAND	Inmate A	NMH	120m
	9/03/2017	BROAD RIVER	Inmate B	L4	145m

Data Source-AUOF System Cross-referenced with AMR

SCDC Use of Force Reviewers were able to verify the length of time inmate A was in the restraint chair. The videos and the Automated Medical Records confirm that inmate A was placed in the restraint chair at 7:40 pm; however, the time he was released could not be determined based on the information provided. UOF Reviewers were unable to find documentation indicating who determined the length of time the inmate was authorized to remain in the restraint chair.

December 2017 Recommendations: QIRM continue to track and monitor compliance with use of the restraints.

2.c.v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs.

Implementation Panel December 2017 Assessment: **compliance 12/2017**

November 2017 SCDC Status Update

UOF staff conducted a review of restraint chair use from June 1, 2017 – October 30, 2017. The report was produced using data from the Automated Use of Force System and cross-referenced with the Automated Medical Records. During this timeframe, the restraint chair was used in two incidents. Only one of the incidents involved self-injurious behavior. This incident occurred at Broad River's CSU. In the second incident, the inmate threw an unknown substance on staff. In this instance, UOF Reviewers did not find documentation that less restrictive measures were implemented that may have been effective in controlling the inmate's behavior as outlined in policy OP. 22.01, Use of Force and Restraints.

This review also assessed the amount of time the inmates were placed in the restraint chair. According to policy, the maximum amount of time that inmate can be placed in the restraint chair is three hours.

In neither incident was the inmate placed in the restraint chair for this maximum amount of time.

MIN #	Date	Location	Inmate	Mental Health Status	Time in Chair
[redacted]	6/28/2017	RIDGELAND	Inmate A	NMH	120m
	9/03/2017	BROAD RIVER	Inmate B	L4	145m

Data Source-AUOF System Cross-referenced with AMR

To limit the amount of time each inmate is held in the restraint chair and to ensure that no inmate is placed in the restraint chair for a pre-determined amount of time, the orders given from the physician must be in compliance with policy OP-22.01, Use of Force and Restraints, section 13.11, "the restraint chair is to be used for control purposes only and will not be used for any longer than the condition warrants."

The Use of Force Reviewers were able to verify the length of time inmate A was in the restraint chair. The videos and the Automated Medical Records confirm that inmate A was placed in the restraint chair at 7:40 pm; however, the time he was released could not be determined based on the information provided. UOF Reviewers were unable to find documentation indicating who determined the length of time the inmate was authorized to remain in the restraint chair.

On 9/3/17 inmate B was ordered to be placed in the restraint chair by Dr. [redacted] due to continued self-injurious behavior at Broad River CI. The inmate was placed in the restraint chair at 12:35 pm and was checked at 1:40 pm. At 2:30 pm the inmate was observed by medical staff scooting the restraint chair towards the wall and banging his head on the wall. Dr. [redacted] was contacted by phone and instructed Medical to extend the time in the restraint chair for up to two hours. The inmate stopped his self-injurious behavior and was removed from the restraint chair at 3:00 pm. There is no video of this restraint chair encounter. The Use of Force Reviewers forwarded this information to SCDC Operation's staff for corrective measures.

December 2017 Implementation Panel findings: Per SCDC update. QIRM collects data and issues quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs.

December 2017 Recommendations: QIRM continue to prepare a Restraint Chair Report for each monitoring period.

2.c.vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

As a part of the plan to implement the accountability component of OP 22.01 Use of Force, and to ensure meaningful corrective action is taken for employees found to have committed use of force violations, the Division of Operations is conferring with RIM to have a field entered on the AUOF Report to capture informal corrective action such as counselling or systems correction.

Training

Mental Health has identified that 62% of their current staff are required to take the Use of Force Class. Of the 98 employees identified 29% of them have completed the required Use of Force Training as of October 23, 2017.

December 2017 Implementation Panel findings:

The IP continues to monitor SCDC Use of Force MINS Narratives monthly and identify incidents where there did not appear to be a reasonably perceived immediate threat that required a use of force.

SCDC Use of Force MINS for June 2017 through October 2017:

June 2017-	165
July 2017-	113
August 2017-	122
September 2017-	100
October 2017-	77

SCDC had 42 Grievances alleging excessive Use of Force from June 2017 to October 2017.

SCDC QIRM review of Use of Force incidents from June 2017 to October 2017 identified 82 incidents with potential violations.

SCDC Employee Corrective Action for Use of Force violations was reported as:

June 2017-	5 employees (all at Kershaw CI)
July 2017-	No Employee Corrective Action taken by SCDC
August 2017-	No Employee Corrective Action taken by SCDC
September 2017-	No Employee Corrective Action taken by SCDC
October 2017-	No Employee Corrective Action taken by SCDC

SCDC Operations reported informal employee corrective action for use of force violations is not officially maintained. Efforts are being made to develop a system to maintain and report informal employee corrective action for use of force violations.

The IP did not request information from SCDC Police Services regarding their involvement in Use of Force investigations:

- Referrals Received
- Investigations Opened
- Investigations Pending
- Investigations Closed and Substantiated, Unsubstantiated, or Unfounded.

The information will be requested for the next Settlement Agreement relevant period.

The IP Use of Force Reviewer and SCDC Operations Leadership has initiated a procedure to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force.

SCDC has trained forty-four (44%) percent, or 2,682 of the 6,108 employees on the revised use of force policy. It is unlikely that SCDC employees will complete the revised Use of Force training by December 31, 2017.

The IP Panel received inmate complaints during the site visits to Kirkland CI, Lieber CI, Kershaw CI, Lee CI, and Camille Graham CI alleging inappropriate and excessive use of force by SCDC employees.

The SCDC Use of Force Policy accountability component does not appear to be functioning appropriately based on the number of potential Use of Force violations with minimal employee corrective action.

December 2017 Recommendations:

1. Operations and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM and Operations leadership continue weekly meetings to discuss UOF and other relevant issues;
3. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
4. The IP Use of Force Reviewer and SCDC Operations Leadership continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force;
5. SCDC develop a system to maintain and report informal employee corrective action for use of force violations;
6. IP request information from SCDC Police Services regarding their involvement in Use of Force investigations;
7. All staff complete the revised March 2017 Use of Force Training.
8. SCDC ensure the accountability component of OP 22.01 Use of Force is implemented and meaningful corrective action is taken for employees found to have committed use of force violations;

2.c.vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

Based on SCDC policy OP 22. 01, section 6.3 Chemical Munition, the MK-4 should be the standard issued chemicals delivery system for incident control. Escalation beyond MK-4 in a closed cell environment will only occur when exigent circumstances exist (Examples include but are not limited to the inmate is armed, is barricaded in a cell, is actively assaulting another person, etc.) Use of any chemical munitions delivery system other than MK-4 must involve a Planned Use of Force, unless the need for use of the delivery systems is emergent, and a delay could cause bodily harm or death. The issue and use of all chemical munitions, other than MK-4, must be authorized and assigned by the RHU supervisor or higher. QIRM Use of Force Reviewers reviewed use of chemical munitions incidents involving crowd control canisters including MK-9 from July 1, 2017- October 27, 2017.

Based on RIM reports, there were 51 use of force incidents in which MK-9 was used between July 1, 2017 and October 27, 2017.

- There were 29 (57%) uses of force incidents in which the officer's actions were justifiable based on circumstances set forth in agency policy OP- 22. 01, Use of Force. This is down from 76 out of 85 (89%) from the last reporting period. However, the number of incidents involving the use of MK-9 has decreased from 85 to 51 (40%) since the last reporting period.

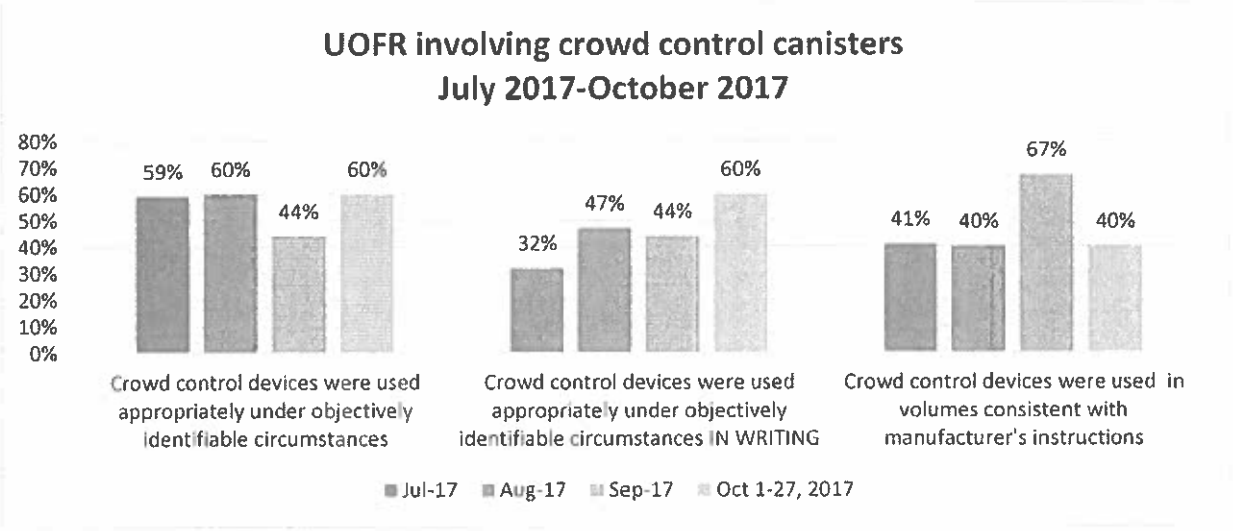
- There were 21 (41%) incidents where the crowd control devices were used appropriately under objectively identifiable circumstances in writing.
- There were 23(45%) incidents where the crowd control devices were used in volumes consistent with manufacturer's instructions.

The following charts and graphs provide additional information comparing uses of crowd control canisters during the reporting period.

	# times crowd control devices were used appropriately under objectively identifiable circumstances	# times crowd control devices were used	% of times crowd control devices were used appropriately under objectively identifiable circumstances
July	13	22	59%
August	9	15	60%
September	4	9	44%
October	3	5	60%

	# times crowd control devices were used appropriately under objectively identifiable circumstances IN WRITING	# times crowd control devices were used	% of times crowd control devices were used appropriately under objectively identifiable circumstances IN WRITING
July	7	22	32%
August	7	15	47%
September	4	9	44%
October	3	5	60%

	# times crowd control devices were used in volumes consistent with manufacturer's instructions	# times crowd control devices were used	% times crowd control devices were used in volumes consistent with manufacturer's instructions
July	9	22	41%
August	6	15	40%
September	6	9	67%
October	2	5	40%



- *December 2017 Implementation Panel findings:* As per SCDC update. SCDC continues to identify incidents where use of crowd control canisters, such as MK-9, are used in individual cells in the absence of objectively identifiable circumstances set forth in writing and only in volumes consistent with manufacturer's instructions. For the July 2017 to October 27, 2017 period there were 43% uses of force incidents in which the officer's actions were not justifiable based on circumstances set forth in agency policy OP- 22. 01, Use of Force. The number of incidents involving the use of MK-9 did decrease from 85 to 51 (40%) since the last reporting period. Crowd control devices were not used appropriately under objectively identifiable circumstances in writing in 59% of the incidents. Crowd control device volumes exceeded SCDC guidelines in 55% of the incidents.

December 2017 Recommendations:

1. Operations and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM Use of Force Reviewers continue to generate reports involving crowd control canisters including MK-9;
3. QIRM and Operations leadership continue weekly meetings to discuss UOF and other relevant issues;
4. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
5. The IP Use of Force Reviewer and SCDC Operations Leadership continue jointly reviewing Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of crowd control canisters including MK-9;
6. Revise Housing Unit Post Orders as they pertain to *Cover Teams* to qualify that MK 9 use will be consistent with manufacturer's instructions;
7. All staff complete the revised March 2017 Use of Force Training.

2.c.viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;

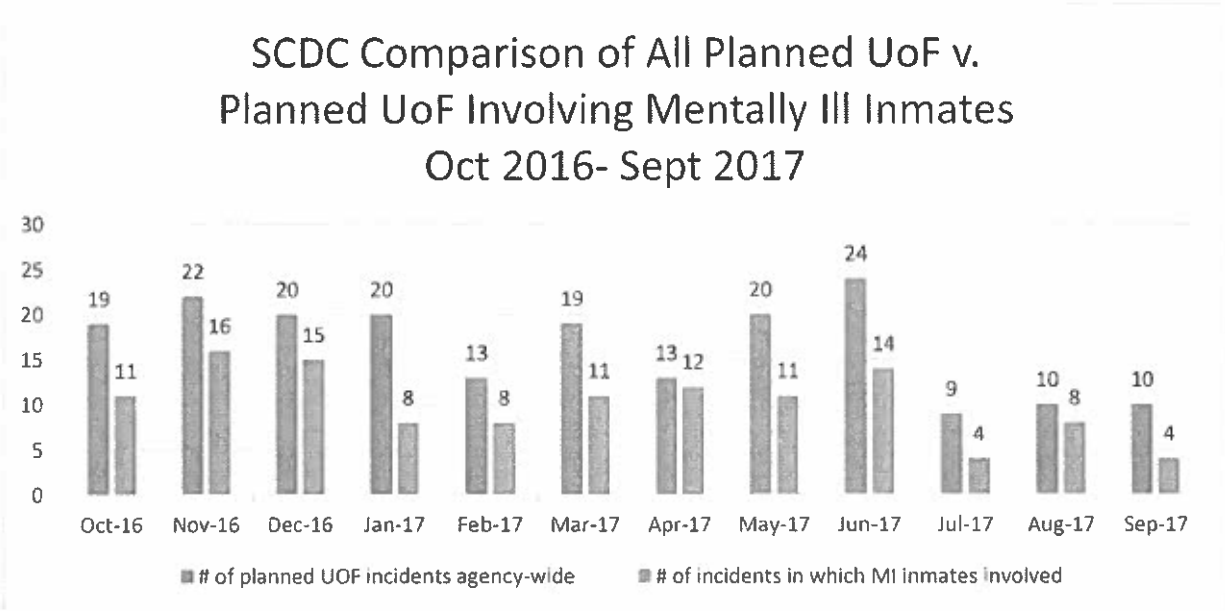
Implementation Panel December 2017 Assessment: **partial compliance**

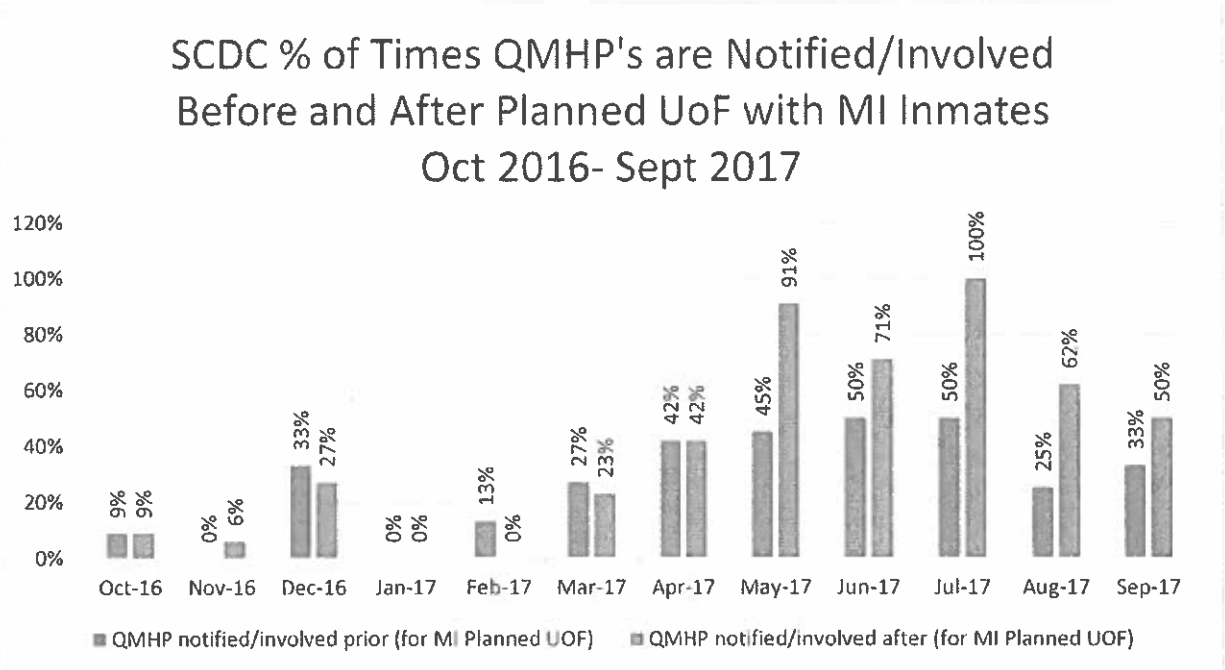
November 2017 SCDC Status Update

UOF reviewers track the number of planned uses of force involving inmates with a mental health classification to determine if a mental health counselor is contacted prior to the incident The following reports shows the rates at which mental health counselors have been notified since January 2017.

In May 2017 RIM began tracking the number of CIT officers notified prior to a planned use of force. The goal is to decrease the number of uses of force by using trained staff to de-escalate situations when possible.

	16-Oct	16-Nov	16-Dec	17-Jan	17-Feb	17-Mar	17-Apr	17-May	17-Jun	17-Jul	17-Aug	17-Sep
# of planned UOF incidents agency-wide	19	22	20	20	13	19	13	20	24	9	10	10
# of incidents in which MI inmates involved	11	16	15	8	8	11	12	11	14	4	8	4
# of incidents in which QMHP notified/involved	1	1	4	0	1	4	6	10	12	4	6	3
# CIT Officer notified/involved prior (for MI Planned UOF)								4	1	1	2	1
% of times QMHP notified/involved, when required, prior (for MI Planned UOF)	9%	0%	33%	0%	13%	27%	42%	45%	50%	50%	25%	33%
% of times QMHP was notified/involved when required, after (for MI Planned UOF)	9%	6%	27%	0%	0%	23%	42%	91%	71%	100%	62%	50%


SCDC Comparison of All Planned UoF v.
Planned UoF Involving Mentally Ill Inmates
Oct 2016- Sept 2017
30
25
20
15
10
5
0
19
11
22
16
20
15
20
8
13
8
19
11
13
12
20
11
24
14
9
4
10
8
10
4
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
# of planned UOF incidents agency-wide
# of incidents in which MI inmates involved


SCDC % of Times QMHP's are Notified/Involved
Before and After Planned UoF with MI Inmates
Oct 2016- Sept 2017
120%
100%
80%
60%
40%
20%
0%
9%
9%
0%
6%
33%
27%
0%
0%
13%
0%
27%
23%
42%
42%
45%
91%
50%
71%
50%
100%
25%
62%
33%
50%
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
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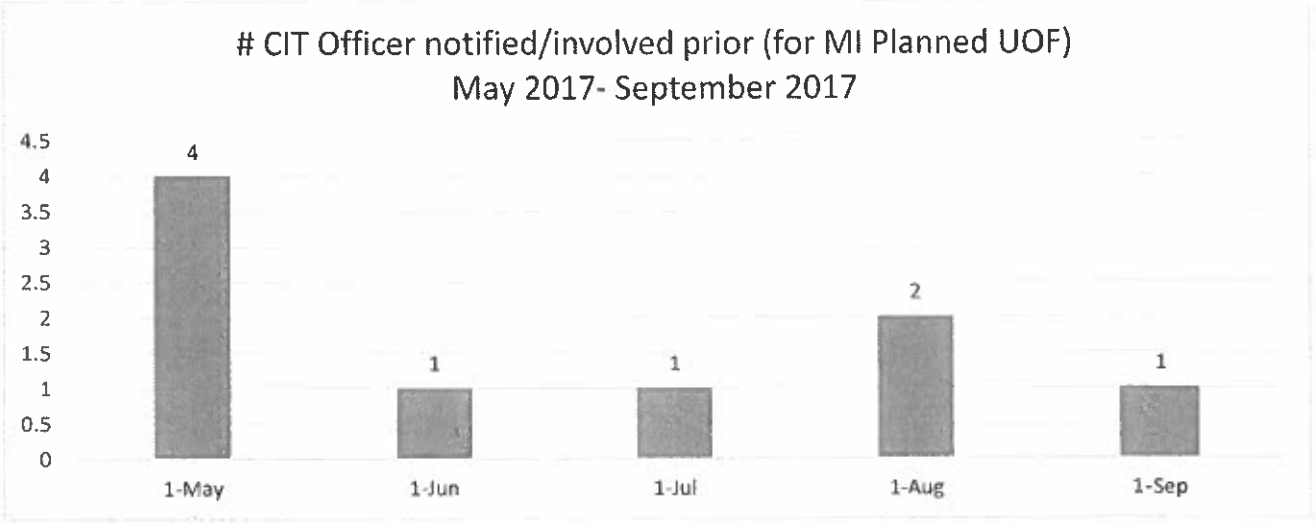
Jul-17
Aug-17
Sep-17
QMHP notified/involved prior (for MI Planned UOF)
QMHP notified/involved after (for MI Planned UOF)



December 2017 Implementation Panel findings: Per SCDC update. SCDC data identifies continued issues with notifying clinical counselors (QMHPs) to request their assistance prior to a planned use of force. CIT Officers do not meet the requirement of clinical counselor notification prior to a planned use of force. SCDC provided data for the period of June 2017 through September 2017, that QMHPs were contacted prior to a planned use of force as follows:

June 2017-	50%
July 2017-	50%
August 2017-	25%
September 2017-	33%

December 2017 Recommendations: Provide additional training to Operations Supervisory and Mental Health Staff on their duties and responsibilities in a planned use of force. Ensure Operations and Mental Health staff are aware that CIT Officers do not meet the requirement of clinical counselor notification prior to a planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness.

2.c.ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

The South Carolina Department of Corrections Training Academy reports the following information for 1 January 2017 – 10 October 2017. There was no information provided about the number of employees enrolled in each class to determine the completion rate.

Course Completion
1/1/17 – 10/10/17

Class Code	*Class Title*	*# completed*
3.00	*Correctional Officer Basic Training*	*508*
3.60	*Non-Security Basic Training*	*90*
3.99	*Cadet Basic Training*	*36*
3.97	*Correctional Officer Basic Training Non-uniform/ Non-certified*	*5*
3.96	*Non-uniform/ Non-certified Incomplete*	*9*

The Correctional Officer Basic Training (COBT) includes the following classes:
1. Introduction to Mental Health Class - 1.5 hours
2. Suicide - 2.0 hours
3. Pre-Crisis Intervention – 2.5-3.0 hours

The Non-Security Basic Training consists of the same classes as (COBT) except for firearms training. Cadet Basic Training is for correctional officers age 18-20, these officers did not complete the Pistol Certification. The Non-Uniformed / Non-Certified COBT category describes the employees who move to a position that requires certification. Therefore, they returned to the Training Academy for the classes needed to complete their certification. There were nine (9) individuals who were unable to complete the courses identified in the Non-Uniformed/ Non-Certified Training.

Agency Orientation is comprised of several classes of various lengths. The SCDC Training Academy and RIM report that there were 953 employees who completed the 1.5 hour Introduction to Mental Health Class between January and October 2017. There is also a two hour Suicide Class identified in the Agency Orientation however, the number of employees who completed this class was not provided on the report by class code.

Interpersonal Relations: Pre-Crisis Intervention is a 2.5 – 3.0 hour class that has been completed by 1,903 employees between January and October 2017. During the same In-Service category of classes there are three Suicide classes taught through instructor led and video classes. The Instructor led Suicide class is two hours long and has been completed by 2,545 employees. Part I of the Inmate Suicide Prevention Class is one hour and has been completed by 2,666 employees. The last hour of the Inmate Suicide Prevention Class, Part 2, has been completed by 2,585 employees.

December 2017 Implementation Panel findings:
SCDC remains in partial compliance. The mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates is as follows:

Introduction to Mental Health	1.5 hours	Orientation (all new employees)
Mental Health	2.0 hours	Basic Training
Pre-Crisis and Suicide Prevention	3.0 hours	Basic Training
Interpersonal Communications	10.0 hours	Basic Training
Communication Skills/Counseling	1.5 hours	Annual In-Service
Mental Health Lawsuit	4.2 hours	Annual In-Service
Suicide Prevention	4.0 hours	Annual In-Service

SCDC has not provided documentation that all required correctional officers have received the training.

December 2017 Recommendations:

The SCDC Training Division provide documentation verifying the number of required employees that have completed the mandatory training for appropriate methods of managing mentally ill inmates and the number that has not completed the required training for 2017.

2.c.x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates;

Implementation Panel December 2017 Assessment: **compliance (3/2017)**

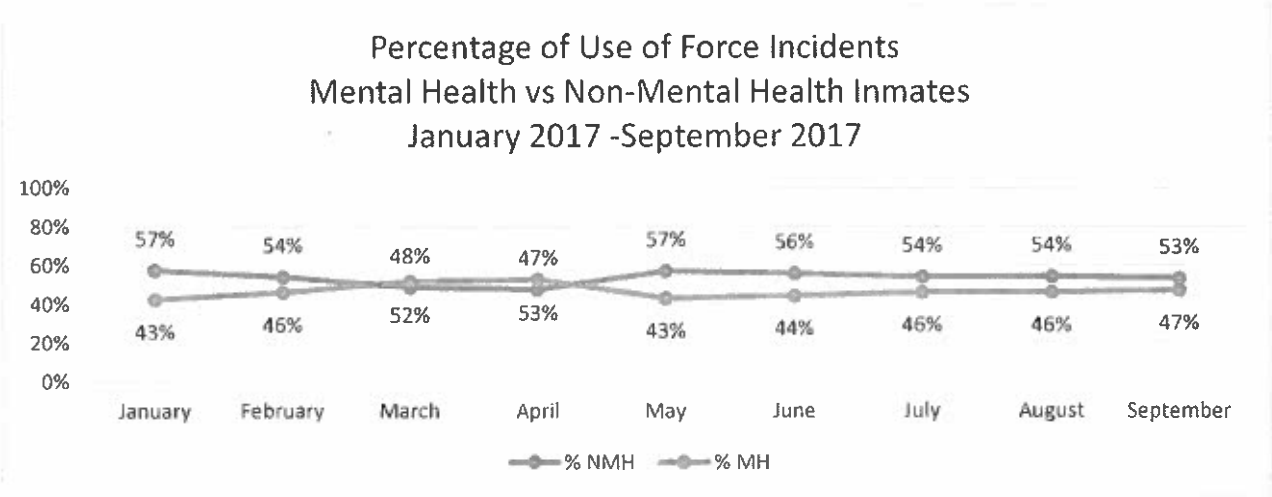
November 2017 SCDC Status Update

QIRM's Use of Force Reviewers continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report. This report is attached as Appendix L.

This report is sent to the IP UOF expert, Wardens, and Agency leadership. This report also details:

- Agency Use of Force by Type
- Video Review
- Grievances Related to Use of Force
- Grievances Filed by Inmates with a Mental Health Classification
- MINS: Mainframe vs Use of Force Application
- Exception Reports

The following graphs show the UOF for mentally ill vs non-mentally ill inmates since January 2017.



December 2017 Implementation Panel findings: SCDC continues to generate a monthly UOF Report Mentally Ill vs. Non-Mentally Ill. No issues were identified with the use of force data utilized to produce the report.

December 2017 Recommendations: Continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

2.c.xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

A new protocol is being established that will require the hiring of an additional staff person to review the UOF follow-up from MH Staff across the state. This person will be placed in the section of Quality Management and report to Ms. [redacted] The position will post as a QMHP based on the scope of the review. Their primary job functions will be to:

- Ensure Planned UOF incidents are being followed up on and documented according to policy
- Ensure MH staff are providing the appropriate interventions when responding to a Planned UOF.

December 2017 Implementation Panel findings: The Mental Health Division has developed a protocol to review UOF incidents that involve mentally ill offenders (SCDC Quality Review of Use of Force Incidents-Mental Health). The new protocol will require the hiring of an additional staff person to review the UOF incidents involving mentally ill inmates. Review by the IP revealed the protocol does not have any intervention component.

December 2017 Recommendations: Revise the SCDC Mental Health Quality Review of Use of Force Incidents and include an intervention component. Hire the additional Mental Health staff person to review UOF incidents involving mentally ill inmates and implement the Mental Health Quality Review of Use of Force Incidents involving mentally ill inmates.

3. Employment of enough trained mental health professionals:

3.a. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update
See response provided for 2.a.iv

Health Services Issue/Area of Concern: Increase clinical staffing ratios

December 2017 Implementation Panel findings: See 2.a.iv.

December 2017 Recommendations: See 2.a.iv.

3.b. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

See Attachment 4 for data specific to this provision.

December 2017 Implementation Panel finding: Significant improvement is noted relevant to the percentage of involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams as compared to prior site visits, with Camille Griffin Graham CF showing the greatest level of compliance. The reasons for partial compliance varies according to institution related to various staffing vacancy issues. Refer to Attachment 4 for a relevant summary specific to this provision

December 2017 Recommendations: Remedy the significant mental health staffing vacancies.

3.c. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
According to the provided RIM report. Mental Health has 59 employees who have completed a Correctional Officer Basic Training Course. This course includes Introduction to Mental Health (1.5 hours), Mental Health (2.0 hours), Suicide (2.0), Interpersonal Relations: and Pre-Crisis intervention (3.0 hours). The list is attached as Appendix M.

December 2017 Implementation Panel findings: We requested, but did not receive, data regarding the percentage of the mental health staff that have completed the Correctional Officer Basic Training Course.

December 2017 Recommendations: Provide the requested data as part of the pre-site document request for the March 2018 site assessment.

3.d. Develop a plan to decrease vacancy rates of clinical staff positions, which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;

Implementation Panel December 2017 Assessment: **compliance (12/17)**

November 2017 SCDC Status Update
See response for 2.a.iv

December 2017 Implementation Panel findings: See 2.a.iv.

December 2017 Recommendations: See 2.a.iv.

3.e. Require appropriate credentialing of mental health counselors;

Implementation Panel December 2017 Assessment: **compliance (3/2017)**

November 2017 SCDC Status Update:
SCDC Policy 19.15, Mental Health Services - Mental Health Training, Section 3.4 stipulates that QMHPs will be required to maintain their professional licensure based on the requirements of their individual licensure board (Licensed Professional Counselor, Licensed Social Worker, etc.) and provide verification of continued licensure.

Those mental health counselors who are not licensed but were hired prior to above requirement are allowed to continue working under the supervision of a licensed counselor.
The attachment at Appendix N outlines current licensure prior to 2013, new staff with licensure hired as of 2013, and existing staff with licensure obtained since 2015 and the percentage of licensed staff. Based on the provisions outlined in policy, 40/40 or 100% are appropriately licensed.

December 2017 Implementation Panel findings: Compliance continues.

December 2017 Recommendations: Continue to monitor.

3. f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update:
Routine audits will begin November 2017 following the attached schedule provided earlier in the document drop. When problems are identified from reviews the following actions will occur at outlined in H.S.-19.07:

- An improvement plan specifying the tasks, suggested completion dates, and parties responsible
- Identified training issues needed to correct/rectify deficiencies
- The restriction of work responsibilities for individual employees until identified problems are corrected
- A re-review to ensure identified findings are corrected
- Recommendation of sanctions/disciplines for repeated findings after 2nd review.

December 2017 Implementation Panel findings: Attachment 5 provides a summary of the performance audits that will be performed as per the SCDC schedule provided.

December 2017 Recommendations: Implement the above.

3.g. Implement a formal quality management program under which clinical staff is reviewed.

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update
See response in 3f

December 2017 Implementation Panel findings: See 3.f.

December 2017 Recommendations: See 3.f.

4. Maintenance of accurate, complete, and confidential mental health treatment records:

4.a Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:

4.a.i. Names and numbers of FTE clinicians who provide mental health services;

Implementation Panel December 2017 Assessment: **compliance (3/2017)**

November 2017 SCDC Status Update

RIM continues to produce and distribute a weekly "Medical Personnel Report." The following screenshot provides a snapshot of the detailed report. The most recent report was distributed on November 6, 2017. See screenshots below: (click here to access the November 13, 2017 report)

Summary of Medical Positions as of COB Yesterday
run on November 13, 2017

Medical Job Classifications		FTE Positions			Temporary Positions			All Positions		
Code	Description	Filled	Vacant	Total	Filled	Vacant	Total	Filled	Vacant	Total
9999	UNCLASSIFIED	0	0	0	0	1	1	0	1	1
AA50	ADMIN SPECIALIST II	10	6	16	0	0	0	10	6	16
AA75	ADMINISTRATIVE ASSISTANT	9	2	11	0	0	0	9	2	11
AC07	SUPPLY MANAGER I	2	0	2	0	0	0	2	0	2
AD28	ACCTNT/FISCAL MGR I	1	0	1	0	0	0	1	0	1
AH10	ADMINISTRATIVE COORD I	5	0	5	0	0	0	5	0	5
AH15	ADMINISTRATIVE COORD II	2	0	2	0	0	0	2	0	2
AH20	ADMINISTRATIVE MGR I	5	0	5	0	0	0	5	0	5
AH35	PROGRAM COORDINATOR I	3	1	4	0	0	0	3	1	4
AH40	PROGRAM COORDINATOR II	0	1	1	0	0	0	0	1	1
AH45	PROGRAM MANAGER I	3	0	3	0	0	0	3	0	3
AH50	PROGRAM MANAGER II	3	0	3	0	0	0	3	0	3
BB30	STATISCL & RESRCH ANAL II	2	0	2	14	3	17	16	3	19
BH10	RECORDS ANALYST I	3	0	3	0	0	0	3	0	3
EA10	LICENSED PRACTICAL NURSE	56	30	86	1	9	10	57	39	96
EA15	LPN II	1	0	1	0	0	0	1	0	1
EA20	REGISTERED NURSE I	63	44	108	7	18	25	71	62	133
EA30	REGISTERED NURSE II	13	5	18	0	0	0	13	5	18
EA60	NURSE PRACTITIONER I	0	0	0	1	0	1	1	0	1

December 2017 Implementation Panel findings: Compliance continues.

December 2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance.

4.a.ii. Inmates transferred for ICS and inpatient services;

Implementation Panel December 2017 Assessment: **compliance (7/2017)**

November 2017 SCDC Status Update
RIM continues to develop, produce and maintain reports of inmates transferred to ICS or GPH or Correct Care beds. This continues to provide MH staff the ability to track the number and timeliness of inmates being transferred to GPH, contractual providers and ICS programs.

December 2017 Implementation Panel findings: As per SCDC status.

December 2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance.

4.a.iii. Segregation and crisis intervention logs;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update
Policy 22.38. Restrictive Housing Units, section 3, number 14 says that correctional officers assigned to the RHU are to conduct security checks and to personally observe each inmate at least every 30 minutes on an irregular, unannounced schedule. The time of each security check will be recorded in the RHU permanent log book and SCDC Form 19-7A, "Cell Check Log."

As part of SCDC's endeavor to accurately monitor and document the mentally ill population who are housed in a segregated or crisis intervention units, the Division of Behavioral Health and Substance Abuse Services currently uses a manual system to track and document 30 minute irregular cell checks, as required by policy 22.38, and unstructured activities such as showers and recreation. QIRM conducted a QI study to determine whether this manual system is effective in identifying inmates who are not given the opportunity to participate in unstructured out of cell activities for a at least 10 hours per week.

The results from the CQI study indicated that as a whole, the Agency's compliance rate for cell checks occurring at least 30 minutes irregular intervals is 26%. These results suggests that inmates are not being monitored regularly as required by Agency policy. This may be attributed to security staffing shortages.

Other issues identified that should be addressed are:

- The collection of the data was all in a paper form as opposed to an electronic form that would allow more accuracy and eliminate the issues of legibility.
- Some of the data was illegible to include times, and initials of Correctional Officers.
- Some times were written in military time and others in standard time. Those instances when standard time is used, it is difficult to determine an accurate time of day. (i.e. am or pm).

The final report, attached Appendix O was shared with the Division of Operations to outline a plan of action based on the results.

December 2017 Implementation Panel findings: As per SCDC status update section.

December 2017 Recommendations: Remedy the above and perform a QI relevant to this issue.

4.a.iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

Clinical encounter data is available in the AMR (with additional information in the paper chart at GPH). New encounter types have been created that will better account for the type of care provided in each encounter. Staff have now received training on the new types of encounters.

Activity and cell check logs remain on paper and are addressed in 4.a.iii., but RIM is working to create an automated system.

December 2017 Implementation Panel findings: As per the SCDC status update section.

December 2017 Recommendations: As per the rollout schedule for the EMR.

4.a.v. Use of force documentation and videotapes;

Implementation Panel December 2017 Assessment: **compliance (3/2017)**

November 2017 SCDC Status Update

Retention policy for video and audio recordings is listed in policy OP 22.01; recordings must be retained for six years after the date of the incident, at that point, only the main report synopsis is forwarded to State Archives for permanent retention.

December 2017 Implementation Panel findings: As per SCDC update.

December 2017 Recommendations: Operations and QIRM continue to monitor use of force documentation and videotapes through the SCDC automated use of force system.

4.a.vi. Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;

Implementation Panel December 2017 Assessment: **compliance (3/2017)**

November 2017 SCDC Status Update

- RIM continues to produce and disseminate a monthly, "UOF Report Mentally Ill vs. Non-Mentally Ill," report.
- UOF Reviewers continue to track and report the number of UOF incidents involving mentally ill vs non-mentally ill inmates. This report is sent to it IP UOF expert, Wardens, and Agency leadership. This report also details:
    - Agency Use of Force by Type
    - Video Review
    - Grievances Related to Use of Force
    - Grievances Filed by Inmates with a Mental Health Classification
    - MINS: Mainframe vs Use of Force Application
    - Exception Reports

December 2017 Implementation Panel findings: As per SCDC update.

December 2017 Recommendations: Continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

4.a.vii. Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;

Implementation Panel December 2017 Assessment: **compliance (3/2017)**

November 2017 SCDC Status Update

A "CY CISP Admissions" report continues to be produced quarterly by RIM. This report shows if an inmate stays in a CI cell in an outlying institution longer than the 60 hours allowed to have him transferred to CSU. (Click here to access the October 31, 2017 report).

The report of CISP entries entered through October 31, 2017 shows the following:
1,491 entries in the CISP application
Average number of days on crisis =6
Average Time to CSU Placement = 34:16 (Hours: Minutes)
Average Days in CSU = 5
Average Days in Outlying Facility = 3

RIM continues to produce and a weekly spreadsheet that provides a list of inmates currently in SD, DD, MX or SR custody by institution. The most recent report was disseminated on November 9, 2017 See screenshot below:

December 2017 Implementation Panel findings: Compliance continues.
Per the SCDC update:

1,491 entries in the CISP application
Average number of days on crisis =6
Average Time to CSU Placement = 34:16 (Hours: Minutes)
Average Days in CSU = 5
Average Days in Outlying Facility = 3

The weekly SCDC Report *Listing of Inmates Currently in SD, DD, MX or ST Custody in SCDC Institutions* provides the length of stay in segregation for mentally ill and non-mentally ill inmates by segregation status and by institution.

Average Time Served (in days) for Removals from **Short Term RHU Custody (DD and ST)** by month

Month Removed from Short Term RHU (DD and ST custody)	Average Time Served All Removals	Average Time Served Non-Mentally Ill	Average Time Served Mentally Ill
2017 January	26	27	24
2017 February	23	23	22
2017 March	22	22	21
2017 April	22	23	21
2017 May	23	24	20
2017 June	20	19	21
2017 July	23	23	22
2017 August	26	27	24
2017 September	24	23	26
2017 October	25	24	28

Note: Numbers reflect removals from short term RHU custody (DD - disciplinary detention and ST - short term lockup) during each month and show the average days served in short term RHU upon removal.

Inmates who were placed in RHU custody and removed from RHU custody on the same day were excluded. The mental health classification is based on the inmate's status at time of removal from RHU.

Average Time Served (in days) for Removals from **Long Term RHU Custody (SD and MX)** by month

Month Removed from Long Term RHU (SD and MX custody)	Average Time Served All Removals	Average Time Served Non-Mentally Ill	Average Time Served Mentally Ill
2017 January	331	284	358
2017 February	377	273	458
2017 March	891	327	1097
2017 April	310	333	175
2017 May	282	286	271
2017 June	812	920	770
2017 July	282	313	265
2017 August	293	310	274
2017 September	511	684	209
2017 October	601	343	972

Note: Numbers reflect removals from long term RHU custody (SD - security detention and MX - maximum) during each month and show the average days served in long term RHU upon removal. Because of the small number of inmates removed monthly from long term RHU, averages can vary greatly. Inmates who were placed in RHU custody and removed from RHU custody on the same day were excluded.

The mental health classification is based on the inmate's status at time of removal from RHU.

December 2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance. Revise the weekly SCDC Report *Listing of Inmates Currently in SD, DD, MX or ST Custody in SCDC Institutions* to include the average lengths of stay in segregation for mentally ill and non-mentally ill inmates by segregation status and institution.

4.a.viii. Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;

Implementation Panel December 2017 Assessment: **compliance (3/2017)**

November 2017 SCDC Status Update

QIRM Analysts had been providing a summarized report on inmates in segregation by institution, custody, and mental health classification to Operations staff. After meeting with Operations leaders, it was determined that the QIRM report is duplicative to the RIM report. RIM continues to produce

and distribute the "Weekly Lockup by Custody and Mental Health Classification." This monthly report is shared with institutional and agency leaders. The most recent report was produced and distributed by RIM on November 8, 2017.

December 2017 Implementation Panel findings: Compliance continues.

December2017 Recommendations: Continue internal monitoring via QIRM to demonstrate continued compliance.

4.a.ix. Quality management documents; and

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update
Quality management documents, including reports, audit tools, audits, and other forms of documentation continue to be available in shared network folders. Access to each folder is managed by system administrators through the IT Access Request menu. This allows for central storage of documentation for access across divisions and institutions. Examples below.
SCDC is also working to automate as many processes as possible to make data collection simpler and easier.

December 2017 Implementation Panel findings: Improvement continues relevant to the implementation of this provision.

December 2017 Recommendations: Continue to develop the QI process.

4.a.x. Medical, medication administration, and disciplinary records

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update
For SCDC to expand its ability to develop, produce and maintain reports for medical and medication administration, the agency continues to assess and monitor plans for the rollout to all male institutions. Please consult the project plan timeline summary below for more information.

Remaining Overall EHR timeline:

Task:	Start	End
Female Facility Retraining	12/12/17	12/14/17
Male Facility End User Training Week 1	1/23/18	1/26/18
Male Facility End User Training Week 2	1/30/18	2/2/18
Level 3 Institution Go Live (except Kirkland) – Broad River, Lee, Lieber, McCormick, Perry	2/12/18	2/16/18
Male Facility End User Training Week 3	2/27/18	3/2/18
Kirkland Go Live (EHR, EDR, Scheduling only)	3/6/18	3/9/18

Male Facility End User Training Week 4	3/20/18	3/22/18
Level 2 Institutions Go Live (partial) – Allendale, Evans, Ridgeland, Turbeville	4/3/18	4/6/18
All remaining Institutions Go Live – Catawba, Goodman, Kershaw, Livesay, MacDougall, Manning, Trenton, Tyger River, Wateree	4/17/18	4/20/18
Kirkland eZmar Go Live	4/30/18	5/3/18

SCDC is in the process of hiring 8 new staff members to help support the EHR.

- 1 additional Help Desk staff member able to specifically address NextGen issues.
- 1 additional RIM staff member to conduct system configuration edits and produce reports and analysis of the NextGen data.
- 6 additional RIM staff members who will serve as statewide support staff for use of all aspects of the system: EHR, EDR, Scheduling, eZmar, interfaces, etc. These staff members will have assigned territories and perform most of their duties onsite in the institutions alongside members of the Health Services staff.

SCDC is also considering an upgrade of the Correctional Health clinical content suite in order to better facilitate the tracking of our quality measures.

QIRM recommends the EHR training be videotaped and made available online so that it can be referenced when staff have questions.

December 2017 Implementation Panel findings: As per SCDC status update section.

December 2017 Recommendations:

1. Implement the plan as per SCDC status update section.
2. For reasons summarized in other sections, QI studies should address medication administration and medication management issues (e.g., level of compliance with policies and procedures specific to medication noncompliance, continuity of medications, etc.).

4.b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

End users are able to submit change requests to RIM for review and implementation by the system administrator after consultation with subject matter experts. Necessary changes and improvements will be rolled out on a continual basis rather than annually. Below is a list of enhancements already implemented since the two female facilities went live on NextGen on March 28, 2016:

- Improved user maintenance: [redacted] now has the capability to create accounts, re-

enable accounts and reset passwords immediately instead of having to log a support case with NextGen for them to do so.

- Added max out date to the patient's demographics bar.
- New Standing Order medication ordering template to all Standing Order meds can be ordered from one place within the nursing visit. Continued maintenance of picklists (visit types, copay exempt reasons, reasons for visit, treatment plan objectives, etc.).
- More user workgroups (Scheduling, Lab, R&E) to help separate areas of responsibility within the Clinical Tasking Workflow. Staff can now control which workgroups they are participating in based on their job role for the day.
- Increased nurse/provider communication: Nurses and providers can write comments from their own templates that get saved to the record on the document and routed to the intended recipient for follow up or response.
- An overhaul of the SCDC formulary has taken place in the medications module. All provider are defaulted to only search the formulary list instead of the complete FDB medication listing. This should hopefully cut down on unusual meds being requested from the pharmacy and improve standardization of the sigs.
- Improved Referral workflow that will mirror the FE Medication template and be more user friendly.
- Improved printing workflows.
- EHR software upgrades are published by the vendor on an intermittent basis. Adoption of each new release will be determined by weighing the degree of technical and end user functionality gained against the resources required to implement the upgrade.
- Initial install: NextGen version 5.8.22/KBM version 8.3.10
- Upgrade completed 3/1/17: NextGen version 5.8.3/KBM version 8.3.11
- October, 2017: New release announced
- June, 2018: Tentative upgrade to NextGen version 5.9/KBM 8.4

December 2017 Implementation Panel findings: As per SCDC status update.

December 2017 Recommendations: Implement the EHR as planned.

5. Administration of psychotropic medication only with appropriate supervision and periodic evaluation:

5.a. Improve the quality of MAR documentation;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

Health Services Issue/Area of Concern: Improve the quality of MAR documentation

Health Services –Medical Scope/Impact	Multidisciplinary Team Scope/Impact	Assessment	Action/Anticipated Outcome
) MAR's audits and medication accountability monitored weekly/monthly.) Implementation of the E HR. system is anticipated to increase clinical efficiency, documentation standardization, and enhance the overall provision and delivery of health services though out SCDOC.) E HR./Next Gen issues impacting overall implementation of the E HR throughout SCDOC. : 1) Interface issues between Nextgen and pharmacy systems CIPS, Script Pro and EZ MAR. 2) Problems in medication orders/pharmacy receipt of complete order information through Next Gen due to data stream updates/refresh of the system in 3 second intervals. Requests from SCDOC to Medicalistics for adjusted data stream system refresh from 3 seconds to 30 minute intervals. 3) Missed medications/doses notices not automated-creating a dual system of an E HR. documentation and continued paper system. Medicalistics has recently activated the capability of a missed dose notification to providers. This process is in the preliminary monitoring stages. Inconsistency in staffing levels has created difficulty in staff training/reinforcement creating gaps in knowledge and training. Fluctuation in staffing agency nurses creates an ongoing need for training.	Pharmacy Operations Providers	The MAR's are being monitored weekly and monthly in all facilities. Camille/Leath are audited using E HR. information. Camille was audited in July as a result of information and identified problems with inmate medication administration. Information from the Camille July audit was forwarded to the IP auditors in July, 2017. This compiled information identified areas for SCDOC improvements such as: 1) documentation of the provider notifications regarding the inmates missed meds/refusal of meds. 2) interruption in the data stream for pharmacy orders from medical due to updates/refresh cycles of the Next Gen system, and 3) gaps in some re-orders/new orders of medications. Institutional MAR's audits are compiled monthly and provided to the HSOA's. HSOA's and E HR. staff have tabulated findings and results from the audits. MAR Audit results from Camille for August/September, 2017 were forwarded to the IP auditors during the week of October 23, 2017. A survey of the Camille inmates (those previously audited in July) was administered by pharmacy staff and E HR. staff in October, 2017. The purpose of the survey was to review progress levels at Camille, identify any new or existing problems areas, and to address the inmates concerns regarding their medications.	Continued monthly MAR audits will facilitate ongoing identification of issues/problematic areas allowing corrections within appropriate timeframes. Development/ implementation of standardized documentation processes within EZ MAR and Next gen will allow for improvements in data collection, documentation and delivery of health services. Completion of IT technological problems in this area/anticipated resolution of issues by end of 2017. Staff training and follow up for reinforcement training sessions ongoing at Camille by E HR. staff and IT staff. This process is expected to continue through December, 2017 and escalate in numbers of staff participation in 2018. Automation of notifications to providers for missed medication dosages and refusals of medication within EZ Mar will improve communications between pharmacy and medical. Anticipated resolution of automation requirements and from Medicalistics is December, 2017.

December 2017 Implementation Panel findings: Significant problems relevant to medication administration were found in the Marion housing unit at the Broad River Correctional Institution as

previously summarized in another section of this report. Specifically, medications were administered at the cell front because this housing unit was essentially on a locked down status. In cells that did not have a food port, medications were delivered under the door of the cell. Inmates also reported that medications were left on the food port and that it was unclear whether some inmates were receiving the medications that had been prescribed to them. In addition, other inmates were not receiving prescribed medications on a timely basis.

Similar problems were present at all other institutions assessed during this site visit except for Camille Griffin Graham CI.

December 2017 Recommendations: The above described medication administration process is unacceptable and needs to be remedied. A QI process should be established to assess the remedy that is implemented.

Also see provision 4.a.x. recommendations.

5.b. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;

Implementation Panel December 2017 Assessment: **noncompliance**

November 2017 SCDC Status Update

Health Services Issue/Area of Concern: Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs

Health Services –Medical Scope/Impact	Multidisciplinary Team Scope/Impact	Assessment	Action/Anticipated Outcome
Ongoing training for providers and nurses is required for continuous process adherence. Collaborations between providers/pharmacy/medical planned for increased levels of efficiency and enhanced health service delivery. Failure to comply with policies and procedures will be addressed through corrective action processes.	a) Providers b) Pharmacy c) Nurses d) Medical Director		Multidisciplinary teams of medical, pharmacy, and operations are working on shared projects for optimization of workspace/resources/workflow organization and overall enhanced health service delivery. A variety of shared collaborations are underway such as: Camille-) Pharmacy, IT, E HR. staff and nursing participated in the July audits and compilation of results from the audits.) IT and E HR. staff have facilitated ongoing E HR. training/support for several months. Pharmacy/nursing facilitated reorganization of pill rooms/tools for improved efficiency in October, 2017. In October, 2017, Pharmacy developed a modified stock supply order /forward to institutions automatically rather than individual orders. 5) Review of the current pill line times and feasibility of revised schedules is underway between pharmacy, medical, and operations. Pharmacy and medical will conduct a site visit to Leath in November, 2017 to review Leath's processes and Camille's/share ideas. Pharmacy staff and E HR. staff conducted a survey of Camille inmates in October, 2017. The survey participants

			were previously identified in July, 2017 with concerns regarding medication administration. Kirkland-Pharmacy/Medical staff reviewed pill room workflow processes/organization in October, 2017. Wall panels to enhance pill room efficiency and space utilization were ordered by the pharmacy in October, 2017. Ideas for stock supplies/orders/organization have been discussed with pharmacy/medical with ongoing plans for future collaboration on audits/process reviews between the two departments. Pharmacy assisted in the organization and distribution of flu vaccines throughout the state in October, 2017. Vaccine administration/results will be monitored by pharmacy and medical through the end of 2017.

December 2017 Implementation Panel findings: See findings relevant to the previous provision specific to the medication administration process. Based on such findings, it is clear that the process described in the SCDC status update section has not been effective. The audit findings at CGG and the administration of medications "under the doors" and " on the food ports" at male institutions are unacceptable and must be corrected.

December 2017 Recommendations: Remedy the above referenced processes and perform a follow-up QI process.

5.c. Review the reasonableness of times scheduled for pill lines; and

Implementation Panel December 2017 Assessment: **noncompliance**

November 2017 SCDC Status Update

Health Services Issue/Area of Concern: Review the reasonableness of times scheduled for pill lines

Health Services –Medical Scope/Impact	Multidisciplinary Team Scope/Impact	Assessment	Action/Anticipated Outcome
Variability in pill line schedules/medication administration times are limited due to controlled movement schedules, frequent institutional- lock downs, and staffing shortages of officers and nurses.	Medical Providers Operations Mental health	Individual institutional staff (operations and medical) will meet consistently to review existing needs and changes to the inmate populations. Frequent communication between operations/medical regarding pill line times/schedules/medication orders will enhance knowledge and awareness of each disciplines requirements creating more cooperative environment for both areas.	Institutional meetings between operations/medical targeted for monthly or as needed basis. Frequent changes in population/transfers between facilities as well as the medical/mental health needs are indicative of the need for ongoing meetings/communication between operations/medical.

December 2017 Implementation Panel findings: HS medications were still not being provided to the ICS at Kirkland CI or at Camille Griffin Graham CI. Pill call lines were problematic at the Camille Griffin Graham CI ICS as summarized in an earlier section of this report.

December 2017 Recommendations: Implement the appropriate steps to resume HS medication administration at the ICS's and elsewhere when clinically indicated. Adequately identify and address other pill call line issues.

5.d. Develop a formal quality management program under which medication administration records are reviewed.

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

Health Services Issue/Area of Concern: Develop a formal quality management program under which medication administration records are reviewed.

Health Services –Medical Scope/Impact	Multidisciplinary Team Scope/Impact	Assessment	Action/Anticipated Outcome
Incorporation of the individual items listed for component #5 support development of a formal quality management program with MAR reviews.	Medical Providers Mental Health Operations Pharmacy	Collection and review of audit findings/results will be ongoing by DON, HSOA's and departmental members. Incorporation of the E HR. statewide will facilitate more efficient monitoring/evaluation of programs and medication administration ensuring a minimum of 90% compliance with standards and quality clinical indicators. Missed medications/doses and refusals will be monitored through E HR. facilitating more expedited responses to changes in medication compliance, treatments and health service delivery. Stabilization of staffing/resources will support the ongoing efforts of a formal quality management program	Monthly/weekly audit reviews are currently conducted for all institutions. The introduction of statewide use of the E HR. 2018 will facilitate greater sample sizes for monitoring and identification of additional variables/factors for inclusion in the measurement processes. Anticipated start dates for statewide use is the first quarter of 2018. Electronic notifications of missed medications/ doses or refusals will simplify the provider notification process and enhance the treatments prescribed/administered. Anticipated start dates for the notification system is December, 2017. Additional funding requested for salary increases in medical will create increased numbers of clinical staff in all institutions. Notification of legislative budget approval/denial expected in the first quarter of 2018.

December 2017 Implementation Panel findings: See prior findings relevant to medication administration.

December 2017 Recommendations: The above recommended audits need to be included in the reports by QIRM relevant to this issue

6. A basic program to identify, treat, and supervise inmates at risk for suicide:

6.a. Locate all CI cells in a healthcare setting;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update
The Division of Facilities Management has completed all renovations on designated CI cells. The Division Director for Mental Health has approved the safe cells as outlined below.

Safe Cells			
Institutions	**# or Cell**	**Location**	**Approved as Safe Cells**
Allendale Correctional Institution	4	RHU	Approved- KD
Broad River Correctional Institution	4		Approved- KD
	13	CSU	Approved- KD
Camille Graham Correctional Institution	4	RHU	Approved- KD
	13	Blue Ridge	Approved- KD
Evans Correctional Institution	3	Infirmary & RHU	Approved- KD
Kershaw Correctional Institution	4	RHU & Medical	Approved- KD
Kirkland Reception & Evaluation Center	8	F-1	Approved-KD
	5	GPH	Approved-KD
Leath Correctional Institution	4	Phoenix - A-Side	Approved- KD
Lee Correctional Institution	4	RHU	Approved- KD
Lieber Correctional Institution	4	RHU	Approved- KD
McCormick Correctional Institution	2	RHU - B-Wing	Approved- KD (need repairs based on riot)- sprinklers/ cameras damaged - reported - 10/27/17
Perry Correctional Institution	6	RHU - B-Dorm, Z-Wing	Approved- KD
Ridgeland Correctional Institution	2	RHU - South	Approved- KD
Trenton Correctional Institution	1	RHU	Approved- KD
Turbeville Correctional Institution	4	RHU - Murray	Approved- KD
Tyger River Correctional Institution	2	RHU - East	Approved- KD
TOTAL	**87**		

December 2017 Implementation Panel findings: As per SCDC status update section. Some cells in the GPH did not have a functional sprinkler. Safety cells in the CGG and Lieber CI RHUs were not suicide resistant.

December 2017 Recommendations: Continue to monitor. Repair the sprinklers in cells within GPH that need repair. Remedy the lack of suicide resistant cells in the CGG and Lieber CI RHUs.

6.b. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;

Implementation Panel December 2017 Assessment: **compliance (December 2017)**

November 2017 SCDC Status Update
Logs provided to the HSOAs did not identify inmates being placed in a holding cell or other alternative space. In a review of the cell check logs by QIRM staff, there was no documentation to indicate the cells being used were prohibited alternative spaces.

December 2017 Implementation Panel findings: As per SCDC status update section.

December 2017 Recommendations: Continue to monitor.

6.c. Implement the practice of continuous observation of suicidal inmates;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update
QIRM staff continue to be informed that the practice of continuous observation is being implemented in the institutions, and have witnessed the practice in action; however, CSU continues to be the only area where this is documented consistently based on the use of the 19-7C, Inmate Constant observation log.

QIRM has identified that possible issues may be attributed to the lack of appropriate documentation.

Identified Issues

- The policy references 19-7, but there are 5 version of 19-7 (A, B, C, D and E)
- Since QIRM has been tracking and reporting no actual version of the 19-7 has been seen in use.
- The language in the policy might be confusing.
    - Section 8.9 states "**Custody and/or health care staff assigned to provide continuous observation during suicide watch shall document observed behaviors every 15 minutes on SCDC Form 19-7".**
    - Section ***9.5*** states "**Cell Check Log: Security will document observed behaviors at irregular intervals, at least every fifteen minutes/continual. Security will document checks on SCDC Form 19-7, "Cell Check Log."**
        - They both reference continuous/continual

- They both instruct staff to use the 19-7

QIRM has made the following recommendations to Operations to address concerns.

If instructions are sent to security staff in the form of a memo, consider using an instruction sheet with screenshots of the forms and instructions for when to use **each** form. QIRM is drafting an instruction like that provided to CGI for the shower and temperature log reviews.

Recommendations
1. Update the policy to reflect the new and appropriate forms (A, B, C, D). (Remove reference to 19-7).
2. Address the use of the correct forms during shift briefing and provide instructions when to use each form.
3. Consider using the attached instruction manual (please review and update as appropriate).
4. Documentation that staff have been briefed on the use form. (Signatures)
5. QIRM will verify staff awareness of proper forms during institutional CQI meetings.

December 2017 Implementation Panel findings: As per SCDC status update section.

December 2017 Recommendations: As per recommendations in SCDC status update section.

6.d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update

A CQI study was completed to assess the provision and maintenance of clean and available suicide-resistant clothing, blankets, and mattresses to inmates in C. The results of the study are attached as Appendix P.

This study was conducted to determine if Suicide Prevention clothing and resources were being cleaned each time it was returned from an inmate on Crisis. Tracking the issuing and cleaning of these resources will enable SCDC to ensure that inmates are receiving clean, hygienic suicide prevention clothing and equipment when placed on Crisis.

Results showed that twenty-one (21), or eleven (11) percent of the Agency's 185 Suicide Blankets have been reported as in disrepair, with Lieber reporting almost half of their blankets in this status. There are 175 Suicide Smocks available across the state with 10% of them in disrepair. Broad River CSU reports that 15 of their 38 smocks are in disrepair. There were inmates on CI status at various institutions during the time of this audit and they were utilizing the equipment.

December 2017 Implementation Panel findings: As per SCDC status update section.

Our July 2017 report included the following: " [N]ot all CI safe cells currently have suicide resistant mattresses."

December 2017 Recommendations: Remedy the above issues described in the SCDC status update section. Add to the monitoring study the presence or absence of suicide resistant mattresses. Ensure there is documentation each inmate placed in a CI safe cell was provided clean, suicide-resistant clothing, blanket, and mattress.

6.e. Increase access to showers for CI inmates;

Implementation Panel December 2017 Assessment: **noncompliance**

November 2017 SCDC Status Update
Logs used to record cell checks for CI inmates do not include documentation of the provision of showers.
QIRM recommends that SCDC Form M-120, "Crisis Intervention" be evaluated by the Mental Health and Substance Abuse Division Director, Mr. [redacted], for updates to include information about showers for inmates on CI status. Pursuant to a preliminary review, Mr. [redacted] has suggested this form be changed to require a mental health professional to evaluate the inmate for a shower once on CI for 24 hours. This will provide the security staff with specific instructions on the inmate's ability to shower versus current instructions which state "showers as tolerated.

December 2017 Implementation Panel findings: As per SCDC status update section.

December 2017 Recommendations: Remedy the above and continue to monitor results.

6.f. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;

Implementation Panel December 2017 Assessment: **noncompliance**

November 2017 SCDC Status Update
The Division of BMHSAS completed a QI study to examine what types of mental health sessions were being provided to CI/SP inmates and the frequency of the various types of sessions. This study is attached as Appendix Q.

Results showed that among the three categories of mental health sessions used for this study, total number of cell front sessions, total number of confidential sessions and total number of sessions in other locations, confidential sessions accounted for the smallest portion and cell front sessions for the largest. Confidential sessions made up a relatively small minority of the mental health sessions provided to CI/SP inmates in the months of July, August, and September in the studied institutions. Cell front sessions make up the largest category, but sessions conducted in other places account for a significant minority. Mental Health staff likely chose to conduct sessions in other locations in an effort to provide the inmates with as much privacy as possible, even when they cannot be totally confidential. While this effort is laudable, it falls short of SCDC's goal to provide confidential mental health sessions to inmates on CI/SP status and in CSU. The largest stumbling blocks to

reaching this goal have been a lack of clear data regarding this issue and a shortage of security staff needed to escort inmates to sessions.

December 2017 Implementation Panel findings: As per SCDC status update section. We were also informed by custody staff that it was common for GP mental health caseload inmates to not be seen in a confidential setting as a default due to clinicians' safety concerns.

December 2017 Recommendations: Remedy the above and continue to monitor results.

GP mental health caseload inmates should not always, or almost always, be assessed/treated in a non-confidential setting due to clinicians' safety concerns. It is appropriate to not see inmates in a non-confidential setting when there are clinical reasons that justify safety concerns by the clinicians.

6.g. Undertake significant, documented improvement in the cleanliness and temperature of CI cells;

Implementation Panel December 2017 Assessment: **partial compliance**

November 2017 SCDC Status Update
See response at 2.b.vi.

December 2017 Implementation Panel findings: See 2b.vi.

December 2017 Recommendations: See 2b.vi.

6.h. Implement a formal quality management program under which crisis intervention practices are reviewed.

Implementation Panel December 2017 Assessment: **noncompliance**

November 2017 SCDC Status Update
See 2.b.vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.

December 2017 Implementation Panel findings: During the afternoon of December 5, 2017, we observed a treatment team meeting in the crisis stabilization unit at the Broad River Correctional Institution. This 36-bed unit was located in the Greenwood Unit with a census during the monitoring period ranging from 15-20 inmates. There were no on-site psychiatry hours provided although some psychiatric coverage was provided via telepsychiatry.

Staffing data reported was as follows:

> A psychologist provided on-site coverage on a two day per week basis for an average of 15 hours per week.

3.0 FTE QMHP positions were allocated with no vacancies although the staffing plan requested 7.0 FTE QMHP positions.

9.0 FTE MHTs were allocated with 3.0 FTE vacancies.

8.0 FTE nursing staff positions were allocated with 3.0 FTE vacancies. 12.0 FTE nursing staff positions were requested in the staffing plan.

We observed the staffing of two CSU inmates. A psychiatrist was not part of the treatment team planning process. The treatment team planning process demonstrated significant systemwide issues, which included the following:

1. Lack of adequate communication between the sending facility and the CSU staffs.
2. Lack of adequate communication between the CSU and the ICS staffs.
3. Lack of adequate communication between the CSU and GPH staffs.
4. Significant difficulties addressing custodial issues that were directly related to an inmate's admission to the CSU related to a variety of issues involved in the custodial housing decision process.

The "reinterpretation" of the Suicide Prevention and Management Policy by the Division of BMHSAS to extend the time period allowed for inmates in safety cells in institutions to exceed 60 hours and up to 120 hours by changing the inmates status from "suicide watch" to "observation" is a clear violation of the Settlement Agreement and must be corrected.

December 2017 Recommendations: Develop and implement a plan to address the above systemic issues.

Conclusions and Recommendations:

The IP has provided its recommendations on specific items in the Settlement Agreement in this report and while on-site. We have also provided suggestions to SCDC to continue in their pursuit of development of their own internal processes and support systems for adequate mental health services delivery system and quality management system. This report reflects the IP's findings and recommendations as of December 8, 2017. The IP is hopeful that this report has been informative. We look forward to further development of the mental health services delivery system within the South Carolina Department of Corrections and appreciate the cooperation of all parties in pursuit of adequate mental health care for inmates living in SCDC.

Sincerely,

Raymond F. Patterson, MD
Implementation Panel Member

On behalf of himself and:

Emmitt Sparkman
Implementation Panel Member

Jeffrey Metzner, MD
Subject Matter Expert

Tammie M. Pope
Implementation Panel Coordinator