SCDC POLICY

This policy has been developed in response to and as a portion of the Remedial Plan agreed upon by the parties in the settlement of T.R. v. South Carolina Department of Corrections, No. 2005-CP-40-02925. As agreed by the parties in the Settlement Agreement, it is the understanding and agreement of the parties that implementation and effectuation of the provisions of this policy as a portion of the Remedial Plan shall be phased in over time and all aspects shall not become effective immediately. (Section 2 - Summary of Agreement and Section 4 (f) - Implementation Phase-In of Settlement Agreement effective May 2, 2016.)

NUMBER: GA-06.06

TITLE: CONTINUOUS QUALITY IMPROVEMENT REVIEW

ISSUE DATE: AUGUST 6, 2020

RESPONSIBLE AUTHORITY: OFFICE OF *THE DEPUTY DIRECTOR OF* LEGAL AND COMPLIANCE

OPERATIONS MANUAL: GENERAL ADMINISTRATION

SUPERSEDES: (June 23, 2017); NEW POLICY

RELEVANT SCDC FORMS/SUPPLIES: M-185

ACA/CAC STANDARDS: 4-ACRS-7D-01, 4-ACRS-7D-02, 4-4017, 4-4408, 4-4410

STATE/FEDERAL STATUTES: 42 C.F.R. §164.512(K)(5).

THE LANGUAGE USED IN THIS POLICY DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS POLICY DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENTS OF THIS POLICY, IN WHOLE OR IN PART.

PURPOSE: To ensure continuous quality improvement through a process of self-evaluation and action planning.

POLICY STATEMENT: SCDC has established a Legal and Compliance Office to review data concerning inmate safety and security, analyze operational performance, identify deficiencies, recommend process improvement plans, and ensure compliance with Agency policy on an ongoing basis.

TABLE OF CONTENTS

SPECIFIC PROCEDURES:

1. QUALITY IMPROVEMENT OVERVIEW:

1.1 SCDC is committed to providing healthcare that meets generally accepted medical standards. The Agency strives to foster an atmosphere that promotes comprehensive, compassionate, quality, and professional healthcare (both physical and mental health) through education, provision of resources, clinical oversight, and administrative support. SCDC will establish standards and strategies to effectively manage its operations through systematic analyses, self-audits, and system accountability. Goals and outcomes of SCDC's quality improvement process will include, but will not be limited to:

- Improving inmate and staff safety and security;
- Enhancing operational efficiencies;
- Enhancing feedback for informed decision-making;
- Conducting periodic staff*ing* analyses to be presented to the Deputy Director of Administration for resource allocation;
- Reviewing and compiling relevant internal and external compliance reports;
- Reviewing process improvement plans (PIP*s*) and follow-ups;
- Supporting the development and/or revision of policies and protocols, based on trends identified through data analysis; and
- Improving the quality of care to inmates by monitoring clinical activity, identifying opportunities to improve clinical outcomes, and identifying educational and training needs of staff.

2. SCDC QUALITY IMPROVEMENT COMMITTEES:

2.1 Continuous Quality Improvement Structure in SCDC is comprised of three (3) committees:

- Senior Management Board (section 2.2.);
- Agency-wide Continuous Quality Improvement Review Committee (CQIRC) (section 2.3); and
- Institutional Continuous Quality Management (ICQMC) Committee (section 2.4);

2.2 Senior Management Board: The Senior Management Board monitors the Agency-wide Continuous Quality Improvement Review Committee, which oversees all Institutional Continuous Quality Management committees. While data is available to all committees simultaneously, generally data is first analyzed by the Institutional Continuous Quality Management committees. Their findings are sent to the Agency-wide Continuous Quality Improvement Review Committee who, in turn, send data and findings to the Senior Management Board.

2.2.1 The Senior Management Board is comprised of: the Agency Director or appointee; Deputy Director of ***Medical*** Services, Deputy Director of Operations, Deputy Director of Administration, Division Director of Quality Improvement and Risk Management (QIRM), Director of Nursing, ***Deputy*** Director of Behavioral Health, ***Communications Director***, Deputy Director of Programs and Services, Deputy Director of Police Services, and ***Deputy Director of*** Legal and Compliance.

2.2.2 The Senior Management Board will be chaired by the Division Director of QIRM.

2.2.3 The Board will meet at least twice per year to review and identify potential patterns or trends in the areas of supervision, staffing, incident reporting, referrals, investigations, classification, grievances, etc., that could result in general security issues. The review shall include the following:

- Concerns related to underperforming indicators;
- Process improvement plans (PIPs) implemented or to be recommended;
- Recommended changes to policy, training, and/or accountability measures; and
- Issues and/or questions to be forwarded to the Division Director of QIRM for further analysis, research, etc.

2.3 Continuous Quality Improvement Review Committee (CQIRC):

2.3.1 CQIRC is an Agency-level committee that supports institutional continuous quality improvement (CQI) committees, and reviews and discusses the results of institutional audits, reports, and data; monitors improvement activities; and evaluates PIPs. The PIPs, when deemed necessary by the committee, can be initiated by the CQIRC and implemented by affected disciplines within sixty (60) days of each quarterly review.

2.3.2 The CQIRC will be chaired by the QIRM Division Director. This committee is comprised of the following additional staff whose attendance shall be documented via signature at every quarterly CQIRC meeting:

- ***Deputy Director of*** Behavioral Health ***or Assistant Deputy Director of Behavioral Health***;
- Deputy Director of Operations or Assistant Deputy Director of Operations;

- Deputy Director of ***Medical*** Services or Assistant Deputy Director of ***Medical*** Services;
- Deputy Director of Programs and Services or Assistant Deputy Director of Programs and Services;
- Deputy Director of Police Services or Assistant Deputy Director of Police Services;
- ***Chief Medical Officer***;
- Division of Resource and Information Management (RIM) appointee as identified by the Resource Information Management Division Director;
- Director of Nursing;
- Regional Nurses;
- Mental Health Directors;
- Division of Administration appointee;
- Division of Training and Staff Development appointee;
- Pharmacist;
- Warden or Associate Warden;
- QIRM Manager
- QIRM Analyst; and
- Division of Operations appointee.

NOTE: Meeting attendance will be tracked and reported to the QIRM Division Director, other responsible Division Directors, and Deputy Directors. Recurrent failure to attend quarterly CQIRC meetings will result in corrective action as identified by Deputy and Division Directors.

2.3.3 As deemed appropriate by the committee chair, based on data presented to QIRM during the quarter, the mandatory quarterly CQIRC meeting may also be attended by the staff listed below:

- Environmental Health and Safety Officer (EHSO);
- Institutional Dentist/Dental staff;
- Staff nurse(s);
- Operations Regional Director; and/or
- Other division directors, clinical, administrative, security, or support staff.

2.3.4 Reporting Data to the CQIRC:

- Present data and facilitate discussions regarding trends, patterns ***and PIPs*** to the CQIRC to increase collaboration and expedite system-wide changes as identified. QIRM's responsibility is to collect data in order to report accurately and transparently what is happening within SCDC so that the Agency can bring areas of deficiency into compliance with its own policies.
- Representatives from each discipline will present projects and reports, and will present concerns, as appropriate, in order to determine if ***a CQI process or outcomes study*** should be initiated.

2.3.*5* CQIRC is charged with:

- Reviewing data from Institutional Continuous Quality Management committees;
- Identifying/analyzing notable trends;
- Identifying quality improvement studies;
- Initiating and tracking PIPs (SCDC Form M-185, "Process Improvement Plan");
- Preparing summary reports for the Senior Management Board;
- Writing Annual Quality Improvement Plan; and
- Forming subcommittees as needed.

2.3.*6* CQIRC Meeting Format: CQIRC shall maintain meeting minutes and other appropriate records of CQIRC activities. These minutes shall:

- Be forwarded to the QIRM Division Director for review and editing prior to submission to the Senior Management Board;
- Reflect a summary of the discussion and activities;
- Include date, time, and attendance; and
- Be forwarded to staff not attending the meeting to ensure that they are informed of findings and improvement initiatives.

2.3.*7* Agenda for CQIRC Meeting: The CQIRC committee meeting shall follow a standardized agenda for each meeting. The following are mandated CQIRC agenda items:

- Call to order;
- Sign-in of committee members and attendance;
- Previous meeting minutes review and acceptance;
- Monitoring and evaluation of operations practices and conditions of confinement;
- Monitoring and evaluation of healthcare services;
- Review of utilization of resources;
- Adverse event review and risk prevention;
- Review of grievances;
- Discussion of staffing;
- Report of peer review activities;
- Report of staff education and training;
- Review of results and intervention from CQIRC studies; and
- Review of PIPs.

2.3.8 Quarterly Reports and Annual Plan: The CQIRC submits summary reports for meeting minutes to the Senior Management Board and develops an Annual Quality Improvement Plan. The Annual Quality Improvement Plan consists of two (2) parts: a review of the prior year; and a comprehensive plan for the upcoming year. The review of CQIRC's activity during the prior year includes highlights of accomplishments and processes that have been strengthened, and areas in need of further improvement. The comprehensive plan for the upcoming year includes:

- ***Process indicators;***
- ***Identification of data to be collected and analyzed;***
- ***Goals and objectives with quantifiable and timeframe measures;***
- ***Committees/entities/staff responsible for each indicator/objective;***

- ***Description of processes/tools to evaluate the effectiveness of institutional operations and activities; and***
- ***Utilization review - review of resources which may include, but is not limited to: emergency/crisis transports, hospitalizations, facilities resources, and equipment resource management.***

2.4 Institutional Continuous Quality Management Committees (ICQMC):

2.4.1 At the institutional level, the ICQMCs serve as the main driving force behind continuous quality improvement and provide support to institutional staff by identifying problems, initiating, implementing, and monitoring PIPs, and studying their effectiveness. These local committees ensure that correctional facilities use a structured process to identify areas that need improvement and that, when such areas are found, staff develop and implement strategies for improvement.

2.4.*2* The ICQMC chair will serve for two (2) years and rotate across the following staff:

- Warden
- Associate Warden
- Health Care Authority;
- Regional Nursing Director; and
- Regional Mental Health Supervisor.

2.4.*3* This ***ICQMC*** is comprised of the following staff whose attendance shall be documented via signature at every ***quarterly*** ICQMC meeting:

- Warden;
- Associate Warden of Programs or Warden's designee;
- QIRM Analyst;
- Regional Nursing Director;
- Health Care Authority (HCA) or designee;
- Mental Health Clinical Supervisor or Qualified Mental Health Professional, or designee;
- Environmental Health and Safety Officer (EHSO);
- Division of Operations line staff appointee as identified by the Warden;
- Institutional Trainer/Training Liaison; and
- Other staff, as indicated and approved by the Committee.

NOTE: Meeting attendance will be tracked and reported to the QIRM Division Director, other responsible Division Directors, and Deputy Directors. Recurrent failure to attend ***quarterly*** ICQMC committee meetings will result in corrective action as identified by Deputy and Division Directors.

2.4.4 QIRM compiles data and reports to the institution at least one (1) week in advance of the ICQMC meeting. This will allow the staff to review the information and be prepared to discuss their plans to address any identified deficiencies.

2.4.*5* The ICQMC i***s charged with***:

- Review***ing*** and analyz***ing*** defined data;
- Determin***ing the need for*** PIPs to: 1) facilitate quality healthcare; 2) improve access to healthcare; 3) improve provider/patient interaction; 4) monitor and improve Operations practices and conditions of confinement; and 5) ensure the proper utilization of mental and physical healthcare resources;
- Us***ing*** continuous quality improvement tools and techniques to identify, plan, study, and remedy problems/processes;
- Continuously review***ing*** components of the care delivery system while working towards continuous improvement in the delivery of healthcare; and
- Us***i***ng a multidisciplinary team in the implementation of this process.

2.4.*6* The ICQMC will follow a standardized agenda for each meeting, including the following items:

- Call to order;
- Sign-in of committee members and attendance;
- Previous meeting minutes review and acceptance;
- Monitoring and evaluation of healthcare services;
- Monitoring and evaluation of Operations practices and conditions of confinement;
- Utilization of resources;
- Adverse event review and risk prevention;
- Review of grievances/complaints/inmate representative committee issues;
- Discussion of staffing;
- Discussion of staff concerns;
- Report of peer review activities (not necessarily results);
- Report of staff education and training; and
- *Review of PIPs.*

2.4.7 Quarterly Reports: QIRM submits data from ICQMC meetings to the CQIRC (see 2.3.4)

3. INDICATORS:

3.1 Through the Continuous Quality Improvement Process created by this policy, SCDC will self-monitor and develop PIPs to ensure that compliance requirements are met by reviewing and assessing the following indicators as outlined by the T.R., P.R., and K.W., and Protection and Advocacy for People with Disabilities, Inc., v. South Carolina Department of Corrections Mental Health Settlement Agreement:

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

3.1.2 The development of a more 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.

3.1.3 Employment of a sufficient number of trained mental health professionals.

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

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

3.1.6 Provision of a basic program to identify, treat, and supervise inmates at risk for suicide.

3.2 Additional indicators can be added as identified by the CQIRC and outlined in the Annual Quality Improvement Plan to include an assessment of adequate resources and support for compliance efforts.

4. CONFIDENTIALITY:

4.1 Select quality improvement records are confidential and privileged ***as created at the request of the Deputy Director for Legal and Compliance in anticipation of litigation*** and may not be disclosed to any person or entity except as provided within policy. All appropriate quality improvement records shall be marked as "Confidential." All participants in Quality Improvement Committees and Quality Improvement Program activities shall sign a Statement of Confidentiality agreeing to maintain the confidentiality of all information emanating from these activities.

5. RECORDS RETENTION: Reports, records, and documents shall be maintained according to the SCDC records retention schedule and SCDC Policy OP-21.10, "Agency Records Management."

6. DEADLINES AND EXTENSIONS: All data/information collection and reporting deadlines established by this policy and the Deputy Director for Legal and Compliance through QIRM or other designee must be timely met. Only the Deputy Director of Legal and Compliance may extend data/information collection and reporting deadlines that are necessary for this process, to include the data, information, or reports necessary for the Mental Health Implementation Panel. Appropriate corrective action will be taken if deadlines are not met as established.

7. **DEFINITIONS:**

Continuous Quality Improvement Outcomes Study - A CQI outcomes study examines whether expected outcomes of patient care were achieved.

Continuous Quality Improvement Process Study - A CQI process study examines the effectiveness of the health care delivery process.

Healthcare refers to all actions, preventive and therapeutic, provided for the physical and mental wellbeing of inmates in SCDC custody. Healthcare includes medical, dental, and mental health services.

Inmate Healthcare Provider refers to a professional entity that provides healthcare services to the inmate population on behalf of SCDC.

Patterns refers to consistent and recurring characteristics or traits evident in operational processes that can assist in the identification of problems or serve as a marker and/or indicator for areas requiring additional monitoring and/or PIP.

Process Improvement Plan refers to a plan to correct deficiencies.

Quality Improvement refers to the implementation of system-wide administrative and operational activities designed to ensure quality of services and the identification and remedy of issues that affect desired outcome measures.

SIGNATURE ON FILE

s/Bryan P. Stirling, Director

ORIGINAL SIGNED COPY MAINTAINED IN THE OFFICE OF POLICY DEVELOPMENT.

Date of Signature

ATTACHMENT A

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS

POLICIES ATTACHED TO THE MENTAL HEALTH SETTLEMENT AGREEMENT

POLICY NUMBER	POLICY NAME
HS-19.03	Inmate Suicide Prevention and Crisis Intervention
HS-19.04	Mental Health Services - General Provisions
HS-19.05	Mental Health Services - Treatment Plans and Treatment Team Meetings

HS-19.06	Mental Health Services - Disciplinary Detention for Inmates Classified as Mentally Ill
HS-19.07	Mental Health Services - Continuous Quality Management (CQM)
HS-19.08	Mental Health Services - Clinical Use of Restraints for Mental Health Purposes - RESTRICTED
HS-19.10	Mental Health Services - Behavioral Management Unit (BMU)
HS-19.11	Mental Health Services - Reception and Evaluation: Mental Health Screening, Evaluation, and Classification
HS-19.12	Mental Health Services - Intermediate Care Services (ICS)
HS-19.13	Mental Health Services - Gilliam Psychiatric Hospital (GPH)
HS-19.14	Mental Health Services - Inmate Health Records General Guidelines
HS-19.15	Mental Health Services - Mental Health Training
OP-22.01	Use of Force - RESTRICTED
OP-22.14	Inmate Disciplinary System
OP-22.38	Restrictive Housing Unit