CD-011700 NMCD Internal Operations Monitoring	Issued: 02/27/85 Effective: 03/06/85	Reviewed: 5/11/22 Revised 07/11/18
Alisha Tafoya Lucero, Cabinet Secretary		***Original Signed and Kept on File***

AUTHORITY:

A. NMSA 1978, Section 33-1-6, as amended.
B. Policy *CD-010100*

REFERENCES:

A. ACA Standards 2-CO-1A-20, 2-CO-1A-21 and 2-CO-1A-22, *Standards for the Administration of Correctional Agencies*, 2nd Edition.
B. ACA Expected Practices 5-ACI-1A-17, 5-ACI-1A-18 and 5-ACI-1A-19, *Performance Based Standards and Expected Practices for Adult Correctional Institutions*, 5th Edition.
C. ACA Standard 4-APPFS-3D-07 and 4-APPFS-3D-08, *Standards for Adult Probation and Parole Field Services*, 3rd Edition.
D. ACA Standards 1-CTA-1A-14, *Standards for Corrections Training Academies,* 1st Edition.
E. ACA Manual of Accreditation Policy and Procedure 2017

PURPOSE:

To establish an internal operational monitoring system for the methodical examination, review and verification of departmental compliance with applicable standards, policies, procedures, directives, laws and regulations

To establish guidelines and procedures for Internal Audits and Standards Compliance (IASC) Bureau staff.

APPLICABILITY:

All Corrections Department staff.

FORMS:

None

ATTACHMENTS:

5C Corrective Action Plan Sample Format Attachment (*CD-011702.A*)

DEFINITIONS:

A. *5C Corrective Action Plan*: five step procedure for the development of a plan to come into compliance with a non-compliant finding which includes:
   Condition: What is the particular problem found?
   Criteria: What is the standard that was not met? The standard may be a policy, procedure or other benchmark.
   Consequence: What are the potential negative outcomes because of the finding?
   Cause: Why did the problem occur?
   Corrective Action: Recommendation which treats the listed cause, and steps to bring the condition into compliance

B. *American Correctional Association (ACA) Accreditation*: comprehensive, national standards program for corrections implemented voluntarily to measure compliance with those standards.

C. *Green, Amber, Red Inspection System (GAR)*: New Mexico Corrections Department database system used for completion and storage of assigned internal operations monitoring reports. Levels of compliance:
   Green: area monitored shows significant compliance
   Amber: area monitored does not meet established policies, procedures or standards
   Red: area monitored does not meet established policies, procedures or standards resulting in a serious breach of security of the institution, or any area that has been found non-compliant on three prior consecutive monitoring assignments. The Director of Adult Prisons or designee will make a determination whether to place the facility into lockdown status.

POLICY:

A. The New Mexico Corrections Department shall conduct internal monitoring of its operations at least annually in order to accomplish the following: **[2-CO-1A-20] [2-CO-1A-21] [2-CO-1A-22]**

   1. Determine if applicable professional standards and established policies and procedures are being met.

   2. Provide management personnel with timely information with which to make decisions/plans and correct deficient practices.

   3. Provide a means of measuring progress toward goals.

B. All Corrections Department staff shall fully cooperate with auditors, provide any information or records requested to the extent allowed by law and allow access to facilities and personnel as may be required to complete each audit.

C. The Department shall monitor operations and programs through inspections and reviews. This monitoring is conducted by the Warden or designated staff at least annually and by qualified professionals not affiliated with the facility or system at least every three years. **[5-ACI-1A-17]**

D. The institutions shall report their activities at least quarterly to the parent agency. These reports are in writing and include major developments in each department or administrative unit, major incidents, population data, assessment of staff and inmate morale, and major problems and plans for solving them. **[5-ACI-1A-18]**

E. Accredited institutions shall submit an Annual Report to the Performance Based Standards & Expected Practices Accreditation of the American Correctional Association. The report is due on the anniversary of the accreditation date. Where applicable, the agency must submit a completed Significant Incident Summary and Outcome Measures Worksheet with the required Annual Report. **[5-ACI-1A-19]**

F. Institutions shall conduct self-monitoring in areas assigned by the IASC Bureau. All reports shall be completed and submitted into the GAR System by the last work day of the month.

F. Probation and Parole shall have an internal system to monitor operations and programs at least annually through inspections and reviews by the agency administrator or designated staff. **[4-APPFS-3D-08]**

G. The probation/parole department shall have an internal system for assessing and documenting achievement of goals and objectives. Performance is reviewed at least annually, and program changes are implemented in response to findings as necessary. **[4-APPFS-3D-07]**

H. The New Mexico Corrections Academy shall monitor operations and training programs through inspection and reviews. This monitoring is conducted by the director or designated staff at least annually. **[1-CTA-1A-14]**

I. Corrections Industries shall monitor operations and programs through inspection and review. This monitoring is conducted by the director or designated staff at least annually.

AUTHORITY:

Policy *CD-011700*

PROCEDURES: **[2-CO-1A-20] [2-CO-1A-21] [2-CO-1A-22] [4-APPFS-3D-08]**

Monitoring of all operations and programs shall be conducted at least annually.

A. Initiation of Operational Monitoring

1. Request by Management:

   All levels of management may request monitoring of specific operational or administrative areas in order to ascertain the effectiveness of established procedures, compliance with policies, standards, codes, etc. or to measure progress toward goals. Such requests will be routed through the chain of command and must be approved by the appropriate Division Director and Deputy Secretary.

2. Secretarial Directive:

   The Secretary or Director of Adult Prisons may direct monitoring or review of any area under his/her jurisdiction.

3. Established Schedules:

   Schedules for the conduct of specific operational monitoring may be formulated by the Internal Audits and Standards Compliance Bureau. The Department shall monitor operations and programs through inspections and reviews. The Warden or his/her designee shall conduct this monitoring at least annually. **[5-ACI-1A-17]**

   The institutions shall report their activities at least quarterly to the parent agency in accordance with Policy *(CD-010600)* **"Management Plan & Quarterly Reporting to Central Office"**. These reports are in writing and include major developments in each department or administrative unit, major incidents, population data, assessment of staff and inmate morale, and major problems and plans for solving them. **[5-ACI-1A-18]**

B. Operations monitoring reports are conducted in order to provide management with accurate information on the operational status of the area being monitored so that timely action can be taken to correct substandard practices, course adjustments can be made to more efficiently achieve goals and planning can be enhanced.

1. The Secretary of Corrections or Director of Adult Prisons may, at his/her discretion, identify persons who have expertise in a particular area and temporarily assign or employ such persons to aid in the operations monitoring assignments.

2. Persons who are independent of the division being monitored and who have expertise in the area will be chosen for monitoring assignments.

3. When necessary to monitor both administrative functions and operational functions, the appropriate Deputy Secretary will coordinate activities.

4. Except where surprise monitoring is justified, the appropriate management personnel will be advised of the time, date and area to be monitored.

5. Upon completion of an operations monitoring assignment, a written report of findings and recommendations will be prepared by the team and forwarded to the final authority that ordered the report.

6. Where findings of scheduled operations monitoring indicate corrective action is required, facility IASC staff will enter the non-compliant finding into the GAR System and follow the 5C Corrective Action Plan (CAP) format Attachment (*CD-011702.A*). A follow-up will be scheduled after the estimate to complete date to determine the adequacy of corrective action taken.

7. Operational Monitoring Files will be maintained by facility IASC staff to support all decisions of levels of compliance and shall be disclosed only to persons upon approval of the Secretary of Corrections, Director of Adult Prisons, or Inspector General.

C. Probation and Parole:

The probation/parole department shall have an internal system for assessing and documenting achievement of goals and objectives. Performance is reviewed at least annually, and program changes are implemented in response to findings as necessary. **[4-APPFS-3D-07]**

1. In a system review, overall performance of the entire field organization in achieving goals and objectives is measured.

2. In a program review, effectiveness of a particular program in the achievement of an immediate objective is measured.

D. Upon receipt of results, the chief executive of the area, i.e., Warden, Division Director, etc., will prepare a written response detailing the corrective action taken to correct deficiencies. The Warden must enter a Corrective Action Plan within 5 working days for an Amber finding, and within 3 working days for a Red finding.

E. Facility Wardens will meet quarterly with Adult Prisons Division and IASC Bureau staff to determine status of corrective action plans.

AUTHORITY:

Policy *CD-011700*

PROCEDURES:

A. CD and Facility Policy and Procedures will be placed on an 11-month review/revision cycle. This will ensure policy does not exceed the annual review/revision date.

B. Facility IASC Staff shall be responsible for ACA training, monitoring and tracking the ACA process and reporting to the Warden.

C. Facility IASC Staff will assign each Department Head applicable ACA standards, following review and approval by the facility Warden.

D. Facility IASC Staff will ensure that each Department Head maintains a soft file with a monthly sample of documents for each ACA standard.

E. Facility IASC Staff will:

1. Review soft files on a quarterly basis and report results to the warden
2. Submit quarterly reports
3. Make rounds of the facility:
    a. Talk to staff
    b. Talk to inmates
    c. Monitor services (Medical, Behavioral Health, Food Service, Inmate activity, etc.)
    d. Monitor cleanliness and sanitation
    e. Restrictive Housing

F. The Facility IASC staff will collect process indicators four times (quarterly) per year and place in the ACA audit folder.

G. The Facility IASC Staff will maintain ACA audit files as follows:

1. Non-mandatory files will be in green/blue 4-part folders, mandatory files will be in red 4-part folders.

2. Part 1: Standards Compliance Checklist
    a. Type in the Protocol

b. Type in the Process Indicator

3. Part 2: Sheet of paper labeled "Protocol." The policy will be located under the sheet of paper, tabbed and lettered to coincide with the standards compliance checklist. The policy will have any page(s) that pertain to the ACA standard. The procedure will have any page(s) that pertain to the ACA standard. All ACA standards will be highlighted in the policy and procedure.

4. Part 3: This section intentionally left blank.

5. Part 4: Process indicator section will be tabbed and lettered that coincide with the ACA standard and the standards compliance checklist. Documentation should be in chronological order ascending. Larger documents: Highlight or color tape on the bottom right hand corner to identify the top of each bi-annual sample (Any deviation from the file instructions will have to be approved by the Bureau Chief of Internal Audits and Standards Compliance).

    a. Lettered tabs shall be placed on top of the document that is being presented to meet the standard.

    b. For any ACA Standard requiring a weekly sample, two consecutive weeks of the sample must be in the file to show that it is done weekly. This procedure will also be followed for ACA Standards which require monthly or quarterly process indicators.

    c. Reports (EID, Fire Marshals, etc.) will have corrective action reports attached, to include Final action.

H. Update policy and procedure to include a policy review form prior to a pre-audit, ACA accreditation audit, or an ACA re-accreditation audit.

AUTHORITY:

Policy *CD-011700*

PROCEDURES:

A. Central Office Divisions ACA Accreditation

1. CD Policy and Procedures will be placed on an 11-month review/revision cycle. This will ensure policy does not exceed the annual review/revision date.

2. The designated ACA Manager shall be responsible for ACA training, monitoring and tracking the ACA process and reporting to the Division Director.

3. The designated ACA Manager will assign each department head/manager applicable ACA standards, following review and approval by the Division Director.

4. The designated ACA Manager will ensure that each department head/manager maintains a soft file with a monthly sample of documents for each ACA standard.

5. The designated ACA Manager will:

   a. Review soft files on a quarterly basis and report results to the Division Director.
   b. Submit quarterly reports

6. The designated ACA Manager will collect process indicators four times (quarterly) per year and place in the ACA audit folder.

7. The designated ACA Manager will maintain ACA audit files electronically as follows:

   a. Each standard will have its own electronic file labeled with the ACA Standard.
   b. Within each ACA Standard folder, process indicators which show compliance with the associated standard will be saved in the following format:
   Ex: "A. Document Name 1st Qtr 2018"

8. Electronic ACA file presentation must be in Microsoft PowerPoint format and approved by the IASC Bureau Chief prior to use.

B. Central Office, Training Academy, Corrections Industries (CI), and Probation and Parole Division (PPD)

1. Each area of responsibility in Central Office and the Training Academy will maintain soft files for each applicable ACA standard. The soft files will contain monthly samples of documentation.

2. Each CI program area will maintain soft files for each applicable ACA standard. The soft files will contain monthly samples.

3. Each PPD Region office (I – IV) will maintain soft files for each applicable ACA standard. The soft files will contain monthly samples from each district office.

NEW MEXICO CORRECTIONS DEPARTMENT
5C Corrective Action Plan Sample Format

Condition-description of status of operational area audited.

A review conducted on_____[date; i.e., state the date of inspection/field work] of relevant documents revealed that the last inspection and testing took place in the 2nd quarter, 2017. No documentation was found to indicate that the area was inspected and tested during the 3rd quarter, 2017.

Criteria- applicable ACA standards, policies, procedures, directives, laws and regulations
CD-13101 which states that "A quarterly inspection/test will be conducted to ensure the emergency keys work.

ACA Standard generally applies to Tools and Equipment and does mention keys specifically to vehicles.

Institutional operational awareness of the importance of emergency keys to ensure they are inspected and tested quarterly per NMCD policy and procedures. [i.e., putting first things of importance first and as prescribed in policy]

Consequences-potential negative outcomes if the operational area remains non-compliant with applicable ACA standards, policies, procedures, directives, laws and regulations

Without regular inspections and testing, there is less evidence that area monitored will operate as intended upon future application. A lapse of protocol of significant proportion could occur if/when such a situation arises when an emergency key(s) does not work.

Causes
Resultant failure of responsible staff to complete the required quarterly inspection and testing of the area. This, in turn, could have been caused by such things as lack of proper supervision, lack of training, lack of interest and attention paid to the task at hand, among others. [i.e., include the obvious and if meaningful, speculate on other contributing causes]

Corrective Actions-recommendations to bring the condition into compliance with the criteria
Ensure (e.g. the Armory Officer) by all means available that future required quarterly emergency key inspections and testing is scheduled, completed and clearly documented per the above mentioned NMCD policy and procedure. [i.e., start all recommendations with an active verb]

Notes: Discussions with the Armory Officer indicated that he/she will establish the schedule and implement the requirements starting on 10/24/17. [i.e., this section could include Facility intent as exemplified here.