"Service with Excellence And Integrity"

Arkansas Department of Community Correction
Two Union National Plaza Building
105 West Capitol, 2nd Floor
Little Rock, Arkansas 72201-5731
(501) 682-9510 Fax: (501) 682-9538

ADMINISTRATIVE DIRECTIVE: 07-16 AMERICAN CORRECTIONAL ASSOCIATION (ACA) INTERNAL AND EXTERNAL AUDITS

TO: DEPARTMENT OF COMMUNITY CORRECTION (DCC) EMPLOYEES

FROM: G. DAVID GUNTHARP, DIRECTOR

SUPERSEDES: AD 03-07

APPROVED: Signature on File EFFECTIVE: DECEMBER 3, 2007

I. APPLICABILITY. This policy applies to Department of Community Correction (DCC) employees.

II. POLICY. It is DCC policy to ensure efficient and responsible operations through quality improvement practices that use the results of monitoring and evaluating activities as a basis for ongoing program improvement. (4-ACRS-2D-02) (3-3023) 2-CO-1A-22

III. DEFINITIONS. Following are American Correctional Association (ACA) definitions of key terms used in Performance-Based Standards Manuals: [1]

A. **Expected Practice(s).** Actions and activities that, if implemented properly (according to protocols), will produce the desired outcome. What we *think* is necessary to achieve and maintain compliance with the standard – but not necessarily the *only* way to do so. These are activities that represent the current experience of the field, but that are not necessarily supported by research. As the field learns and evolves, so will practices.

B. **Goal Statement.** A general statement of what is sought within the functional area.

C. Outcome Measures. Measurable events, occurrences, conditions, behaviors, or attitudes that demonstrate the extent to which the condition described in the performance standard has been achieved. Outcome measures describe the

[1] Source: American Correctional Association's Performance-Based Standards for Adult Community Residential Services, Fourth Edition, © 2001 by American Correctional Association, 4380 Forbes Avenue, Lanham, MD 20706-4322; phone 1-800-222-5646

consequences of the program's activities, rather than describing the activities themselves. Outcome measures can be compared over time to indicate changes in the conditions that are sought. Outcome measure data are collected continuously but usually are analyzed periodically.

D. Process Indicators. Documentation and other evidence that can be examined periodically and continuously to determine that practices are being implemented properly. These "tracks" or "footprints" allow supervisory and management staff to monitor ongoing operations.

E. Protocol(s). Written instructions that guide implementation of expected practices, such as policies/procedures, post orders, training curriculum, formats to be used such as logs and forms, offender handbooks, diagrams such as fire exit plans, internal inspection forms.

F. Standard. A statement that clearly defines a required or essential condition to be achieved and maintained. A performance standard describes a "state of being" a condition, and does not describe the activities or practices that might be necessary to achieve compliance. Performance standards reflect the program's overall mission and purpose.

IV. PROCESS.

A. Center Supervisor and Area Manager Responsibilities. Center Supervisors and Area Managers are responsible for the following:

1. monitor, evaluate, and report progress toward attaining goals and objectives. Make appropriate program changes to facilitate goal/objective attainment.

2. ensure accurate and timely data collection, analysis, and reporting

3. manage the monitoring and evaluating process in compliance with this guidance

4. monitor operations to ensure compliance with DCC policy, ACA expected practice, and documentation requirements for internal ACA audits

5. train staff to collect, report, and analyze data and to conduct audits

6. recommend trained staff to conduct internal ACA audits

7. ensure compliance with guidance in this section

8. respond to requests for information or assistance made by the DCC ACA Coordinator

B. Electronic Offender Management Information System (eOMIS) Data Verification All eOMIS users must take reasonable precautions to verify the accuracy and reliability of data they enter. This is necessary to ensure subsequent decisions and evaluations are based on accurate information. (4-ACRS-7D-05[P])

C. Audits of Offender Records. The Deputy Director of Residential Services and Assistant Director of Probation/Parole Services must ensure their staff thoroughly reviews offender records.

1. Objective. The primary objective of supervision audits is to determine the quality, effectiveness, and adequacy of offender supervision and to provide a means for correcting deficiencies and recognizing significant accomplishments, innovations, and enhancements.

2. Responsibilities. Audits of supervision activities of probation and parole offices and residential centers will be conducted by the appropriate area or center supervisor, their assistants, or another authorized supervisor. Under no circumstances will a
supervisor audit activities for which he/she is directly responsible.

3. Guidance. The appropriate Deputy or Assistant Director must provide written procedural guidance for conducting supervision audits delineating responsibilities, audit frequency, reporting, and providing for their consistent application. Consistency must be maintained in the application of audit procedures.

D. Goals and Objectives. Center Supervisors, Area Managers, and others tasked to monitor and evaluate progress made toward achieving goals and objectives, must report progress and obstacles in the monthly input for the Director's report to the Board of Corrections. As necessary, program changes must be implemented in response to findings in the goals and objectives report. (4-ACRS-7D-02)

E. Internal ACA Audit Responsibilities. Internal ACA audits are audits conducted by qualified staff members to determine compliance with ACA standards.

1. Chief Deputy Director, Deputy Director of Residential Services and Deputy Director Probation/Parole Services. The Chief Deputy Director, the Deputy Director of Residential Services and the Deputy Director Probation/Parole Services will ensure an annual "internal ACA audit" of all ACA documentation. The schedule must allow timely identification and resolution of problems prior to an audit by ACA auditors and/or the annual report to the ACA. An ACA Accreditation Manager must be designated for each residential facility and Probation/Parole office. Audit teams must be qualified and each team must have a lead auditor.

2. DCC ACA Coordinator. The DCC ACA Coordinator coordinates the overall internal and external accreditation process activities.

3. ACA Manager. The Center and Probation/Parole Services ACA Manager are primarily responsibility for managing the ACA accreditation process. He/she must work with staff to ensure sufficient documentation is available for ACA audits and keep supervisors and appropriate managers/administrators appraised of problems. Responsibilities of the ACA Manager include the following:

   a. Establishing folders with ACA documentation using an approved format.
   b. Placing policy excerpts ACA folders to show the written requirement that fulfills the ACA standard (expected practice). Highlighting the appropriate text with a yellow high lighter. Only highlighting the minimum words necessary to demonstrate compliance. Yellow high lighting is required because it allows documents to be copied cleanly. Other high lighters will show dark marks after photocopying
   c. When an expected practice (standard) has a list of requirements, include process indicators (secondary documentation) in the same order as the items in the list. Number the items in the expected practice and process indicators to allow easy association.

4. Audit Team Chairperson. The chairperson of the audit team will fulfill the following duties:

   a. Conduct an entrance and exit meeting with key facility staff.
   b. Assign each team member specific areas to be audited.
   c. Assign mentors to new audit teams as observers.
   d. Serve as spokesperson for the team.
   e. Serve as final authority in regard to compliance/non-compliance issues.

   The above duties are not applicable to Central Office.

5. Internal ACA Auditors. Staff selected to perform internal ACA audits must follow applicable guidance in this section.

6. All employees. All employees must support the ACA accreditation process through such means as providing timely and adequate documentation and cooperating with the ACA Accreditation Manager and auditors. All employees involved in the ACA audit process will follow applicable guidance in subsequent paragraphs.

F. ACA Internal Audit Process. The American Correctional Association (ACA) sends an audit team for initial accreditation and, when we meet standards, subsequently every three years for re-accreditation. If there are problems, our accreditation status could be withheld or made conditional based on progress noted in additional audits. Although there may be an occasional reference to ACA audits conducted by the ACA, in this section, "audits" primarily refers to "internal ACA audits" conducted by DCC staff to determine the likelihood of DCC passing an audit by the ACA auditors and to identify and resolve problems.

G. ACA Internal Audit Requirement. Annual internal ACA audits at CCCs will be conducted by a qualified team of auditors from another center. Annual internal ACA audits of Probation/Parole Services Areas will be conducted by qualified auditor(s) from another Area and/or by the Probation/Parole Administrator in charge of the Area. At CCCs, usually four auditors are needed and the audit process takes one full day plus report preparation time. Auditors may be accompanied by staff from either the auditing or audited center/area for training purposes.

H. ACA Internal Audit - Qualified Auditor. Qualified auditors for internal ACA audits must understand the operation(s) being audited to include related policies and procedures; the ACA system of expected practices, protocols (primary documentation), and process indicators (secondary) documentation; the audit process described here; and report writing. For audits at CCCs, auditors with special expertise are recommended so they may focus on expected practices in their area of expertise in addition to conducting a physical facility inspection and interviewing staff and offenders. At CCCs, auditors with the following expertise are recommended:

1. Food and Sanitation Auditor. The qualified individual must be trained in the Administrative Procedures of the Arkansas State Board of Health and the Arkansas Department of Health. The qualified individual must be able to inspect every building, room, or other place occupied or used for the production, storage, sale, or distribution of food, and all utensils and appurtenances relating thereto. This includes commissary operations.

2. Fire Safety Auditor. The qualified individual must be trained in the prevention, detection, and protection of fires in accordance with the National Fire Prevention Life Safety Code Handbook. A qualified individual will be familiar with the special challenges associated with protecting incarcerated individuals.

3. Chemical Control Auditor. The qualified individual must be trained according to specific guidelines for storage, use, and disposal of toxic, flammable, and combustible liquids under the Federal Hazardous Substances Act and capable of determining substantial compliance with applicable requirements. A qualified auditor would be expected to assure constant inventories are kept and maintained for all toxic, flammable and caustic material used in each department.

4. Internal File Review Auditor. The qualified individual must meet the requirements outlined above for all auditors. This auditor is responsible for reviewing accreditation files, personnel records, and offender records, as assigned by the team chief.

I. Staff Preparation for ACA Audits. Some of the preparation requirements are described here. The ACA Manager must ensure appropriate documentation is

available. The Center Supervisor and Probation/Parole ACA Manager must provide the audit team chief with the following information to be used in the final report, note this is for the "real" audit, not audits by our staff: current information regarding operations and programmatic description, offender population, personnel statistics, organization charts, etc. for use in the "agency narrative" section of the report. Also provide a litigation summary limited to case number, cause of action, and resolution of class action suits and consent decrees. When there is a decree of judgments, information should be detailed and include the scope and specific requirements. Individual actions need not be included. The Center Supervisor/Area Manager gives a brief presentation to the audit team at the entrance meeting. At this time, he/she may want to provide information the audit team chief can use in the important part of the report concerning "quality of life." The quality of life statement that the ACA auditor must include in his/her report addresses consideration of staff training, room size, time outside room, current population, adequacy of medical services, offender programs, recreation, food service, classification, sanitation, use of segregation, crowding, and reported and/or documented incidents of violence. The facility representative will also supply the team chief with a copy of the last accreditation or annual audit report and where applicable a copy of the facility outcome measures.

J. Audit Team Auditing Process Overview. Following is an overview of key aspects of the internal ACA audit process. This process parallels the process used by ACA.

1. Arrival. Upon arrival at the facility or area, the members of the audit team will meet with the center supervisor or area manager for introductions and the team chief will ask whether there are any specific areas needing review or potential problem areas.

2. Entrance Meeting. An entrance meeting with selected staff will then be conducted. At this meeting the facility representative will provide the audit team with a description of the unit, accomplishments, introduction of key staff, and designated primary liaison. Next, the team chief introduces the audit team to include a brief summary of their work experience and credentials, then describes the audit purpose and planned audit activities/schedule. Following this the facility administrator will give a brief tour. As part of the tour the facility administrator will show the team where the required documentation can be found. For the "real" ACA audit, this includes items mentioned in paragraph 7-12 above.

3. Auditor Tasks. Auditors will follow guidance in paragraphs 7-14 and 7-15. Auditors will write reports and may be tasked to conduct follow up audits.

4. Exit Meeting. The audit team chief will conduct an exit meeting with key staff to briefly cite findings in order to facilitate immediate corrective action.

K. ACA Internal Audit Guidance for Auditors and Staff. The following guides auditors in evaluating and documenting compliance. This information is provided to ensure adequate -- but not excessive -- documentation is placed in the ACA files for review by ACA auditors.

1. General. Components of the facility review include the following:

    a. Direct observation of physical evidence.
    b. Verbal evidence obtained by interaction and interviews with staff and offenders.
    c. Written evidence to include policy, procedures, inspection reports, and offender records.
    d. Audit of all standards/expected practice files and accompanying documentation to ensure proper evaluation of compliance, non-compliance levels, or non-applicability.
    e. Conducting employee and/or offender interviews as needed.
    f. Any mandatory standard thought to be in non-compliance or a serious breach of safety or security will immediately be reported to the facility or area administrator for corrective action.
    g. Prior to a final finding of non-compliance, the standard will be reviewed by all team members.
    h. All agency program records, personnel, and properties relevant to the audit being conducted will be made available to the audit team.

2. Exceptions. In some situations, corrective action is not necessary for accreditation standards/expected practices where State statute and/or physical plant limitations preclude the agency from meeting a particular standard(s). In addition, corrective action is not required if an accreditation waiver is in place for any standard/expected practices. Auditors must report all standards/expected practices that are not met for such reasons and provide the Area Manager/Center Supervisor's explanation. For example, if a deficiency is found in square footage, the amount of square feet must be indicated.

3. Review of Personnel and Offender Records. Auditors must review a random selection of personnel and offender files to ensure forms are completed properly and records are up to date.

4. Review of Outcome Measures. Outcome measures must be examined early in the audit process. If the outcome measures or related analysis by the facility staff suggest potential problems, auditors must look for procedures and factors that contributed to the poor numbers. All outcome measures must be submitted to the Accreditation Coordinator prior to ACA audits. Individual Centers or offices cannot submit outcome measures directly to ACA.

5. Review of ACA Audit Folders. Auditors will assess the adequacy of file documentation prepared by DCC staff.

   a. Probation/Parole Services maintains one set of accreditation folders for the entire Probation/Parole Services division rather than having separate folders for each area. These folders must be reviewed annually by both Probation/Parole Administrators. In addition, a checklist approved by the Deputy Director of Probation/Parole Services will be used as a basis for auditing each area. These area audits will be conducted by an Area manager from a different area and the Probation/Parole Administrator from the area being audited.

   b. The first step in reviewing ACA documentation folders is to determine whether the expected practice (standard), to include relevant aspects in the comment, is adequately addressed in the protocols (primary documentation; usually as expressed in a policy). The next step is to determine whether the expected practice (standard), to include relevant aspects in the comment, is being done, as evidenced by the process indicators (secondary documentation). When the highlighted portion of the protocol/policy requires more than the ACA standard the process indicators (secondary documentation) must reflect compliance with the protocol/policy. For example, if the expected practice is to conduct one emergency drill each quarter, but agency policy requires one drill each month, then the process indicators (secondary documentation) must show monthly drills to be considered adequate.

   c. Auditors should interpret standards strictly; it is detrimental to the audit process to give the benefit of the doubt to the facility or area office. If a conclusion is questionable or a standard/expected practice is not fully documented, the auditor should conclude non-compliance. Auditors will typically bring non-compliance issues to the attention of the facility representative or designee during the audit to allow the representative time to find and provide more complete documentation when available.

   d. Re-accreditation will require staff to maintain file documents over a three-year period. The three-year period begins the date accreditation is awarded by the ACA Commission on Corrections. The latest copy of any policy must be present in the file folder. New policy may mean limited documentation. If practice has changed, proof of practice should be evident by process indicator documentation (secondary documentation). When documentation collected before the policy change does not adequately show compliance with the expected practice, appropriate action should be taken such as a note of explanation, and if appropriate, a copy of the old policy.

e. Documentation of expected practices pertaining to “environmental conditions” is required only once during the three year period unless there is a substantial change in the environment. Documentation is usually done in the third year of accreditation for expected practices pertaining to environmental conditions.

f. For those standards/expected practices that are not re-occurring events over the three year period, a memo should be available indicating that the condition(s) has not occurred.

g. Compliance with physical plant requirements.

h. Accuracy and completeness of staff and client records.

i. In area offices emphasis is placed on those files that address probationer/parolee supervision, case record maintenance to include eOMIS and paper records, and caseload management.

j. ACA requires neat and legible file copies. Accreditation Managers must not over document. The ACA has indicated that documentation could be reduced by as much as 60 to 70 percent and still be sufficient to support compliance with a standard or expected practice.

k. ACA has stated that there is no need to go beyond the requirements of the standard or expected practice when supplying ACA documentation. Copies should be attached to the file folders, allowing sufficient space for easy reading of documents without removal. Copies should be in portrait orientation, avoiding landscape printing unless there are no other alternatives. All legal size documents should be reduced to letter size.

l. ACA prefers singled sided copies because they can be reviewed more efficiently.

m. The most recent primary documentation available must be used.

n. Accreditation managers should choose a method of proving compliance and remain consistent. Ideally, the same method should be used at each center.

o. Auditors should ask staff for additional documentation when documentation is insufficient. Staff may provide documentation from existing files. Staff must not create additional documentation once the audit has begun (per ACA guidance)

.

p. Be aware of problematic standards. Ensure documentation reflects compliance with the entire standard. For example, evacuation drill documentation should reflect all areas of the facility were evacuated at least quarterly on each shift when the majority of offenders are present.

L. Reports and Follow-up Audits.

1. Audit Report. Each auditor will provide their report to the team chief within 3 work days. Reports must include all expected practices (standards) found to be in noncompliance, citing the reference number, then the finding including recommended corrective action where deficiencies are noted. Although not required, additional observations may be included. The audit team chief must prepare a final written audit report within 10 work days of the site visit. Audit reports identify each subject area inspected and departure from established policy or procedural guidance. Other appropriate content includes the following: effective practices and programs, enhancements and accomplishments and, recommended corrective action where deficiencies are noted.

2. Initial Follow-up Report and Actions. The audited Area Manager/Center Supervisor must submit an initial response to the report within 30 calendar days. For each audit finding, the report must indicate agreement or disagreement with the finding, corrective action taken/planned or an explanation why correction is unnecessary, when corrective action was or will be taken, and the person responsible for implementing the action(s).

3. Subsequent Progress Reports. Subsequent progress reports must be made monthly until problems are adequately resolved. The audited Area Manager/Center Supervisor must ensure timely resolution of identified problems.

4. Distribution of Reports. Send all audit reports to the appropriate deputy/assistant director, with a copy to the audited Area Manager, Probation/Parole Administrator or Center Supervisor, and DCC ACA Accreditation Coordinator.

5. Follow-up Audit. The DCC ACA Accreditation Coordinator, audit team chief, audited area manager/center supervisor, or audited Probation/Parole Administrator may recommend a follow-up audit. Follow-up audits will be authorized by the appropriate deputy/assistant director.