



<p style="text-align: center;">SOUTH DAKOTA</p>  <p style="text-align: center;">DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURE</p>		POLICY NUMBER	PAGE NUMBER
		700-10	1 OF 6
		DISTRIBUTION:	Public
		SUBJECT:	Quality Management Program
RELATED STANDARDS:	ACA-5-ACI: 6A-29, 6A-36, 6D-02 (M)	EFFECTIVE DATE:	March 15, 2026
		SUPERSESION:	03/15/2025
DESCRIPTION: Clinical Services	REVIEW MONTH: February	 NICK LAMB SECRETARY OF CORRECTIONS	

I. POLICY

It is the policy of the South Dakota Department of Corrections (DOC) to maintain a multi-disciplinary Quality Management Program for Clinical Services that evaluates and improves offender care.

II. PURPOSE

The purpose of this policy is to establish an overview of the structure, authority, and general operating principles of the Quality Management Program. The mission of the Quality Management Program is to develop and implement processes to facilitate, monitor, and improve quality throughout the Clinical Services healthcare system. The Quality Management Program will identify system issues that may compromise offender healthcare outcomes and is not intended to address personnel issues.

III. DEFINITIONS

Continuous Quality Improvement:

A structured process within the healthcare delivery system used to identify areas for improvement; once identified, a plan for improvement is developed and implemented to correct the area and a follow-up review is conducted to evaluate the success of the plan implementation.

Health Authority:

The health authority for the South Dakota Department of Corrections is the director of Clinical and Correctional Services.

Healthcare Practitioner:

A clinician trained to diagnose and treat patients, e.g., physicians, dentists, psychologists, nurse practitioners, or physician assistants.

Quality Occurrence:

Event or happening outside expected healthcare standards or one that is contrary to administrative regulations or clinical standards of practice.

IV. PROCEDURES

1. Overview:

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- A. The Quality Management Program (QMP) provides *a system of documented internal reviews that will be developed and implemented by the health authority. The necessary elements of the system will include:*
1. *Participating in multi-disciplinary quality improvement committee.*
 2. *Collecting, trending, and analyzing data combined with planning, intervening, and reassessing.*
 3. *Evaluating defined data which will result in more effective access, improved quality of care, and better utilization of resources.*
 4. *Onsite monitoring of health services outcomes on a regular basis through:*
 - a. *Chart reviews by the responsible healthcare practitioner or designee, including investigation of complaints and quality of health records.*
 - b. *Review of prescribing practices and administration of medication practices.*
 - c. *Systematic investigations of complaints and grievances.*
 - d. *Monitoring of corrective action plans.*
 5. *Reviewing all deaths in custody, suicides or suicide attempts, and illness outbreaks.*
 6. *Implementing measures to address and resolve important problems and concerns identified (corrective action plans).*
 7. *Reevaluating problems or concerns to determine objectively whether the corrective measures have achieved and sustained the desired results.*
 8. *Incorporating findings of internal review activities into the organization's education and training activities.*
 9. *Maintaining proper records (in other words, meeting minutes) of internal review activities.*
 10. *Issuing a quarterly report to be provided to the health services administrator and facility or program administrator of the findings of internal review activities.*
 11. *Requiring A provision that records of internal review activities comply with legal requirements on confidentiality of records [ACA 5-ACI-6D-02 (M)].*
 12. *In the event of an offender death by suspected suicide then a psychological autopsy will be completed by a qualified mental health practitioner who is capable as determined by the mental health authority in conducting a psychological autopsy. This is a retrospective reconstruction of the individual's life with an emphasis on the risk factors that may have contributed to the individual's death [ACA 5-ACI 6A-36].*
- B. Structure and function of the QMP.
1. The QMP structure consists of the QMP Committee, the facility CQI Committee, the Suicide Prevention Committee, and the Infectious Disease Committee.
 2. These committees monitor and improve the quality of health care provided to offenders in the DOC.
- C. Quality occurrence reporting and review.
1. A *Quality Occurrence Reporting Form* (attachment #1) will be completed by clinical employees and contract workers who are witness to, knowledgeable about, or affected by quality occurrences.
 - a. *A system of documented internal review will be developed and implemented by the [behavioral] mental health authority to monitor and improve mental health care/delivery of services [ACA 5-ACI-6A-29].* All suicides, suicide attempts, use of force, and assaults involving offenders with a psychological code (P-code) of P3M, P3O, or P4-5 which may be associated with a safety precaution, medications, the use of restraints, and any other related trends require a quality report.
 - b. The health services administrator (HSA) will review the relevant incident reports related to the incidents listed above and will enter the quality report.
 2. DOC Clinical Services employees or contract workers are required to use the electronic quality occurrence reporting system.
 - a. Quality reporting forms completed by clinical services staff or contract workers will be sent to the chief of clinical operations (CCO) or designee.
 - b. If the electronic system is not functional, the Quality Occurrence Reporting Form will be completed and sent to the CCO.
 3. Quality occurrence reporting is the responsibility of the employee discovering the quality issue.
 4. The occurrence must be reported by the end of the shift at the time of discovery and must include information necessary to promote a clear understanding of it. If a quality occurrence requires a facility

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incident report, a quality occurrence report will be completed. Incident reporting does not take the place of the quality occurrence report; both must be completed. However, protected healthcare information is not included in an incident report.

5. Quality occurrence reports will be reviewed daily by the CCO or designee who will assign an initial severity code based on the circumstances of the incident. The initial severity code is subject to change after documentation has been received and reviewed. Severity codes are defined as follows:
 - a. Level 0: No quality issue identified.
 - b. Level 1: Action or inaction resulting in no adverse effect and of itself does not rise to a level requiring intervention; however, tracking and trending could reveal a more significant concern necessitating advancement to a level 2 or 3 based on frequency or pattern of occurrence.
 - c. Level 2: Action or inaction which resulted in or could have resulted in a minor adverse outcome. This type of issue may warrant notification for purposes of increasing awareness of the concern and in some cases may require corrective measures to be implemented at the facility level. The CCO or designee will track and trend these cases, if applicable.
 - d. Level 3: Action or inaction that resulted in, or could have resulted in, a sentinel event or a serious adverse outcome.
 - 1) A root cause analysis will be completed within one (1) week of the event by the facility of occurrence on all level 3 actions.
 - 2) This analysis will be presented at the monthly QMP Committee meeting.
 - 3) If additional information is required after the initial quality occurrence report has been submitted a *Case Review Worksheet* (attachment #4) may be sent to the facility for completion.
 - 4) The CCO or designee will conduct follow-up on plans of action and provide feedback to the QMP Committee, if applicable.
 - e. Level 4: Offender death. For purposes of reporting, there are two (2) categories of Level 4 cases determined by final review:
 - 1) 4A: No quality issues identified. Natural expected or unexpected offender deaths.
 - 2) 4B: A quality issue identified where an error occurred that may have contributed to or resulted in an expected or unexpected offender death.
6. Quality occurrences assigned a severity level 1 may initially be utilized to track and trend reoccurring issues or problems.
7. Quality occurrences assigned a severity level 2 will be researched by the affected facility HSA or designee and a case review worksheet may be requested unless determined otherwise by the CCO or designee. These cases will be discussed at the facility continuous quality improvement (CQI) meetings.
8. Quality occurrences assigned a severity level 3 will be researched by the CCO or designee. The facility CQI committee will complete a root cause analysis and may be required to complete a case review worksheet. Findings will be reported to the CCO or designee. The results of the root cause analysis will be presented at the QMP committee meeting.
9. Quality occurrences assigned a severity level of 4 will be assigned to a healthcare practitioner for a case review and presented to the QMP committee.
 - a. A *Clinical Mortality Review* (attachment #5) will be completed.
 - b. If the chief medical officer and the assigned healthcare practitioner determine there were no quality issues identified the cases will be placed on a consent agenda and closed as a 4A after the motion is approved by the committee.
 - 1) If a quality issue was identified by either the CMO or the assigned health care practitioner, the case will be presented at the QMP committee meeting.
 - c. QMP committee decisions/findings will be communicated to the applicable HSA in writing.
 - d. Level 4 suicide occurrences will result in a case review completed by the behavioral health supervisor within seventy-two (72) hours of the occurrence. The review report will be presented to the QMP Committee.
10. The HSA will notify the chief of clinical operations of any event requiring a root cause analysis be conducted with the facility CQI team and a plan of action will be created. These events include, but are not limited, to the following:

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- a. Any offender death, fall, paralysis, coma, or other major permanent loss of function associated with a medication error or delay of care.
 - b. An offender suicide.
 - c. An invasive procedure on the wrong side of an offender's body, on the wrong site on an offender's body, or on the wrong offender.
 - d. Use of force on offenders with a P3 code or higher that results in death or major permanent loss of function.
 - e. Offender suicide attempts that result in major permanent loss of function.
11. All DOC employees and contract workers, including non-clinical personnel, are required to respond to a quality committee request for information regarding a quality occurrence investigation or a quality initiative. The response will be complete and detailed.
 12. The HSA will notify the chief of clinical operations of any quality issues posing imminent danger. The chief of clinical operations will work with the other chiefs of service to determine immediate action.

D. Structure and function of the Quality Management Programs.

1. General Provisions:
 - a. The committee chair will appoint committee members.
 - b. All committee meeting minutes will be completed and shared on OneDrive within seven (7) days.
 - c. With the exception of standing committee members, members will be appointed for a term of one (1) year and will serve until the end of that period unless the member's successor is appointed sooner. One-third of the appointed membership will turn over every year.
 - d. Any committee member may resign by submitting a letter of resignation to the director of clinical and correctional services.
 - e. Missing more than two (2) meetings per year may jeopardize appointed membership status on the committee.
 - f. If a member ceases to be a member in good standing because of, but not limited to, employment status, corrective/disciplinary action, professional standards review, or absenteeism, that member will be removed by the director of clinical and correctional services. The member will be notified in writing.
 - g. Written reports of committee activities will be provided by the committee chairs to the CCO or designee.
 - h. Decisions and recommendations are approved or denied by quorum.
 - i. Should more than one-third of the membership be absent at any committee meeting, the meeting will be adjourned and noted as such in the meeting minutes.
 - j. All committees will meet as specified below.
 - k. Ad hoc committee members will be assigned as needed.
2. Any information and/or documents utilized as part of the quality management review process are privileged and confidential. Any information derived from participation in the QMP is protected from subpoena, discovery, testimony, and further dissemination.
3. Under no circumstance will a committee member or other DOC employee or contract worker in good standing be subject to reprisal, retaliation, or performance documentation for participating in any quality management proceedings while acting in good faith and within the respective scope of their capacity.

E. QMP Committee:

1. The QMP committee will be composed of multi-disciplinary employees.
2. Committee membership will consist of the following standing members:
 - a. Director of clinical and correctional services (chair).
 - b. Chief of clinical operations (co-chair).
 - c. Inspector general.
 - d. Chief medical officer.
 - e. Chief of behavioral health.
 - f. Chief dentist.

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- g. Deputy director of prisons.
3. Appointed members will include:
 - a. HSA.
 - b. Healthcare practitioner.
 - c. Mental health professional.
4. The QMP committee will review reports based on severity code as outlined in the *Quality Management Program Flowchart* (attachment #3) The committee will meet monthly and will review level 3 quality occurrence cases to include the root cause analysis and all offender deaths.
5. The warden or designee from the appropriate facility will ensure all records pertaining to offender deaths are obtained and delivered to the committee chair within thirty (30) days of the offender's death.
6. Communication of committee decisions will be forwarded to the responsible HSA within ten (10) business days of the committee meeting.
7. The HSA will develop a plan of action to address committee decisions, which will be forwarded to the CCO or designee within ten (10) working days of notification with monthly updates thereafter until completion.
8. The QMP committee will oversee facility based CQI Committee processes and outcomes of CQI activities to ensure they are being conducted in the manner specified and within the specified timeframes.

F. Facility CQI Committees:

1. Facility CQI Committees will be composed of multi-disciplinary employees who will meet at a minimum of once per month or as indicated by the chair.
2. Committee membership will consist of the following standing members:
 - a. Facility HSA (chair).
 - b. Facility warden (co-chair).
 - c. Facility nurse supervisor.
3. Appointed members will include:
 - a. Healthcare practitioner.
 - b. Behavioral health supervisor.
 - c. At least one (1) representative from custody/control, food service, programs, and case management.
4. Meeting attendance is mandatory. Two-thirds of multi-discipline member attendance is required for decision-making purposes at every meeting. Should more than one-third of the membership be absent or the chair (or co-chair) at any committee meeting, the meeting will be adjourned and held at a later date within the mandated timeframe.
5. Proceedings of the committee meetings are confidential, and non-DOC committee members will sign the *Quality Management Program Confidentiality Statement* (attachment #2), annually. The completed forms will be maintained electronically on OneDrive by the committee chair.
6. Meetings focus on CQI, and infection control activities designed to improve facility operations related to patient care. Meeting minutes will contain information discussed to include, at a minimum, communicable disease statistical reports, management plan review, corrective action plan evaluation and follow-up, and round table discussions. Facility quarterly reports may also be discussed at this meeting.

G. Suicide Prevention Committee:

1. The Suicide Prevention Committee will meet at least quarterly to discuss suicide prevention strategies.
2. The committee will review all suicides within DOC facilities.
 - a. A Psychological Autopsy Report will be completed by the chief of behavioral health and will be included in the review process.
 - b. The results of each review, including the Psychological Autopsy Report, will be presented to the QMP committee by the chief of behavioral health.

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3. Committee membership will consist of the following standing members:
 - a. Chief of behavioral health (chair).
 - b. Chief medical officer (co-chair).
 - c. Director of Clinical and Correctional Services.
 - d. Chief of clinical operations.
 - e. Psychiatrist.
 - f. Deputy director of prisons.
4. Appointed members will include:
 - a. Health services administrators.
 - b. Behavioral health supervisors.
 - c. Mental health practitioner.

H. Infectious Disease Committee:

1. The Infectious Disease Committee will develop procedures to identify and assess infectious diseases and related health concerns. They will implement practices and procedures that reduce disease incidents, prevalence, and attenuation of health risks.
2. Committee membership will consist of the following standing members:
 - a. Chief medical officer (chair).
 - b. Infection control nurse (co-chair).
 - c. Director of Clinical and Correctional Services.
 - d. Chief of clinical operations.
3. Appointed members will include:
 - a. HSA.
 - b. Health care practitioner.
4. The Infectious Disease Committee will meet monthly.
5. The director of Clinical and Correctional Services or designee will also serve as the division liaison to the South Dakota Department of Health for reportable occurrences and joint projects related to quality control and/or infectious diseases.

V. RESPONSIBILITY

The director of Clinical and Correctional Services is responsible for reviewing this policy annually and updating it as necessary.

VI. AUTHORITY

- A. **SDCL § [36-4-26.1](#) Proceedings of peer review committees confidential and privileged--Availability to physician subject of proceedings.**

VII. HISTORY

March 2026

March 2025 – New policy

ATTACHMENTS

1. Quality Occurrence Reporting Form
2. Quality Management Program Confidentiality Statement
3. Quality Management Program Flowchart
4. Case Review Worksheet
5. Clinical Mortality Review

CLINICAL SERVICES QUALITY OCCURRENCE REPORTING FORM

Date of Report: _____

Facility of Occurrence: _____

Date of Occurrence: _____

Name of Reporter: _____

Title of Reporter: _____

Name of Offender Involved: _____

DOC Number: _____

Description of incidents and actions taken:

Name of the healthcare practitioner notified (if applicable): _____

Date and time the healthcare practitioner was notified: _____

Action taken by the healthcare practitioner:

Date this form was *emailed to the facility HSA* _____

CLINICAL SERVICES QUALITY MANAGEMENT PROGRAM CONFIDENTIALITY STATEMENT

The South Dakota Department of Corrections, Clinical Services Quality Management Program (QMP) was established to evaluate and improve patient care. I understand that any information related to the QMP and/or documents utilized as part of the quality management process are privileged and confidential. I also understand that any information derived from my participation in the QMP is protected from subpoena, discovery, testimony, and further dissemination.

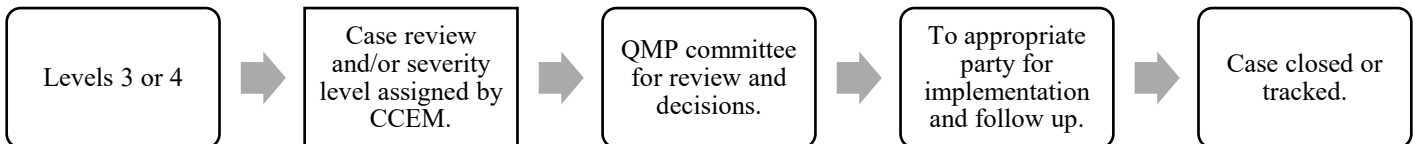
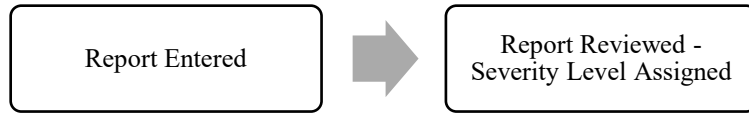
I will maintain the confidentiality of all quality management information related to specific QMP assigned duties, including but not limited to the tracking and trending of facility-specific quality occurrences and infectious disease reports, facility quality case reviews, quality audits, and/or peer reviews.

Name (Print) Title: _____

Name (Signature) Date: _____

Facility: _____

QUALITY MANAGEMENT PROGRAM FLOWCHART



CLINICAL SERVICES CASE REVIEW WORKSHEET

Problem Study/MAJOR SERVICE AREA REVIEW/Repeat study

~(FACILITY)~

~ AREA OF STUDY~

Associated ACA Standard

Initiation Date: / /

Completion Date:

PROBLEM/AREA OF REVIEW:

BASELINE STUDY:

The data or criteria that will be reviewed include:

- 1.
- 2.
- 3.
- 4.
- 5.

The threshold for compliance is set at ___%.

The results are as follows:

___ charts were audited.

The data shows that compliance of _____ is ___%.

This does/does not meet the threshold percentage.

CORRECTIVE PLAN OF ACTION (CPOA)

CLINICAL MORTALITY REVIEW

Name:		Date of Birth:	
Number:		Facility:	
BH Code:		Date of Report:	
Location of Incident:		Date and Time of Death:	

Medical Summary

Pre-Death Diagnosis:

Was Death Expected:

Medications:

Summary of Emergency Response:

Behavioral Health Summary

Mental Health Diagnoses (per most recent psychiatric provider notes):

Substance Use Disorder (SUD) Diagnoses (per most recent SUD assessment):

Psychotropic Medication:

Medication Management History:

Was the Patient on a Behavioral Management Plan:

Summary of Psychiatric Contact:

Summary of Behavioral Health Contact:

Past Suicide Attempts or Self-Harm Incidents Summary:

Behavioral Health Summation of Findings:

Health Services Administrator Summary

Autopsy Report Received:

Autopsy Report Attached:

Final Autopsy Diagnosis:

Could medical response at the time of death be improved upon?

If yes, how?

Was earlier intervention possible?

If yes, how?

Independent of cause of death, is there potential for improvement of patient care?

If yes, how?

Were there any system failures or potential problems with DOC staff and/or contractor response?

If yes, comments:

Are there any trends identified?

If yes, comments:

Clinical summary of findings:

Action plan:

Health Services Administrator Signature

Date