

# AMERICAN CORRECTIONAL ASSOCIATION

## Manual of Accreditation Policy and Procedure



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## FORWARD

Perhaps one of the American Correctional Association's greatest contributions to the field of corrections has been the development of a national accreditation process. ACA performance-based standards and expected practices address services, programs, and operations essential to effective correctional management. Through accreditation, an agency is able to provide an environment that safeguards the life, health, and safety of the public, staff and offenders while at the same time providing the necessary education, work, religious, and rehabilitative opportunities that enable an offender to prepare for successful reintegration into the community. Performance-based standards and expected practices set by ACA reflect best practices and current relevant policies and procedures and function as a management tool for over 1,300 correctional agencies in the United States.

This Accreditation Policy Manual is offered as a foundation of policy and procedure that will enable correctional programs to achieve their goals of providing the highest levels of effectiveness and efficiency while accomplishing proven and meaningful positive outcomes. It will provide guidance to participating programs, field auditors, and other interested parties.

We hope you find that this manual enhances the accreditation process while balancing the goals of integrity, consistency, excellence and most importantly achievability. Together we will further enhance and promote the integrity of our accreditation process and support corrections as an important profession and a bedrock of our democracy.

James A. Gondles Jr, CAE

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## I. Overview of the American Correctional Association

The American Correctional Association (ACA) is a professional membership organization composed of individuals, agencies and organizations involved in all facets of the corrections field, including adult and juvenile services, community corrections, probation and parole and jails. It has thousands of members in the United States, Canada and other nations, as well as over 100 chapters and affiliates representing states, professional specialties, or university criminal justice programs. For more than 150 years, ACA has been the driving force in establishing national correctional policies and advocating safe, humane and effective correctional operations. Today, ACA is the world-wide authority on correctional policy and standards, disseminating the latest information and advances to members, policymakers, individual correctional workers and departments of correction. ACA was founded in 1870 as the National Prison Association and became the American Prison Association in 1907.

At its first Congress of Corrections in Cincinnati, the assembly elected Rutherford B. Hayes, then governor of Ohio and later U.S. president, as the first president of the association. At that same meeting, a *Declaration of Principles* was developed, which became the accepted guidelines for corrections in the United States and Europe. At the 1954 annual Congress of Correction in Philadelphia, the name of the American Prison Association was changed to the American Correctional Association, reflecting the changing philosophy of corrections and its increasingly important role in society.

Since that time, ACA has continued to take a leadership role in corrections and work toward a professional unified voice in correctional policy. In recent years, one of the Association's major goals has been the development of national and international policies and resolutions of significant issues in corrections. Policies are considered for ratification at the Association's two annual conferences and ratified policies are then widely disseminated. Since its formation, ACA has also had a major role in designing professional traditional standards, and more recently performance-based standards and expected practices, for correctional organizations. Since the early 1980s ACA has been involved in a program of accreditation to recognize programs representing excellence in more than 20 different disciplines within the field, with emphasis on evidenced based practices.

The Association conducts research and evaluation activities, provides training and technical assistance, and carries out the regular responsibilities of any professional membership organization, including a full publications program. The Association's two annual conferences, held in varying cities across the nation, includes the participation of delegates and correctional practitioners from the 50 states, U.S. territories, and several foreign countries.

Membership in ACA is open to any individual, agency, or organization interested in corrections and the purposes and objectives of the Association. Members include the majority of state, local, provincial, and territorial correctional agencies, individual correctional institutions, local jails, pretrial programs and agencies, juvenile justice programs, schools of criminal justice in colleges and universities, libraries, and various probation, parole, and correctional agencies. Many of ACA's members are employed at federal, military, private, state, and local agencies. Members also include volunteers affiliated with these agencies as service providers or as members of advisory boards and committees.

## II. Organizational Purposes of the American Correctional Association

Among the most significant purposes of the Association as outlined in its Constitution, are:

- *To provide a professional association of persons, agencies, and organizations, both public and private, who hold in common the goal of improving the profession of corrections and enhancing their contribution to that profession.*
- *To broaden and strengthen support for the Association's goals by advocating Association policies, resolutions, positions, and standards to policymakers and the public and by forming coalitions with other professional organizations sharing these goals.*
- *To develop standards for all areas of corrections and implement a system for accreditation for correctional programs, facilities and agencies based on these standards. Where feasible, standards shall be based on performance outcome.*
- *To conduct or sponsor corrections conferences, congresses, institutes, forums, seminars and meetings.*
- *To publish and distribute journals and other informative materials relating to criminology, crime prevention, and corrections and to encourage and stimulate research of these matters.*
- *To promote recognition of corrections as a profession, and those who work in corrections as professionals, and to ensure validity of that recognition by encouraging the recruitment and development of highly qualified corrections professionals, and by developing and implementing a certification program for corrections professionals.*

In carrying out these purposes, ACA supports programs for policy analysis, demonstration, effective delivery of health services to offender populations and research. ACA also provides testimony, consultation, publications, conferences, workshops, and other activities designed to stimulate constructive action regarding correctional issues.

### **III. Overview of the Commission on Accreditation for Corrections**

The Commission on Accreditation for Corrections (CAC) is a private, nonprofit organization established in 1974 with the dual purpose of developing comprehensive, national standards for corrections and implementing a voluntary program of accreditation to measure compliance with those standards.

The Commission was originally developed as part of the American Correctional Association. In 1979, by joint agreement, the Commission separated from the Association in order to independently administer the accreditation program. Between 1978 and 1986, the organizations shared the responsibility for developing and approving standards and electing members of the Commission. On November 7, 1986, the Commission on Accreditation for Corrections officially realigned itself with the American Correctional Association.

The Commission is governed by a Board of Commissioners who reflect the Association's composition, including adult and juvenile components; the geographical distribution of its membership; and representation of ethnic and racial minorities, women, and management and non-management staff. The responsibility of rendering accreditation decisions rests solely with the Commission.

They represent the following specific categories:

Correctional Administration	Detention
Juvenile	Education
Institutions	Health Care
Probation	Legal
Parole, Aftercare or Post-Release	Architecture
Supervision	Non-correctional administration
Community Programs	

#### **IV. The Accreditation Process**

Perhaps ACA's greatest influence has been the development of a national accreditation process. ACA performance-based standards and expected practices address services, programs, and operations essential to effective correctional management. Through accreditation, an agency is able to provide an environment that safeguards the life, health, and safety of the public, staff and offenders while at the same time providing the necessary education, work, religious, and rehabilitative opportunities that enable an offender to prepare for successful reintegration into the community. Performance-based standards and expected practices set by ACA reflect best practices and current relevant policies and procedures and function as a management tool for over 1,300 correctional agencies in the United States and internationally.

The process leading to initial accreditation normally takes 12 to 18 months to complete. Accreditation is granted for a period of three years. Maintaining continuous accreditation and integrating the expected practices into the day-to-day operations of the facility is an ongoing task. Regardless of the type of program or facility involved, the process remains constant. The basic timelines, requirements, and outcomes of the process are the same for all agencies and programs participating in the accreditation process. All programs and facilities sign a contract, prepare a self-evaluation report, and are audited by independent corrections professionals.

The accreditation process requires both effort and commitment from agency staff. The benefits to an agency are proportionate to the agency's commitment to incorporate the process into its daily management and operation. It is not just achieving accreditation, but also maintaining accreditation that attests to the agency's genuine application of the expectations of the accreditation manual, throughout its operation. Some of the benefits include:

- ✓ Safeguarding the life, health, and safety of the public, staff, and offenders.
- ✓ Providing a systematic evaluation of all areas of agency administration and operation.
- ✓ Improving management through the creation or refinement of written policies and procedures for all areas of agency operation.
- ✓ Providing all staff the opportunity to work together to assess needs and develop solutions.
- ✓ Providing evidence demonstrating compliance with exemplary practices for correctional agencies.
- ✓ Giving recognition for achievement, improving staff morale, and demonstrating accountability to the public.
- ✓ Aiding in the defense of potential lawsuits.
- ✓ Improving outcomes for strategies to successfully reintegrate offenders back into society.
- ✓ Identifying strengths, as well as weaknesses, on an ongoing basis.

## **Performance-Based Standards and Expected Practices Accreditation Department**

Accreditation activities are supported by the staff of the American Correctional Association's Performance-Based Standards and Expected Practices Accreditation Department, under the leadership of the Director of the department. This team is responsible for the daily operation of the accreditation program. Agencies involved in the accreditation process have contact primarily with the Accreditation Specialist assigned responsibility for their state or agency. Contact information for the Performance-Based Standards and Expected Practices Accreditation Department staff can be found at [www.aca.org](http://www.aca.org).

### **Auditors**

Auditors are corrections professionals who have been selected, trained, and certified by the Association. These individuals perform the field work for the Association which includes providing assistance to agencies working toward accreditation and conducting on-site audits of agencies to assess compliance with program requirements. In certain cases, when the Commission believes it necessary, they monitor agencies to ensure maintenance of the conditions required for accreditation. Teams of auditors, referred to as Visiting Committees, are formed to conduct compliance audits of agencies seeking accreditation and reaccreditation.

Auditors are recruited through announcements in prominent criminal justice publications, online and at major correctional meetings. Affirmative action and equal employment opportunity requirements and guidelines are followed in the recruitment of auditors. All auditors have a minimum of five years of corrections experience, worked at an accredited facility/agency, have received a recommendation from an agency administrator, successfully complete new auditor training (classroom and practicum), and have demonstrated knowledge in the substantive area(s) in which they are engaged to assist the Association. In addition, all auditors participate in an ACA sanctioned training every three years (check out [www.aca.org](http://www.aca.org) for details on training dates and times) and be members of the ACA in good standing. All auditors are approved by ACA.

### **Performance-Based Accreditation Model Development**

Development of the traditional ACA standards began in 1974 with an extensive program of drafting, field testing, revising, and approving them for application to all areas of corrections. Since then; local, state, national and international correctional facilities and programs have adopted the traditional standards, performance standards, and expected practices as outlined in ACA's accreditation manuals, for implementation through accreditation.

Steps are taken to ensure that accreditation manuals' development efforts reflect the best judgment of corrections professionals regarding good corrections practice. Traditional standards, performance standards, and expected practices endeavor to be clear, relevant, and comprehensive. The development and approval process for traditional standards, performance standards, and expected practices has involved participation by a wide range of concerned individuals and organizations and over twenty accreditation manuals are now used in the accreditation process:

*Performance-Based Standards and Expected Practices for Adult Correctional Institutions – Fifth Edition*  
*Performance-Based Core Jail Standards-First Edition*  
*Performance-Based International Correctional Core Standards- Adult – First Edition*  
*Performance-Based International Correctional Core Standards- Juvenile – First Edition*  
*Performance-Based International Correctional Core Standards- Mexico – First Edition*  
*Performance-Based Standards for Adult Community Residential Services –Fourth Edition*  
*Performance-Based Standards for Adult Local Detention Facilities – Fourth Edition*  
*Performance-Based Standards for Adult Probation and Parole Field Services-Fourth Edition*  
*Performance-Based Standards for Correctional Industries – Second Edition*  
*Performance-Based Standards for Juvenile Correctional Facilities -- Second Edition*  
*Performance-Based Standards for Therapeutic Communities – First Edition*  
*Performance-Based Health Care Standards for Adult Correctional Institutions – First Edition*  
*Performance-Based Health Care Standards for Adult Local Detention Facilities*  
*Performance-Based Health Care Standards for Juvenile Correctional Facilities, 4<sup>th</sup> Edition*  
*Standards for Administration of Correctional Agencies - Second Edition*  
*Standards for Adult Correctional Boot Camps Programs – First Edition*  
*Standards for Adult Correctional Institutions –Fourth Edition*  
*Standards for Adult Parole Authorities - Second Edition*  
*Standards for Correctional Training Academies – First Edition*  
*Standards for Electronic Monitoring Programs – First Edition*  
*Standards for Food Service Programs - First Edition*  
*Standards for Juvenile Community Residential Facilities –Third Edition*  
*Standards for Juvenile Correctional Boot Camps - First Edition*  
*Standards for Juvenile Day Treatment Programs - First Edition*  
*Standards for Juvenile Detention Facilities –Third Edition*  
*Standards for Juvenile Probation and Aftercare Services –Second Edition*  
*Standards for Small Juvenile Detention Facilities – First Edition*

In January 1996, ACA’s Standards Committee (known today as the Performance Standards Committee) adopted innovative new guidelines for the development of *performance-based* professional standards. In August 1996, ACA President Bobbie Huskey published an article “Measuring Performance: ACA’s New Paradigm in the Making,” in *Corrections Today* which suggested that moving toward performance measurement required “a fundamental shift in thinking” for the field.

Without exception, the drafters of the new performance-based model found that all prior traditional standards described *activities* or *expected practices* that were prescribed for practitioners. The performance-based model, they believed, should emphasize *conditions* to be achieved and maintained.

In August 2000, in San Antonio, Texas, the Performance Standards Committee adopted the Adult Community Residential Services Performance-Based Accreditation manual. For two decades, the ACA has been engaged in the transition of the traditional standards and accreditation system from one that has been focused on the evaluation of acceptable practices from the perspective of process evaluation to one that is fundamentally linked to the measurement of outcomes resulting from the adoption of professional practices. This evolution evolves from the recognition that the

measurement of the successful completion of a process or activity is not sufficient for accreditation purposes. The process must also evaluate and measure the results, the outcomes, of such practices.

To that end, involvement in accreditation now requires an understanding of general “performance standards” and the definition of expected practices and specific measurable outcomes associated with them. This is the foundation of the transition to the performance-based model.

The performance-based accreditation formats flow from the traditional format. A comparison of the general structure of the traditional 4th edition Adult Correctional Institution manual and the 5th edition Performance-Based Accreditation Manual for Adult Correctional Institution serves as an illustration of this.

In summary, the traditional accreditation process and the performance-based accreditation process are distinguished in structure as highlighted in the following example:

<b>Organization of Manuals</b>	
<b>Traditional</b> <small>(i.e.: Adult Correctional Institutions – 4<sup>th</sup> Edition)</small>	<b>Performance-Based Manual</b> <small>(i.e.: Performance-Based Standards and Expected Practices for Adult Correctional Institutions)</small>
<b>Five (5) Parts:</b> I. Administration and Management II. Physical Plant III. Institutional Operations IV. Institutional Services V. Offender Programs	<b>Seven (7) Parts:</b> I. Administration and Management II. Physical Plant III. Institutional Operation IV. Special Management Housing and Restrictive Housing V. Institutional Services VI. Health Care VII. Inmate Programs
-----	7 Goals
32 Sections 32 Principles	37 Sections 37 Performance Standards 37 Sets of Outcome Measures
62 Mandatory Traditional Standards	64 Mandatory Expected Practices
459 Non-Mandatory Traditional Standards	515 Non-Mandatory Expected Practices
521 Total Traditional Standards	579 Total Expected Practices

**FOR THE PURPOSES OF THIS MANUAL, THE USE OF THE TERMINOLOGY “EXPECTED PRACTICE(S)” WILL ENCOMPASS BOTH WHAT HAS HISTORICALLY BEEN REFERRED TO AS “STANDARDS” OR “TRADITIONAL STANDARDS” AS WELL AS THE NEW “EXPECTED PRACTICES.”**

The term “performance-based standard” or “performance standard” is not the equivalent of the traditional term “standard”. The traditional “standard” is replaced by “expected practice” in the performance-based system and has no further utilization in the new performance-based system.

In the traditional accreditation process, validation of compliance with the standards was accomplished through the generation and organization of primary and secondary documentation. The equivalent system exists in the performance-based system except that primary documentation has been renamed “protocols” and secondary documentation has been renamed “process indicators”. Primary and secondary documentation, now termed protocols and process indicators comprise the essential elements of the performance-based compliance file from the agency/program perspective. The concept and documentation of protocols is identical to that of the traditional manual’s primary documentation. The concept and documentation of process indicators is identical to that of the traditional manual’s secondary documentation.

Through this transition, the accreditation process establishes clear goals and objectives critical to the provision of safe, constitutional, effective and humane correctional programs and services. Accreditation addresses services, programs, and operations essential to good correctional practice, including safety, security, order, care, programming, justice and administration and management.

The performance-based standards and expected practices are systematically revised and new performance-based standards and expected practices considered, to keep pace with the evolution of correctional practices and law and performance benchmarks. After careful examination, the ACA Performance Standards Committee determines revisions and updates as necessary.

Suggestions and proposals for revisions to the performance standards or expected practices from the field and interested others are encouraged. The Performance Standards Committee meets before each ACA Conference to review proposed performance-based standards and expected practices, (as well as traditional standards not yet converted to the performance-based model). Proposals from the field should be submitted via the ACA website at [www.aca.org](http://www.aca.org). The portal is opened for submissions approximately four months prior to the next scheduled ACA Conference and remains open for at least four weeks. The portal is then closed and the submitted revisions are formatted appropriately. They are then posted on the ACA website, at [www.aca.org](http://www.aca.org), for the field to comment on for a period of four weeks after which the submissions and comments are taken down and compiled for the Performance Standards Committee’s consideration at the upcoming conference. The minutes from the Committee are posted on the ACA website within four weeks of the end of the conference.

These changes are published by ACA through revision to appropriate agency accreditation manuals as necessary upon the conclusion of semi-annual meetings of the Performance Standards Committee. Agencies are responsible for compliance with the expected practices listed in the applicable manual. New or revised standards following each Performance Standards Committee will list the date it was approved by the Performance Standards Committee, and the date the expected practice will be applicable to be audited for the first time. However, agencies may choose to apply new changes to the expected practices earlier than the date listed. Example is listed below demonstrates the expected practice was approved in August 2018, and will be audited the first time NLT October 1, 2020. Depending on your audit, you may only have one, two, or three years of process indicators.

NEW August 2018; 5-ACI-4B-04 (Effective NLT October 1, 2020) Restrictive Housing units provide living conditions that approximate those of the general inmate population; all exceptions are clearly documented. Restrictive Housing cells permit the inmates assigned to them to converse with and be observed by staff members. Space is available either inside the Restrictive Housing unit or external to the unit for treatment staff consultation with Restrictive Housing inmates

The discussion or comment that follows most of the expected practices is designed to clarify the expectations, provide guidance as to the intent of the language, and offer information that might be used in implementing the expected practice. The agency is *not* held accountable for meeting conditions or suggestions contained in the comment section of an expected practice. In Performance-Based Accreditation manuals, there are protocols and process indicators suggested for many expected practices. These are examples of what may be used to document compliance and should not be considered all encompassing.

Each expected practice has a weight of mandatory or non-mandatory. Mandatory expected practices address conditions or situations that affect the life, health, and safety of the public, staff, and offenders. One hundred percent of the applicable mandatory expected practices must be met at the time of the audit with sufficient documentation to illustrate compliance for an agency to become accredited. Agencies must also meet ninety percent of applicable non-mandatory expected practices. However, when less than 100% compliance is attained, a Plan of Action to come into compliance with an applicable non-mandatory expected practice found noncompliant must be submitted, except where the agency is requesting a Waiver as noted below.

If a Plan of Action is not feasible, the agency may request consideration for a Waiver (to the requirement to submit a Plan of Action) or an Appeal. The ultimate goal is to achieve 100% compliance with all applicable mandatory as well as all applicable non-mandatory expected practices for which a Waiver has not been granted.

For every expected practice in the manual, the agency must reach a conclusion about applicability and compliance. The agency must meet every element of the expected practice in order for the expected practice to be considered compliant in the compliance tally. Most expected practices require evidence of written policy and procedure and documentation demonstrating implementation and practice.

### **Accountability**

The Performance-Based Standards and Expected Practices Accreditation Department requires that agencies post public notices (refer to Appendix B) of the approaching compliance audit, inviting submission of written comments and information about the program from staff, offenders and the public.

All agencies are also required to provide to ACA information about significant judicial activity effecting any aspect of their accreditation including court orders, consent decrees, or other significant litigation or pending litigation concerning the facility or agency.

Copies of the relevant correspondence or other information may be provided to Visiting Committee members for review before the visit to the agency.

Efforts to promote accountability and openness can be enhanced by the agency. When an agency is made aware of media interest in a program involved in the accreditation process, the Performance-Based Standards and Expected Practices Accreditation Department staff request that they be contacted and kept informed. An agency may invite media representatives or other outside parties to the audit exit interview.

### **Confidentiality**

While working to increase openness and accountability, the Association maintains strict requirements for protecting the confidentiality of agencies in the process. In speaking with media representatives, the Association provides information only about the process and application of expected practices for a particular program or institution. This might include an explanation of the requirements of the self-evaluation process, audit policies and procedures, dates and activities of the audit, the reporting process following the conclusion of the audit, the role of the Visiting Committee, and the hearing process.

The Association does not disclose to external parties specific information contained in the agency's self-evaluation report, Visiting Committee Report (VCR), or information discussed in the hearing. The Association does, however, encourage all participating agencies to provide information to the media about their accreditation activities.

### **Eligibility Criteria**

The following conditions must be satisfied prior to an agency's acceptance into the accreditation process. The agency:

- ✓ holds under confinement pre-trial or pre-sentenced adults or juveniles who are being held pending a hearing for alleged unlawful activity
- ✓ holds under confinement convicted adult offenders or juveniles adjudicated delinquent
- ✓ supervises, in the community, adult or juvenile offenders in residential or non-residential settings
- ✓ has a single administrative officer responsible for agency operations
- ✓ does not confine adults and juveniles together in residential and institutional programs

In reviewing agency eligibility, consideration must be given to ACA's active support of the exclusion of juvenile status offenders from the criminal and juvenile justice systems. Status offenders should not typically be confined in juvenile detention facilities or secure correctional facilities.

ACA supports through its policies and its expected practices, the maintenance of sight and sound separation in residential programs between adult and youthful offenders and between delinquent and status offenders.

*The following interpretations are important relative to the accreditation process and are offered for guidance:*

- *Juvenile status offender: a juvenile under the age of criminal majority in a jurisdiction who has not been accused of an offense that would be a crime if he/she were an adult.*
- *Juvenile delinquent offender: a juvenile under the age of criminal majority in a jurisdiction who has been accused of or adjudicated delinquent for an offense that would be a crime if he/she were an adult.*

*The individual's supervision in the justice system is under the umbrella of a juvenile or family court or a court exercising juvenile or family court jurisdiction.*

- *Youthful offender: an individual under the age of criminal majority in a jurisdiction who has been transferred to the adult criminal justice system for treatment as an adult based upon the nature of his/her crime as articulated in the laws of the jurisdiction concerned. (Youthful offenders should receive specialized programming in the adult correctional system.)*
- *Adult offender: an individual of the age of criminal majority in a jurisdiction who violates or is accused of violating the criminal code of said jurisdiction.*

## **Application Process**

The process usually begins with an agency contacting ACA with inquiries about the accreditation process. This initial contact involves an exchange of information and materials.

During this phase of the process, the Accreditation Specialist at ACA and the agency review the elements of the process and work jointly to:

- ✓ Confirm agency satisfaction of eligibility criteria
- ✓ Identify the appropriate accreditation manual (or combination of manuals) for application in the process
- ✓ Determine fees
- ✓ Review the contract and confirm jointly the terms of the agreements, including services provided and the start-up date

In order to complete these tasks, application materials provided to the agency include:

- ✓ Informational material about the expected practices and the process
- ✓ The appropriate accreditation manual for the agency (initial audit only)
- ✓ A contract, which sets out tasks and responsibilities of the agency and the Association, time frames, and fee schedules
- ✓ An Organization Summary to obtain descriptive information about the agency, which is completed by the agency and returned to the Performance-Based Standards and Expected Practices Accreditation Department with the signed contract (Appendix C)

The process formally begins when the agency returns both the completed Organization Summary

and the signed contract. The Accreditation Specialist is a liaison to the agency and is responsible for maintaining contact with the agency, providing assistance, and monitoring the agency's progress. The agency may request assistance through the Accreditation Specialist at any time, and is encouraged to do so, in order to clarify expected practice requirements. The agency may also request on-site technical assistance. The cost of the on-site technical assistance visit is the responsibility of the agency and generally reflects the cost to ACA to conduct the technical assistance visit.

### **Selecting the Appropriate Accreditation Manual**

As noted earlier, the Performance-Based Standards and Expected Practices Accreditation Department has developed and published accreditation manuals of expected practices that address different types of correctional agencies. Some correctional agencies operate with a combination of missions or serve a special function and therefore, cannot be accredited using one manual alone.

The decision to use a combination of accreditation manuals is based on an examination of the offender population, the mission of the program or facility, and approval by the Director of Performance-Based Standards and Expected Practices Accreditation Department.

### **Fees**

Fees are determined during the application period and are included in the contract signed by the agency and the Association. As delineated in the contract, the fees cover all services normally provided to an agency by Performance-Based Standards and Expected Practices Accreditation Department staff, auditors, and the Commission. The costs of orientation training, technical assistance visits, and monitoring visits if required, are in addition to the basic fees. All fees must be paid in full in order to receive a Certificate of Accreditation.

### **Agency Withdrawal**

An agency that no longer wishes to pursue accreditation may withdraw from the process through formal notification in writing to Performance-Based Standards and Expected Practices Accreditation Department staff. Fees paid to the Association are not refundable.

## V. The Pre-Audit Process

### Agency Organization and Activities

When the process has formally begun, the Performance-Based Standards and Expected Practices Accreditation Department is in receipt of a signed contract and completed organization summary, agency activities then include:

- ✓ *Agency Organization:* In order to ensure that the necessary time and resources are committed to prepare for involvement in the process, the agency assigns an Accreditation Manager, provide training for staff, and develop and implement a process work plan.
- ✓ *Assessing Compliance:* Self-evaluation activities entail reviewing expected practices, agency operations, and policies and procedures to assess compliance levels, identifying activities necessary to meet the requirements of the process, and completing the self-evaluation report. While all of the steps in seeking accreditation are important, the self-evaluation part of the process is of great value to ensuring a successful outcome.
- ✓ *Working Toward Compliance:* Preparation for an audit involves developing and implementing policies and procedures to ensure operations are consistent with expected practices, conducting staff training, making physical plant improvements, completing satisfactory inspections by independent safety and sanitation authorities, and preparing documentation and materials to demonstrate compliance.

### The Accreditation Manager

It is essential that the agency and its leadership commit the necessary time and resources to the accreditation process. This includes assignment of an Accreditation Manager who has the full cooperation and support of the agency administrator. The Accreditation Manager develops a realistic plan of activities and staff assignments leading to the completion of the self-evaluation report and other related tasks. The Accreditation Manager also organizes agency resources and activities and serves as the agency's primary contact with the Performance-Based Standards and Expected Practices Accreditation Department. The Accreditation Manager is responsible for ensuring that agency staff receives an orientation to the process. It cannot be overemphasized that all agency staff need to be provided an orientation to the process. This training may be conducted by either Performance-Based Standards and Expected Practices Accreditation Department staff or the Accreditation Manager or other designee. The Accreditation Manager is typically responsible for the following:

- ✓ maintaining an internal information exchange to ensure that agency staff are provided with timely responses to inquiries about the expected practices, as well as the process
- ✓ arranging and coordinating visits to the agency by auditors for technical assistance, compliance audits, re-audits, and monitoring visits

- ✓ preparing and submitting correspondence and reports to the Performance-Based Standards and Expected Practices Accreditation Department within designated time frames, including final organization summary and preparation of the self-evaluation report (initial audits only), annual reports, and other documents requested
- ✓ representing the agency at the panel hearing
- ✓ providing input in the development and revision of accreditation policies and procedures, as well as the expected practices, when requested by the Performance-Based Standards and Expected Practices Accreditation Department

Agencies having several facilities/programs in the process may also have an Accreditation Manager in the central office who acts as the liaison between the programs in the system and the Accreditation Specialist.

The Accreditation Manager prepares and supervises the implementation of a work plan for accomplishing tasks required to achieve and maintain accreditation. This plan identifies agency staff that will be responsible for performing specific tasks and the dates for completing those tasks.

### **Orientation for Agency Personnel**

Each agency should have an orientation and training process for its staff. The training program for those who will directly participate in the accreditation activities should focus on the specific requirements of the agency for successfully completing the self-evaluation phase.

The curriculum should address the following subjects in detail:

- ✓ background and organization of the Association
- ✓ expected practices development and revision process
- ✓ introduction to the accreditation process
- ✓ benefits of the process
- ✓ agency self-evaluation activities, including the organization of resources and staff assignments to the accreditation team and review committee
- ✓ procedures and requirements of preparing the self-evaluation report
- ✓ documentation requirements and procedures
- ✓ audit procedures
- ✓ compliance maintenance procedures

### **The Work Plan**

The agency's activities during the self-evaluation process focus on rating their performance against the expected practices and accumulating documentation to demonstrate compliance. An initial step in the process is the development of a work plan by the agency that provides a structure for accomplishing these activities. The plan should include the following elements:

- ✓ identification of agency needs and specific tasks and resources required to conduct the self-evaluation and bring the agency into compliance with the expected practices
- ✓ staff training, including orientation and periodic sessions to communicate Association

- policies, expected practices interpretations, and different phases of the process
- ✓ plans for communicating accreditation activities
  - ✓ a schedule for task completion
  - ✓ a compliance maintenance system for staff to incorporate into the process, including methods for updating documentation and the development of policies, procedures, and regulations
  - ✓ plans for conducting internal reviews and a mock audit
  - ✓ a method for collecting data relevant to the significant incident summary and applicable outcome measures.

Agencies should establish an accreditation office and arrange logistical support for the program. This includes setting up and ensuring security of the files. The Accreditation Manager may assemble an accreditation team composed of staff members who will be responsible for determining compliance with specific chapters of the accreditation manual, compiling documentation, developing policies and procedures, overseeing implementation of the expected practices, record keeping, and preparing responses to non-compliant expected practices, when appropriate.

There should be an internal review process established to assess the adequacy of the documentation and other accreditation material.

The Accreditation Manager develops and maintains a regular meeting and review schedule for staff involved in the process. Meetings are held for staff to report on their progress, review problem areas, and indicate when outside assistance may be needed to clarify expected practices, or accreditation policy and procedure. In addition, the agency may call on outside specialists, such as the fire marshal, fiscal auditors, medical staff, and staff attorneys, to assist in preparing expected practices compliance documentation. The Accreditation Manager must ensure there is open communication on a regular basis from the agency administrator to line staff, stressing support and expectations for the process.

### **Performance-Based Outcome Measures**

Outcome measures, an integral part of the new Performance-Based Manuals and performance standard evolution, are quantifiable measurable events, occurrences, conditions, behaviors, or attitudes demonstrating the extent to which the conditions described in the corresponding performance standard have been achieved. Outcome measures describe the consequences of the organization's activities, rather than describing the activities themselves. Applicable Outcome Measures Worksheets must be completed. Outcome measures will enable administrators and practitioners to not only monitor activities but also to measure over time the outcomes of their effort. Applicable outcome measures for all accreditation programs will be developed as the transition process continues.

A process to collect applicable outcome measure data must be developed by the agency upon contract initiation. Outcome measure data should then be continuously collected and calculated on an annual basis. Agencies undergoing an initial accreditation will have the required information entered and calculated on the worksheet and available to the Visiting Committee for the period from the development of the outcome measurement process to the initial audit. After the initial audit, agencies submit completed Outcome Measure Worksheets to the Performance-Based Standards and Expected Practices Accreditation Department with the required annual reports. No annual report is required the year of the audit unless directed otherwise by the Performance-Based Standards and Expected Practices Accreditation Department.

The completed outcome measures worksheets for the three-year period between audits will be submitted to and reviewed by the Visiting Committee during the facility reaccreditation audit. All worksheets will be included in the final VCR submitted to the Commission on Accreditation for review. (The facility should supply the audit chair with the Outcome Measures Worksheets in an appropriate electronic (Word or Excel) format for inclusion in the audit report.)

Outcome measures are developed and published by ACA's Performance-Based Standards and Expected Practices Accreditation Department Staff with input from multiple fields, research, and other external resources.

### **Significant Incident Summary**

Enclosed with the audit materials is a form entitled Significant Incident Summary (Appendix G). The form requires information regarding assaults, escapes, disturbances and other significant events. The information must be provided for the *12 months* preceding the initial audit and annually thereafter with the exception of the year of your audit or directed otherwise by ACA staff. The Significant Incident Summaries are provided to the Visiting Committee and included in the final audit report submitted to the Commission on Accreditation for Corrections. The audit chair should summarize the significant incident summaries in the final audit report. (The facility should supply the audit chair with the Significant Incident Summary in an appropriate electronic (Word) format for inclusion in the audit report.)

The formal time period for reaccreditation data collection is at the discretion of the agency/program, as long as the entire audit cycle is included. The relevant time period for the initial audit data collection is variable depending on the expected practice and the program data collection criteria and initiatives.

## VI. Developing Documentation

In order to substantiate a finding of compliance with an expected practice, the agency must be able to demonstrate to the Visiting Committee that it is in compliance with *all* parts of the expected practice at *all* times. This is accomplished through presentation of written/electronic documentation, interviews with staff and offenders, and observations which clearly demonstrate that the agency is meeting the requirements of the expected practice. It is perhaps the most time consuming and demanding aspect of the process for the agency.

The agency must initially have documentation to demonstrate continuous compliance from the point of the development of the expected practice process indicators in audit preparation to the time of the initial audit. Thereafter, compliance documentation must be maintained to demonstrate continuous compliance during the prior three-year audit cycle.

Documentation should directly relate to the expected practice. It is the expected practice, not the discussion or comment of the expected practice, upon which the agency is audited and a compliance decision is made.

There are several methods of determining compliance:

- ✓ Written/electronic documentation, which includes, but is not limited to, policies, procedures, records, forms, and/or logs
- ✓ Photographs
- ✓ interviews with staff and offenders
- ✓ observation or sight confirmation

The members of the Visiting Committee depend on all of these methods when they visit the agency to conduct the audit. Verbal reports alone are never sufficient to support compliance.

The Performance-Based Standards and Expected Practices Accreditation Department distinguishes between two categories of documentation:

- ✓ *Protocols* (Primary Documentation) are the written guideline specifying what will be done and how it will be accomplished. This is generally provided in agency policies and procedures.
- ✓ *Process Indicators* (Secondary Documentation) are the material that demonstrates written policies and procedures have been implemented. In order to show compliance, there must be evidence that what is required is actually being accomplished through facility practice. This type of documentation is generally drawn from agency logs, records, photographs, and routine reports and may be supplemented by sight confirmation.

Questions related to applicable process indicators supporting compliance should be directed to the Performance-Based Standards and Expected Practices Accreditation Department.

## **Setting up Files**

In preparing for a compliance audit, documentation is compiled for each expected practice. The documentation materials contained in the files are organized in a logical sequence. The Compliance File Documentation Guide (Appendix A) provides more specific direction regarding file documentation.

## **Compliance Checklists**

For each expected practice file, there is a compliance checklist page that must be included in the front of every file. (Appendix D). Information recorded by the agency on the checklist includes:

- ✓ Determination of applicability, compliance, non-compliance.
- ✓ List of documentation to support compliance, justification for findings of non-applicability, or explanation of non-compliance
- ✓ Signature of the individual(s) responsible for determining compliance and compiling documentation

The agency completes the left side of the checklist for every expected practice ensuring that all of the required information is provided. Guidelines for conducting the assessment, preparing documentation, or submitting Plans of Action or requests for a Waiver of the requirement that plans of action be submitted are contained in later sections of this manual. During the compliance audit, Visiting Committee members will complete the right side of the checklists and forward the checklists for non-compliant and non-applicable expected practice to the Performance-Based Standards and Expected Practices Accreditation Department staff for inclusion in the VCR. Agencies should ensure they make copies of those checklists for their own records prior to the conclusion of the Visiting Committee's compliance audit.

## **Protocols**

It is not necessary to place an entire document or policy in a file. Copies of operational manuals, classification manuals, personnel manuals, or other similar types of manuals, while they should be made available to the Visiting Committee, do not need to be copied in its entirety to support compliance with each and every expected practice in a particular chapter. Relevant pages of the manual that relate to a specific expected practice(s) should be placed in the file, or these manuals may be referenced and made available for an auditor's inspection. All pertinent paragraphs/sections of a document or policy that are placed in the file shall be highlighted for easy reference. It is emphasized that areas being highlighted should pertain to the expected practice being reviewed and not the discussion/comments.

## **Process Indicators**

Compliance files must include examples of supporting documentation for each year being audited; (initial audits require documentation as available for each expected practice at the time of the audit; re-accreditation audits require three years of documentation and should begin with the month of their last Visiting Committee audit). Additional documentation should be readily available for the Visiting Committee review upon their request.

Only materials that demonstrate compliance are included or referenced in the file. Irrelevant or extraneous material that, while related to the expected practice, does not prove compliance, should not be included.

The documentation files must be kept current. A system for continuous updating should be established and those staff members responsible for compiling files should be responsible for updating them.

Documentation periods for a file are not based solely on calendar years or fiscal years, but rather must include data from audit cycle to audit cycle. For example, a facility undergoing reaccreditation should document the file from the time period beginning with the month of their last Visiting Committee audit. While documentation created by calendar or fiscal year is acceptable, the file make-up of supporting documentation for a reaccreditation audit cycle must include the three-year period beginning with the month of the last Visiting Committee audit.

### **Application of Revised Expected Practices**

The expected practices are under continuous quality review and are subject to revision by the Performance Standards Committee as necessary. Changes to performance-based standards and expected practices are published by ACA through revision to appropriate agency accreditation manuals upon the conclusion of semi-annual meetings of the Performance Standards Committee.

Agencies are responsible for compliance with the expected practices listed in the applicable manual. New or revised standards following each Performance Standards Committee will list the date it was approved by the Performance Standards Committee, and the date the expected practice will be applicable to be audited for the first time. However, agencies may choose to apply new changes to the expected practices earlier than the date listed. Example is listed below demonstrates the expected practice was approved in August 2018, and will be audited the first time NLT October 1, 2020. Depending on your audit, you may only have one, two, or three years of process indicators.

NEW August 2018; 5-ACI-4B-04 (Effective NLT October 1, 2020) Restrictive Housing units provide living conditions that approximate those of the general inmate population; all exceptions are clearly documented. Restrictive Housing cells permit the inmates assigned to them to converse with and be observed by staff members. Space is available either inside the Restrictive Housing unit or external to the unit for treatment staff consultation with Restrictive Housing inmates

### **Non-applicable Expected Practices**

A non-applicable response means that the expected practice is clearly not relevant to the program being audited. A written statement supporting the non-applicability is required and should be signed by the agency administrator. The statement can be in memorandum format or noted on the compliance checklist.

For example, if an expected practice applies to female health care and the agency being audited provides services only for males, the expected practice is non-applicable.

Agency compliance percentages are calculated based on the number of applicable expected

practices. The number of non-applicable expected practices is subtracted from the total number that the agency is required to meet. The number found in non-compliance is subtracted from the number that are applicable. The number of expected practices in compliance is divided by the number that are applicable, and that equals the percentage of compliance.

## VII. Technical Assistance

While preparing for the audit, the agency may require clarification of policy and procedure, assistance in determining the applicability of particular expected practices to their program, or interpretations to clarify the meaning and intent of individual expected practices. When technical assistance or guidance is needed, the Accreditation Manager contacts the agency's assigned Accreditation Specialist at ACA to discuss the issue(s). Confusion or uncertainty about policies and procedures often can be alleviated by a telephone conversation or e-mail exchange. Written confirmation of agreements or decisions made by Performance-Based Standards and Expected Practices Accreditation Department staff and the agency is appropriate and generally may be accomplished via email.

In addition to assistance available from staff through an exchange of correspondence, information, and telephone contacts, the Performance-Based Standards and Expected Practices Accreditation Department is able to provide on-site assistance to agencies. This is at the request of the agency and the costs must be assumed by the agency. This assistance entails a visit by a staff member or auditor to an individual facility or program. The purpose of the visit is to provide assistance to the agency in conducting its self-evaluation and preparing compliance documentation. Technical Assistance Visits are encouraged for agencies seeking initial accreditation.

At an agency's request, the Performance-Based Standards and Expected Practices Accreditation Department arranges for an auditor to provide on-site assistance in one or more of the following areas:

- ✓ explanation of policy and procedure, including audit preparations
- ✓ interpretation of the applicability of expected practices to specific areas of concern
- ✓ evaluation of the appropriateness and thoroughness of documents to support compliance

A Technical Assistance Visit typically encompasses a review of selected expected practices, including all mandatory expected practices and documentation prepared by the agency. During the review, the auditor looks for the appropriate application to the agency and addresses organization and completeness of documentation files to ensure that the necessary types of documentation are provided. For residential programs, the auditor tours the facility, checking agency practices for regular physical plant maintenance, facility sanitation and cleanliness, and to determine if the necessary provisions are in place for fire safety as required by the expected practice. For example, the auditor may look for the proper storage and control of flammable, toxic, and caustic substances, upkeep on major appliances and machinery, and the currency of inspection reports by the appropriate authorities. Finally, the auditor reviews policy and procedure and advises the agency of what to expect during the compliance audit.

The determination of need for a Technical Assistance Visit is generally made after the agency has started its self-evaluation. Performance-Based Standards and Expected Practices Accreditation Department staff assist the agency in assessing the need for a visit. If a visit is agreed upon, the activities and schedule are set. The Accreditation Specialist assigned to the agency coordinates the visit.

Transportation and lodging arrangements are handled in the same fashion as for other Association visits. The cost of the Technical Assistance Visit is in addition to the basic accreditation fee.

Details of the technical assistance visit findings are included in a written report submitted to the Performance-Based Standards and Expected Practices Accreditation Department at the conclusion of the visit. The contents of the report vary according to the agency's specific needs; however, the report usually covers the following:

- ✓ names and positions of participants
- ✓ evaluation of compliance with mandatory expected practices
- ✓ general and/or specific physical plant problems related to the expected practices
- ✓ problems regarding expected practice interpretations and/or policy and procedure
- ✓ unique aspects of the agency or facility that could affect the outcome of a compliance audit

If individual expected practices are reviewed for compliance, the report reflects these findings. Likewise, the auditor notes any weaknesses with particular aspects of documentation. These items alert Performance-Based Standards and Expected Practices Accreditation Department staff and the agency to potential problem areas prior to scheduling a compliance audit. Upon receipt of the report from the auditor, Performance-Based Standards and Expected Practices Accreditation Department staff review the report and forward said report to the agency.

A Technical Assistance Visit (TAV) can also occur during an initial audit. If a facility is non-compliant with a mandatory standard or non-compliant with more than 10 percent of the non-mandatory standards, the audit chairperson should contact the Director of the ACA Standards and Accreditation Department for guidance. The Director will determine if the audit should continue or be turned to a TAV. If turned to a TAV, the audit team will teach and assist the facility with their deficiencies for the remainder of the visit, and the audit will be rescheduled for a later date. A reaccreditation audit can not be changed to a TAV,

### **Mock Audits**

For initial accreditations and at the agency's request, the Performance-Based Standards and Expected Practices Accreditation Department can arrange for a full Visiting Committee to conduct a *mock audit* to assess the agency's readiness for the actual accreditation audit. This onsite visit is geared less toward training agency staff and more toward assessing compliance with the expected practices. Transportation and lodging arrangements will be handled in the same manner as other Association visits. In order to assess agency readiness, the team will:

- ✓ tour the facility
- ✓ conduct an examination of the physical plant
- ✓ review records, files, and completed compliance folders
- ✓ interview offenders, staff, and others as appropriate
- ✓ prepare a report for the agency (see above) of the findings that may include recommendations to facilitate compliance

The cost of the mock audit is in addition to basic accreditation fees and is the responsibility of the agency.

## VIII. The Self-Evaluation Report

Self-evaluation documents the agency's progress through the accreditation process. Through self-assessment, the agency identifies specific deficiencies with respect to the expected practices and develops plans for correcting them. Upon completion of the self-evaluation, the agency has attempted to answer the following questions for every expected practice:

- Does the expected practice apply to the agency?
- Does the agency comply?
- How can compliance be demonstrated?
- In instances of non-compliance, what does the agency need to do to comply?

### **Compliance Tally**

The compliance tally is used to indicate the percentage of mandatory and non-mandatory expected practices in compliance by category. Compliance percentages are calculated by dividing the number of applicable expected practices that are found in compliance by the total number of expected practices. Information contained in the self-evaluation must include the percentage of compliance with mandatory and non-mandatory expected practices, a list of those non-applicable and reasons for such, and a list of those non-compliant and their deficiencies. Upon completion of the self-evaluation, agencies can determine if they meet the minimum threshold for achieving accreditation, compliance with 100% of the mandatory expected practices and 90% of the non-mandatory expected practices. Agencies that have not met the minimum threshold are not eligible to request a compliance audit.

### **Submission of the Self-Evaluation Report**

The Performance-Based Standards and Expected Practices Accreditation Department requires that a self-evaluation report be completed by each applicant for initial accreditation. The self-evaluation report is due to ACA at least six weeks prior the audit.

When the agency's self-evaluation report indicates that levels of expected compliance are sufficient for accreditation, the agency may then request an audit. At this point the agency's activities focus on preparing for the compliance audit, which is an on-site review by a Visiting Committee composed of a team of trained auditors.

## IX. The Audit Process

### **Audit Request and Arrangements**

The agency's request for an audit is made initially when requesting a contract. The contract request form requests primary and alternate audit dates as well as conference panel hearing preference. The date may be adjusted later by telephone or e-mail contact between the Accreditation Manager and the Accreditation Specialist assigned to the agency. The audit must be scheduled at least eight weeks prior to the identified preferred conference panel hearing date. These dates are established to allow sufficient administrative time for the processing of the VCR and preparation for the panel hearing. Commission panel hearings are scheduled two times a year: normally January and August.

In the three months prior to the audit, Performance-Based Standards and Expected Practices Accreditation Department staff establish with the agency the dates of the audit. Prior to the confirmed audit dates, Performance-Based Standards and Expected Practices Accreditation Department staff select and confirm Visiting Committee members, clarify audit activities and accreditation manual to be reviewed, and ensure that the necessary information and materials are provided to the agency. Coordination of audit plans and activities is done through telephone contacts, e-mail, and exchange of correspondence and materials between the agency Accreditation Manager and the Accreditation Specialist. Once a determination has been made concerning the Visiting Committee members, the agency Accreditation Manager should correspond with the chairperson of the Visiting Committee, with a copy of all correspondence provided to the Accreditation Specialist. Questions or concerns by the Visiting Committee team members should be directed to the Visiting Committee Chairperson.

The agency Accreditation Manager and Performance-Based Standards and Expected Practices Accreditation Department staff work together to schedule and make arrangements for the audit. If a postponement to the audit is required, it must be requested as soon as possible when the need for such postponement becomes evident. The request must state the reasons for the request. Agencies are subject to payment of any additional fees incurred due to the cancellation or modification of auditor travel arrangements. Performance-Based Standards and Expected Practices Accreditation Department staff must be involved in any discussion of, and approve, any audit cancellations, postponements, or other significant changes in plans affecting the audit.

### **Final Agency Preparation**

To confirm audit arrangements, the Performance-Based Standards and Expected Practices Accreditation Department sends the agency a letter and materials detailing the audit dates and location(s); names, addresses and telephone numbers of Visiting Committee members.

The Performance-Based Standards and Expected Practices Accreditation Department also provides notices to the agency announcing the purpose and dates of the visit by the Visiting Committee.

As part of the Association's policy on public information and openness, the Performance-Based Standards and Expected Practices Accreditation Department requires that all agencies post this public notice of the approaching compliance audit in conspicuous locations throughout the facility, inviting comments from staff, residents and others interested in the agency. This public notice must be posted six weeks prior to the audit or upon receipt from the Standards Accreditation Specialist. Any relevant comments received by the Performance-Based Standards and Expected Practices Accreditation Department are reviewed by the Visiting Committee during the course of the compliance audit.

### **The Visiting Committee**

The Visiting Committee, is composed of one or more auditors who have been assigned by the Performance-Based Standards and Expected Practices Accreditation Department to conduct the audit. The size and composition of the Visiting Committee is determined by the Performance-Based Standards and Expected Practices Accreditation Department staff. In selecting Visiting Committee members, there is always an effort to select auditors with experience and special knowledge about the type of facility or program to be audited. In order to avoid a potential conflict of interest or its appearance, the Visiting Committee will not include any auditors who are, or previously have been, employed by the agency being audited or who work in the same state. In programs where medical services are provided to program participants, an auditor with a medical background may also be assigned.

A Visiting Committee chairperson is designated to organize and supervise the audit activities. The chairperson is the lead representative of the Visiting Committee and, as such, is responsible for carrying out the Association's policies and procedures pertaining to compliance audits. The chairperson's responsibilities include:

- ✓ coordinate with the Visiting Committee team members prior to the audit on administrative matters and audit expectations
- ✓ conduct of the audit and supervision of the other members of the Visiting Committee to ensure consistent and accurate application of policy, procedure, expected practices interpretation, and professionalism in the overall conduct of the audit
- ✓ division of expected practices among team members based on an individual's areas of expertise
- ✓ preparation of the VCR consistent with an established format and guidelines
- ✓ submission of the report and any required attachments to the Performance-Based Standards and Expected Practices Accreditation Department for dissemination to the agency and other members of the Visiting Committee

The agency/facility is responsible for arranging hotel accommodations and local transportation for the Visiting Committee. Hotels that offer special government rates should be given priority considerations. As a reminder, auditors are responsible for payment of their hotel expenses. The Accreditation Manager also plans for, or provides, transportation for Visiting Committee members to and from the airport, hotel, and facility.

The Accreditation Specialist ensures that a descriptive narrative of the agency/facility and any annual reports generated since the last audit, (or generated by the agency prior to the initial audit) are distributed to the Visiting Committee members.

The Visiting Committee should also be provided with information about significant judicial activity affecting any aspect of their accreditation including court orders, consent decrees, or other significant litigation or pending litigation concerning the facility or agency. The Performance-Based Standards and Expected Practices Accreditation Department also requests that agencies provide significant media reports, special reports, and/or other information that impacts their accreditation in either a positive or negative way.

Social events with the facility are highly discouraged. Gifts should be discouraged. Auditors are to pay for all their meals.

## **X. Conduct of the Compliance Audit**

The purpose of the compliance audit is to have the Visiting Committee examine the agency's policies, procedures, and operational practices in order to evaluate compliance with the expected practices based on the documentation provided by the agency. *Accreditation is not determined or awarded by the Visiting Committee; it is determined following a hearing by the Commission on Accreditation for Corrections.* In order to verify expected practices compliance, the Visiting Committee:

- ✓ tours the facility
- ✓ conducts an examination of the physical plant
- ✓ reviews records, files, and written documentation of policies, procedures, and operational practices prepared by the agency
- ✓ interviews the staff, offenders, and others as appropriate

The amount of time required to complete the audit depends on agency size, number of applicable expected practices, different sites or facilities to be visited, and other relevant considerations.

All members of the Visiting Committee usually arrive the evening prior to the first day of the audit. On the evening of arrival, the Visiting Committee chairperson convenes an organizational meeting during which team members establish a preliminary audit schedule and determine audit assignments. This involves dividing sections of the accreditation manual among team members. The Performance-Based Standards and Expected Practices Accreditation Department recommends that the visiting Committee and administrative facility staff as well as the Accreditation Manager meet prior to the audit as an introduction to what the agency can expect. During the meeting agency staff brief the team on the agency's expectations, reviews any recent events that may affect the outcome of the audit, and answers questions regarding the materials received.

The audit day almost always exceeds an eight-hour workday for Visiting Committee members and agency staff. The work can be greatly expedited by a well-organized presentation of documentation by the agency. While Visiting Committee activities vary slightly depending on the type of agency being audited, the compliance audit includes several basic elements:

- ✓ an entrance interview
- ✓ an agency tour
- ✓ a review of compliance documentation
- ✓ interviews with agency staff, offenders, and others
- ✓ daily briefing between the Visiting Committee, Accreditation Manager and agency administrator
- ✓ an exit interview

## **Entrance Interview**

An entrance interview is usually held the first morning of the audit. In addition to the Visiting Committee, those present include the agency administrator, Accreditation Manager, and other staff determined by the agency administrator.

During the entrance interview, team members introduce themselves and provide the agency with a brief summary of their backgrounds and credentials.

The chairperson of the Visiting Committee discusses the purpose of the audit, presents a tentative schedule of the team's activities, and responds to any questions that may arise concerning the conduct of the audit.

During the entrance interview, the agency administrator designates a primary liaison to the Visiting Committee, (typically the Accreditation Manager), and introduces all key staff members to the auditors. The designated staff member should be available to the Visiting Committee at all times during the audit to answer questions, provide additional materials, and serve as liaison between the agency staff and the Visiting Committee.

## **Agency Tour**

Following the entrance interview, the Visiting Committee tours the agency site. Tours work in conjunction with an in-depth evaluation of written documentation to assist the Visiting Committee in assessing compliance for individual expected practices through their observations of the facility during the tour.

The length of the tour depends on the size and type of agency being audited. When large residential facilities are audited, the team may split up to cover separate areas of the institution, satellite camps, or support service areas. The tour includes all areas of the agency, serving mainly to familiarize the Visiting Committee with the layout of the facility, such as the location of particular units, offices, and program areas. In addition, the tour allows Visiting Committee members to meet department heads, supervisors, and program staff. As they review compliance documentation, team members may return to different areas of the facility to conduct more thorough inspections of the physical plant, observe agency operations, and interview staff and offenders. Auditors also conduct an evening/night visit in order to acquire a better understanding of the overall operation and programming of the agency and to verify through observation the documentation reviewed during the day. Agency personnel are notified when Visiting Committee members intend to return to a facility during evening hours.

For residential facilities, the Visiting Committee visits, at a minimum, all living and sleeping areas and other institutional areas related to the health and safety of staff and offenders. Each auditor is expected to visit each shift and eat at least one meal at the facility.

## **Compliance Review**

Visiting Committee members spend much of their time during the audit reviewing the expected practices and documentation prepared by the agency to demonstrate compliance. The Visiting Committee reviews selected case files, expected practice folders, personnel records, the significant

incident summary, and the applicable outcome measures. In addition, interviews with individual staff and offenders are conducted as necessary to supplement written evidence of compliance. The agency ensures that all appropriate personnel are available to the Visiting Committee during the audit.

A room is provided where the Visiting Committee can work throughout the audit. This room should contain chairs and at least one large table, and should afford privacy and an atmosphere conducive to work. The location of the room should allow ready access to the facility, personnel, and offenders. Files, documentation, and reports the Visiting Committee will need to review should be available in the room.

Each team member reviews designated sections of the manual and is authorized to determine compliance. The Visiting Committee, as a whole, reviews and signs the compliance checklists for all non-compliance, and non-applicable findings. When there is an issue regarding the compliance of a mandatory expected practice, the Director of the Performance-Based Standards and Expected Practices Accreditation Department shall be contacted immediately. Issues, questions, or situations requiring special consideration for compliance are also discussed by all team members and, if necessary, referred to Performance-Based Standards and Expected Practices Accreditation Department staff.

It is the agency's responsibility to provide the documentation necessary to demonstrate compliance with each expected practice. In addition, the following principles and guidelines apply for review of documentation by the Visiting Committee:

- ✓ Documentation created once the audit has started will not be accepted. It is permissible to provide additional documentation should the Visiting Committee request it, but such documentation must already have been in existence when the audit began. Once the audit is concluded, an agency cannot bring itself into compliance for the purpose of changing the compliance tally. Compliance achieved subsequent to an audit results from completion of the Plan of Action and is reflected in the agency's annual certification, during monitoring visits, and during reaccreditation.
- ✓ Auditors review a random selection of personnel and offender files to ensure that forms are completed properly and records are up-to-date. A sample of the personnel files, to include individual training records for staff, and offender case records are reviewed during the audit. Personnel and/or offender records are never photo copied or removed from the audit site. If an agency has automated any of their records functions, staff will need to provide access to the records to the designated Visiting Committee member who will provide the names of those staff or offender whose records need to be reviewed through a random selection process.
- ✓ Documentation for agencies going through the process for the first time must demonstrate:
  - Continuous implementation of policies and procedures that were already in place when the agency formally entered into the process and that are relevant to the evaluation of compliance with an expected practice.
  - Implementation of policies and procedures that were initiated in preparation for

- accreditation.
- Newly-implemented policies, procedures, and forms that effect staff or offender records are reflected in those records

Where local policy and procedure have been developed to meet the expected practice, the auditors verify the authority of the facility/program to do so. Local policy may be developed to adapt parent agency policy to local needs. Non-compliance is concluded if the local policy or its implementation conflicts with a noncompliant parent agency's policy. Decisions rendered for other facilities/programs within the same agency are not necessarily applicable agency-wide.

The Visiting Committee's findings for each expected practice are recorded on the same compliance checklists used by the agency in preparing its self-evaluation report. Where collective decisions are required (non-compliance and non-applicable expected practices), the concurrence of all Visiting Committee members is indicated by signatures on the compliance checklists.

If compliance is problematic or questionable, the agency may use photographs to assist the Commission panel in reaching a decision at the time of the hearing. Offenders should not be identifiable in photographs. If it is necessary for photographs to be included in the VCR, the chairperson should request that they be taken by the agency and forwarded following the audit.

*The applicability of certain physical plant expected practices can depend on the date of renovation or construction. This is a determination made by the Performance Standards Committee upon initial issuance or subsequent revision of an expected practice.*

*If the expected practice defines a date of applicability, then the compliance status for that expected practice for those facilities built or renovated before such date shall be found as "not applicable". Such expected practices for facilities built or renovated after that date shall be "applicable" and compliance/noncompliance evaluated appropriately. Distinct sections of facilities may be evaluated independently under a single expected practice. For example, relative to 5-ACI-2B-04, which reads (new construction only after January 1, 1990) single-cell living units shall not exceed 80 inmates":*

- *if the original facility was built in 1988 with single cell living units of 100 inmates, then the accreditation status of this expected practice would be "not applicable".*
- *if the original facility with single cell living units of 100 inmates was renovated in 1992 to add additional single cell living unit of 100 inmates, then the evaluation relative to the original construction would remain "not applicable", but the evaluation for the additional units as added in the renovation would be "applicable" and non-compliant. Therefore, the expected practice would be shown on the tally sheet as "noncompliant" because of the status of the renovation.*
- *if, however, the 1992 renovation had added single cell living units housing 75 inmates, then the evaluation of the original construction under the expected practice would have again remained "not applicable", but the evaluation of the renovation would have been "applicable" and compliant. Therefore, the expected practice would be shown on the tally sheet as such.*

*In both of these cases, the renovation after 1990 determines the final expected practice determination on the tally sheet. Part of the facility remains “not applicable” but the addition is applicable and evaluated as compliant.*

Auditors are trained to interpret expected practices literally and accurately. If compliance is questionable or an expected practice is not documented fully, the Visiting Committee may conclude non-compliance. The agency may appeal such findings by the Visiting Committee in its response to the VCR and to the Commission at the time of the hearing. The Commission on Accreditation for Corrections renders the final compliance decision.

## **Interviews**

Visiting Committee members conduct both formal and informal interviews with all levels of agency staff and offenders during the audit. The Visiting Committee selects the individuals to interview and the issues to discuss in order to obtain verbal confirmation of expected practice compliance or clarify problems that may surface during reviews of documentation. In addition to the voluntary interviews that occur at random, the following guidelines apply in conducting interviews during the audit:

- ✓ In auditing large institutions, all department heads may be interviewed
- ✓ Offenders who have sent correspondence to the Performance-Based Standards and Expected Practices Accreditation Department may be interviewed
- ✓ In cases where the facility is working with a court master or court expert, they may be interviewed
- ✓ Other individuals who respond to the invitation for comments contained in the posted announcement of the audit may also be interviewed, including an institutional ombudsman, members of offender families, or representatives of public interest groups.

## **Daily Out Briefing**

A daily out briefing is held as an assessment of the audit status and to review the plan for the following day. Those usually present at the out briefing are the Visiting Committee, facility administrator and others as determined by the administrator. The audit chair should provide the warden with the status of the compliance reviews. Any outstanding questions or requests for further information should be discussed.

## **Exit Interview**

At the conclusion of the audit, the Visiting Committee meets with the agency administrator, Accreditation Manager, and appropriate staff to discuss the results of the audit. As with the entrance interview, the agency administrator determines the staff and guests who will be present. It is the agency’s responsibility to ensure the exit interview is audio recorded and the recording is submitted to the chairperson at the conclusion of the exit interview. The Visiting Committee reports all findings of non-compliance with expected practice, stating the reasons for each decision; and highlight positive areas and programs of the agency. The Chairperson provides the facility with a copy of the compliance checklists for each non-compliant and non-applicable expected practice/traditional standard, each documenting reasons for the non-compliance and/or

non-applicable status.

The exit interview is not a forum for debate on the merits of the expected practice or the Visiting Committee's assessment of agency documentation. The process for resolving disagreements between the agency and the Visiting Committee occurs through the agency's response to the VCR and at the time of the hearing. All final decisions regarding accreditation rest with the Commission on Accreditation for Corrections.

### **Audits of Probation and/or Parole Agencies**

For both adult and juvenile field services agencies, the Visiting Committee visits the agency's central office and/or regional office and a sampling of field offices within the system. Individual field offices are visited during the compliance audit. The offices to be audited are selected by ACA Accreditation Specialist in consultation with the Accreditation Manager at the time the compliance audit is requested. Staff in the Performance-Based Standards and Expected Practices Accreditation Department may request to have the Visiting Committee visit a particular field office if there is specific justification to do so. The Accreditation Specialist will inform the agency if a particular field office is to be visited. Field offices are selected on the basis of their geographic location, number of staff, and caseloads. Efforts are made to audit a representative sample of field service offices. Transportation to and from the field offices is the responsibility of the agency.

Documentation requirements for field service agencies are the same for individual agencies; however, audit activities vary slightly. During compliance audits of field service agencies, Visiting Committee members convene at the agency's central office on the first day of the audit and review all of the applicable expected practices. During the remainder of the audit, the Visiting Committee members separate to visit individual field offices.

Compliance reviews at each field office include only selected expected practices that require audits at both the central office and field office levels. Emphasis in field offices is placed on review of expected practices that reflect implementation of agency policies, procedures and operational practices, including addressing case record maintenance, field supervision and caseload management. Staff interviews also are conducted to support documentation review. *Since the accreditation of a field service agency is system-wide, a non-compliance finding at one office applies to the entire system.* Following the audits of individual field offices, Visiting Committee members return to the central office for the exit interview.

### **Initial Accreditation and/or Follow-Up Audit Options**

In the event that an agency is found to be in non-compliance with one or more mandatory expected practices or lacks sufficient compliance levels at the time of the initial audit that was modified to a Technical Assistance Visit, a follow up audit will be required. The follow up audit is a visit to the agency that entails a re-evaluation of compliance with mandatory and/or other expected practices necessary to meet accreditation requirements. The cost of the follow up audit is assumed by the agency.

When a follow up audit is required, the agency is responsible for notifying the Performance-Based Standards and Expected Practices Accreditation Department when the deficiencies have been corrected. Arrangements for the follow up audit, including scheduling, transportation, and

accommodations are handled in the same manner as for the initial or re-accreditation compliance audit. The number of expected practices reviewed and the length of the visit are determined in advance by Performance-Based Standards and Expected Practices Accreditation Department staff.

Follow up audit activities follow a format similar to those involved in the compliance audit. Generally, the Visiting Committee member meets with agency staff and takes a short tour of the facility with emphasis given to areas which were non-compliant during the previous review. All basic auditing principles are applicable on a follow up audit, i.e., review of documentation, communication with agency personnel and interviews. Upon finishing the review of compliance documentation, the auditor meets with the agency administrator and designated staff to report the new findings. The exit interview is conducted in the same manner as that of the initial or re-accreditation compliance audit, entailing review and explanation of audit findings.

Following the visit, a written report of audit activities is submitted to the Performance-Based Standards and Expected Practices Accreditation Department. The follow up audit report briefly addresses the conduct of the visit, observations made on the tour, the result of interviews, and any changes in compliance findings since the original audit. This report is combined with the original VCR for use by the Commission when considering the agency's accreditation application.

## XI. The Visiting Committee Report (VCR)

The results of the compliance audit are contained in the VCR. The finished report consists of a number of sections, which are compiled through an exchange of information between the Visiting Committee, the agency, and Performance-Based Standards and Expected Practices Accreditation Department staff. The report is sent to agency staff for review and distribution to the agency administrator. The completed VCR is submitted to the Commission for consideration at the next regularly scheduled panel hearing.

### **Report Elements**

The VCR is prepared according to the following outline:

*Audit Narrative* - This section is prepared by the Visiting Committee chairperson and includes a description of program services, physical plant and number of offenders served on the date of the audit. It also details audit activities and findings, including issues or concerns that may affect the quality of life and services in an agency or facility, as well as information and impressions obtained during interviews with staff and offenders. The quality of life issues include the level of staff training, adequacy of medical services, sanitation, restricted housing, patterns of violence, and crowding in institutions, (including effects on housing (double-celling), offender activity levels, programs, and provision of basic services).

*Compliance Tally* - The tally is completed by the audit chairperson using a form prepared by the Performance-Based Standards and Expected Practices Accreditation Department. Compliance percentages are calculated based on audit findings.

*Audit Findings* - Each expected practice found non-compliant or non-applicable is outlined, as well as the reasons for the findings.

*Significant Incident Summary* – The agency provides an electronic copy of this document to the Visiting Committee.

*Annual Report* – The agency provides its annual report on accreditation status with the exception of the year of the reaccreditation audit. (required annually for accredited facilities and as applicable for initial accreditation).

*Outcome Measures (as applicable)* - The agency provides an electronic copy of these documents to the Visiting Committee

*Agency Response* - This section contains the agency's response to each non-compliance finding (i.e. Plans of Action, requests for Waivers of Plans of Action, or Appeals.)

*Auditor's Response* - This section contains the Visiting Committee's final response to all comments received from the agency and Performance-Based Standards and Expected Practices Accreditation Department staff, including:

- ✓ Comments on agency appeals of the Visiting Committee's findings stating whether or not the committee agrees with the Appeal
- ✓ Comments regarding the acceptance or rejection of Waiver requests
- ✓ Comments on the acceptability of Plans of Action

### **Non-compliant Expected Practices**

If not provided during the audit, then within two weeks of the conclusion of the audit, the agency is required to respond to each non-mandatory expected practice found in non-compliance. The response to non-compliance can be emailed to the audit chair using the Response to Non-Compliance form (Appendix F). Response is achieved with a *plan of action, request to waive the requirement that a plan of action be submitted, or an appeal.*

During the audit exit interview, the Chairperson provides the facility with a written copy of the expected practices found in non-compliance including the reason for the non-compliance. The facility is provided two (2) weeks to respond in writing to the non-compliance utilizing the Response to Non Compliance form provided to every facility in the Audit Packet materials. Upon receipt of the Agency Response(s), the Audit Chair pastes them into the VCR and includes the Auditor Response. The Chairperson then has two (2) weeks to make any edits to the report and email the report to the assigned Accreditation Specialist. According to this timeline, the Chairperson has four (4) weeks from the conclusion of the audit to submit a completed VCR to the assigned Accreditation Specialist.

Compliance with all applicable expected practices designated as *mandatory* is a prerequisite to accreditation.

Upon a finding of non-compliance with an applicable non-mandatory expected practice, an agency must prepare a Plan of Action that, upon completion, will enable it to come into compliance with the expected practice (unless the agency intends to submit an appeal or request a waiver of the requirement that a plan of action be submitted). Such a Plan of Action, must be realistic and include the steps required, responsible parties and time frame for completion. The status of the activities stipulated in the Plan of Action must be reported in each agency accreditation annual report.

The Plan of Action specifies:

- ✓ The statement of deficiencies
- ✓ Description or summary of actions necessary to achieve compliance
- ✓ Tasks to be completed
- ✓ The responsible agency and personnel from that agency for completing the tasks
- ✓ Timetables to be met

For programs and facilities operating under a parent agency, if the Plan of Action requires both the individual program being audited as well as the parent agency to conduct activities that will be required to achieve compliance with a particular expected practice, then both the program or facility and the parent agency will be held accountable for achieving compliance.

In judging the acceptability of Plans of Action, the feasibility of plans to achieve compliance will be reviewed by the Visiting Committee and the Commission, including specific tasks, time frames, and resource availability (staff and funding) for implementing the proposed remedies.

Evidence of good faith efforts and progress towards compliance pursuant to a Plan of Action is required on the agency's part. Absent such efforts, the Commission may order interim compliance reports, monitoring visits, place the agency on probation or deny reaccreditation in extreme cases.

## **Waivers**

The agency may request a Waiver of the requirement that a Plan of Action be submitted to accomplish compliance with a non-compliant, non-mandatory, expected practice if a Plan of Action is not feasible. This could result from potential Plan of Action requirements that would conflict with statutory or other regulatory considerations, require unrealistic physical plant modifications or dictate other changes that would render the generation of the Plan of Action to be beyond reasonable limits. The agency MAY apply for a Waiver only when the totality of conditions safe guard the life, health, and safety of offenders and staff. Further, the Waiver request must address steps that are taken to mitigate the effect of non-compliance with the expected practices on program operations. Waivers are not granted for expected practices designated as mandatory.

The burden of proving that a Waiver is warranted rests with the applicant agency. The granting of a Waiver does not change the conclusion of non-compliance or alter the compliance tally. The Commission renders the final decision relative to the Waiver request during the accreditation hearing.

In response to a Waiver request, the Commission may:

- ✓ Grant a Waiver of the requirement that a Plan of Action be developed for the non-compliant expected practice.
- ✓ Waive only a portion of the expected practice and specify that the agency submit plans to meet the remaining requirements of the expected practice (this may occur with expected practices that contain several different requirements). In these instances, the expected practice remains non-compliant and the partial Waiver does not change the Compliance Tally.
- ✓ Deny the request for the Waiver and require a Plan of Action from the agency.

## **Appeals**

Every expected practice in the manual applied to the applicant program/facility is found compliant, non-compliant or non-applicable. The agency has the opportunity at the accreditation hearing to appeal any findings of the Visiting Committee in an attempt to change the finding. Auditors are trained and required to render the most literal and accurate interpretations of expected practices during the audits. Only the Commission has the authority and discretion to consider appeals by an agency and render interpretations relative to that program. However, the Commission may not

alter the clear intent of an expected practices as the Performance Standards Committee has sole authority relative to the content and meaning of the expected practices.

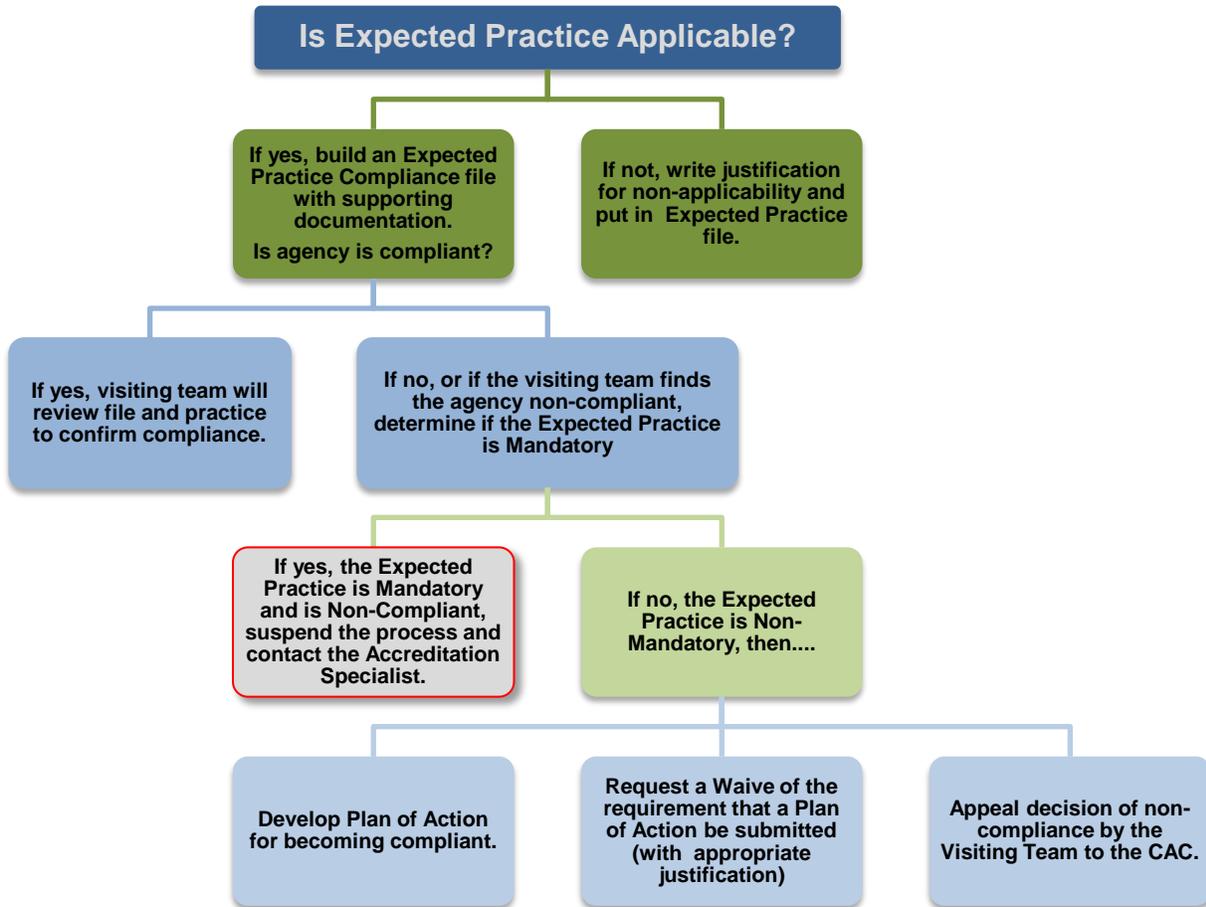
During the hearing, agency representatives may present the agency's position relative to the Visiting Committee findings with which it does not concur.

The agency's opinion relative to the merit of an expected practice is not grounds for an appeal.

The agency may not present documentation that did not exist at the time of the audit. The agency may provide additional documentation to the Commission that the Visiting Committee did not review, understanding that the burden of proof that the documentation existed at the time of the audit is on the agency. The result of a successful appeal is a change in the compliance status (compliance or applicability) and recalculation of the agency's compliance tally. If the Commission denies the appeal, agencies may be required to submit a Plan of Action, (or may receive a Waiver of the requirement that a Plan of Action be submitted). In the event a Plan of Action is requested, the agency must submit a Plan of Action to the Performance-Based Standards and Expected Practices Accreditation Department for coming into compliance with the non-compliant expected practice. The status of all activity relative to completion of the Plan of Action must be noted in each annual report and included in the VCR.

Upon receipt of the VCR, Accreditation staff implement quality assurance procedures which involve formatting and reviewing the finalized VCR prior to sending it to the Agency for review. Should an Agency have questions about their report, they can communicate with their Accreditation Specialist for resolution and the Specialist will contact the chairperson prior to resolving the issue.

# Expected Practice Compliance Processing Chart



## **XII. Accreditation Hearings**

The Commission on Accreditation for Corrections is solely responsible for rendering accreditation decisions and considers an agency's application at its next regular meeting following completion of the VCR. The Commission is divided into panels that are empowered to reach and render accreditation decisions. These panels hear the individual application for accreditation and include a quorum of at least three Commissioners which includes the panel hearing chairperson. Agencies are notified in writing of the date, time, and location of the hearings by Performance-Based Standards and Expected Practices Accreditation Department staff.

With the panel chairperson presiding, panel members discuss issues and raise questions relative to all aspects of agency operations and participation in the process. The information presented during the hearing and in the VCR is considered by the panel members in rendering accreditation decisions.

The agency is invited to have a representative at the hearing and, in most cases, one or more individuals attend. When special conditions warrant, the Visiting Committee chairperson or a member of the Visiting Committee also may be asked to attend the hearings. When this occurs, the auditor provides information to help clarify controversial issues and responds to questions and concerns posed by panel members.

Attendance by any other parties (i.e. media representatives, public officials, or personnel from agencies other than the applicant) occurs only with the permission of the applicant agency. In these cases, the applicant agency representatives and panel members discuss procedures to be followed before commencement of the hearing.

### **Conduct of Hearings**

The panel schedule provides ample time for review of each individual agency pursuing accreditation. Hearings are conducted by the panel chairperson in accordance with established procedures. Panel proceedings require that a formal vote be taken on all final actions, i.e., agency appeals, Waiver requests, and the final accreditation decision of the Commission. All panel proceedings are tape-recorded to assist in preparing minutes of the hearings. Panel activities generally occur as follows:

- Applicant agency representatives are requested by Performance-Based Standards and Expected Practices Accreditation Department staff to be on-call to allow for scheduling flexibility
- A designated waiting area is usually provided for this purpose
- When the panel is ready to review the agency, the Performance-Based Standards and Expected Practices Accreditation Department staff representative notifies agency representative(s)
- The hearing opens with an introduction by the panel chairperson

- The agency representative is asked to give a brief description of the program
- If a Visiting Committee member is present at the hearing, the panel chairperson may request that the auditor present an account of the visit, focusing on matters particularly pertinent to the decision or specific panel actions. In some cases, however, the panel may wish to call on the Visiting Committee member only to request additional information at different points during the hearing
- The panel chairperson leads review of each individual non-compliance finding. The agency representative presents information relative to their requests for Waivers, Plans of Action, and appeals. The agency may also present additional materials, including photographs or documentation, for review by the panel.
- Following the agency presentation, the chairperson has the option of calling the panel into executive session to consider the information provided, determine findings, and make an accreditation decision. Whether or not panel deliberations occur in the presence of agency personnel or in executive session, varies from panel to panel, considering the preference of panel members and the sensitivity of issues to be discussed regarding the application.

In final deliberations, the Commission panel:

- Ensures compliance with all mandatory expected practices and at least 90 percent of all other expected practices
- Responds with a formal vote to all appeals submitted by the applicant agency
- Responds with a formal vote to all requests for Waivers, and Plans of Action submitted by the applicant agency

At this time, the panel also:

- Assures that an acceptable Plan of Action will be submitted for every non-compliance finding, including those for which appeals of non-compliance and Waiver requests have been denied by the panel. In judging the acceptability of Plans of Action, the panel ensures that all of the information requested on the form is provided. Furthermore, the feasibility of plans to achieve compliance is considered, including specific tasks, time frames, and resource availability (staff and funding) for implementing proposed remedies.
- Addresses to its satisfaction any concerns it has with Visiting Committee comments about the quality of life in the facility or program, patterns of non-compliance, or any other conditions reviewed by the panel relating to the life, health, and safety of residents and staff

Following each applicant hearing, a roll call vote is conducted to consider the award of accreditation, extend an agency in the accreditation process or deny accreditation.

If the panel has deliberated in executive session, agency representatives are invited back into the meeting and informed of the panel's final decision and actions or recommendations on all other issues raised by the applicant.

If accreditation has not been granted, the chairperson discusses with agency personnel specific reasons for the decision and the conditions of extension as well as procedures for appeal.

### **Accreditation Decisions**

The decisions available to the Commission panel relating to the accreditation of an agency are:

- *Three-year accreditation award* based on sufficient compliance with expected practices, acceptance of adequate Plans of Action for all applicable non-compliant findings, (or approval of the Waivers of the requirement that a Plan of Action be submitted) and satisfaction of any other life, health, and safety conditions established by the panel.
- *Extension of the applicant agency in initial accreditation process* (initial accreditation only) for reasons of insufficient compliance, inadequate Plans of Action, or failure to meet other requirements as determined by the panel, the Commission may stipulate additional requirements for accreditation if, in its opinion, conditions exist in the facility or program that adversely affect the life, health, or safety of the offenders or staff. Extension of an agency is for a period of time specified by the panel and for identified deficiencies if in the panel's judgment, the agency is actively pursuing compliance.
- Continuation of accreditation in *Probationary Status* after reaccreditation hearings is considered when the panel specifies that compliance levels are marginal, there is a significant decrease in compliance from the previous audit (in the case of reaccreditation), or there are quality of life issues that would indicate continued monitoring. Probationary Status lasts for a specific period of time designated by the Commission to allow for correction of deficiencies. While an award of accreditation is granted, a monitoring visit *must* be completed and the report presented at the next meeting of the Commission. At the end of the probationary status, another monitoring visit *MAY* be conducted to ensure that the deficiencies have been corrected. Following the visit, a report is prepared for review by the Commission at its next regularly scheduled meeting. The Commission again reviews the program and considers removing the probationary status or the revocation of accreditation. When the agency corrects the deficiencies within the probationary status period and the corrections have been verified and accepted by the Commission on Accreditation of Corrections by the Commission on Accreditation of Corrections, the agency resumes its status as an accredited agency.
- *Denial of accreditation* denies initial accreditation or removes the agency from Accredited Status (in the case of reaccreditation) and withdraws the agency from the accreditation program.

Situations such as insufficient compliance, inadequate Plans of Action, failure to meet other requirements as determined by the panel or quality of life issues may lead to the denial of accreditation. If an agency is denied accreditation by the panel, it is immediately

appealed to the full commission. If the agency is denied accreditation by the full commission, it is withdrawn from the process and is not eligible to re-apply (as an applicant) for accreditation status for a minimum of six months from the date of that panel hearing.

The agency receives written notification of all decisions relative to accreditation after the hearing.

### **Accreditation Appeal Process**

The accreditation process includes an appeal procedure to ensure the equity, fairness, and reliability of its decisions, particularly those that constitute either denial or withdrawal of Accredited Status, or placement into probationary status. Therefore, if an agency is denied accreditation, it is immediately appealed to the full commission.

If an agency is put in probationary status by the panel, it may submit an appeal of the placement into probationary status.

The basis for reconsideration of probationary status is based on grounds that the decision(s) were:

- ✓ A misinterpretation of the criteria and/or procedures promulgated by the Commission
- ✓ based on incorrect facts or an incorrect interpretation of facts
- ✓ unsupported by substantial evidence
- ✓ based on information that is no longer accurate

The reasonableness of the expected practices, criteria, and/or procedures for the process may not serve as the basis for reconsideration. The procedures for reconsideration are as follows:

- ✓ The agency can submit a verbal appeal immediately to the Director of Performance-Based Standards and Expected Practices Accreditation Department or a written request for reconsideration within 30 days of the adverse decision stating the basis for the request.
- ✓ The Executive Committee of the Commission, composed of the officers of the Commission, reviews the request and decides whether or not the agency's request presents sufficient evidence to warrant a reconsideration hearing before the Commission. The agency is notified in writing of the Executive Committee's decision.
- ✓ If the decision is made to conduct a hearing, the hearing is scheduled for as soon as possible if the appeal is made verbally or if in writing, for the next full Commission meeting and the agency is notified of the date.
- ✓ The agency, at its option and expense, has the right of representation, including counsel.
- ✓ Following the hearing held before the Commission, the decision, reflecting a majority opinion, is made known to the agency immediately.
- ✓ Pending completion of the reconsideration process, the agency maintains its prior status. Until a final decision has been reached, all public statements concerning the agency's accredited status are withheld.
- ✓ Following completion of the reconsideration process, any change in the status of an agency is reflected in the next regularly published list of accredited agencies.



### **XIII. Accredited Status**

The accreditation period is three years, during which time the agency must maintain the level of compliance achieved during the audit and work towards compliance of those expected practices found in non-compliance. Regular contact with Performance-Based Standards and Expected Practices Accreditation Department staff should also be maintained. The Annual Report, Critical Incident Report and Significant Incident Summary forms discussed below are available on the ACA website at [www.aca.org](http://www.aca.org) or through your Accreditation Specialist.

#### **Annual Report**

During the three-year accreditation period, the agency submits an annual report to the Performance-Based Standards and Expected Practices Accreditation Department. This report is due on the anniversary of the accreditation (panel hearing) date utilizing Appendix I (also available at [www.aca.org](http://www.aca.org)). It contains the following information:

*Current Compliance Levels* - This includes any changes in compliance since accreditation, listing on a case by case basis any expected practice with which the agency has fallen out of compliance or achieved compliance.

*Update of Plans of Action* - A progress report is included with respect to Plans of Action submitted to the hearing panel, indicating the status of the completion of the plans. potential revision to plans reflecting the need to request additional time, funds, and/or resources to achieve compliance should also be included.

*Significant Incident Report Summary* - A report is made of events and occurrences at the agency during the preceding year that impact on compliance, agency operation, or the quality of services provided by the agency. Performance-Based Standards and Expected Practices Accreditation Department staff review the annual report received from the agency and respond to clarify issues or request additional information if necessary.

*Outcome Measures* -- A report is made of outcome measures at the agency during the preceding year that impact on compliance, agency operation, or the quality of services provided by the agency. Performance-Based Standards and Expected Practices Accreditation Department staff review the outcome measures received from the agency and respond to clarify issues or request additional information if necessary. Outcome measures will be provided as applicable to the accreditation manual.

#### **Critical Incident Report**

In addition to submission of the annual report, the agency is responsible for notifying Performance-Based Standards and Expected Practices Accreditation Department staff of any critical incident that has the potential to affect compliance or facility accreditation as soon as possible within the context of the event itself. This information is to be submitted to ACA as soon as possible within the context of the incident itself, using the Critical Incident Report template (Appendix H), also available at [www.aca.org](http://www.aca.org).

## Monitoring Visits

Monitoring visits to agencies in Accredited Status are conducted by an ACA auditor(s) or ACA staff in order to assess continuing compliance. A monitoring visit may be conducted at any time during the accreditation period with notice to the agency. The determination of need for a monitoring visit is based on:

- compliance levels, findings, and recommendations by the Commission on Accreditation for Corrections during the hearing
- incidents or events reported by the agency in its annual report and any Critical Incident Reports
- other incidents or reports that may indicate the need for on-site review

The length of the visit varies depending on the number of expected practices or special issues that must be addressed during the visit. Monitoring visits will be charged to the agency.

Monitoring visits, as a general rule, involve a review of all mandatory expected practices, all non-compliance findings at the time of accreditation, and any other concerns identified. The visit also involves a tour of the agency and interviews with staff and offenders to ensure maintenance of the requirements of accreditation. It concludes with an exit interview during which the auditor informs the agency staff of the findings of the visit.

Following the visit, the auditor prepares a monitoring visit report that addresses findings of the visit.

The report includes a list of expected practices reviewed, explanation of non-compliance findings, results of the tour and interviews with agency staff and offenders, and discussion of any issues believed to be relevant to the agency's accreditation. The report, as with others prepared by auditors, is reviewed and sent to the agency by Performance-Based Standards and Expected Practices Accreditation Department staff.

When a monitoring visit to the agency reveals deficiencies in maintaining adequate compliance levels, including less than 100 percent compliance with mandatory expected practices, the agency prepares a response providing explanation of the problems indicated in the report. When the agency has failed to maintain compliance with all mandatory expected practices, the monitoring visit report and the agency response are submitted to the Commission on Accreditation for Corrections Executive Committee for review and referral to a Commission on Accreditation panel if necessary.

The Performance-Based Standards and Expected Practices Accreditation Department may also request that the agency respond to public criticism, notoriety, or patterns of complaint about agency activity. The Performance-Based Standards and Expected Practices Accreditation Department may conduct an on-site monitoring visit to the agency to verify continued compliance.

## **Revocation of Accreditation**

If a Commission panel believes that an agency's failure to maintain continuous compliance is detrimental to life, health, and safety of residents and staff, the Commission may place an agency on probation or revoke accreditation.

In the event information in annual reports, significant incident reports, or critical incident reports, or monitoring visits describe circumstances that would merit consideration of revocation of accreditation and the Commission on Accreditation for Corrections is not scheduled to be in session in a reasonable amount of time, the Commission on Accreditation of Corrections' Executive Committee may function as a panel for the purpose of consideration of the revocation action.

## **Expiration of Accredited Status**

Accreditation is granted for a three-year period. Unless the agency has applied for reaccreditation and completed activities in the process required for reaccreditation, the Commission withdraws the agency from Accredited Status after this three-year period.

When unanticipated extenuating circumstances occur, (which may include natural disaster, disturbance, or other significant operational disruption outside of the control of the program), that limit an accredited program's ability to present themselves as scheduled for reaccreditation audit and subsequent Commission on Accreditation for Corrections panel action, then the Commission on Accreditation for Corrections Executive Committee or the Director of Performance-Based Standards and Expected Practices Accreditation Department acting on their behalf may extend the accreditation of the program beyond the reaccreditation date pending resolution of the relevant issue and subsequent audit and Commission on Accreditation for Corrections Panel action.

## **XIV. Reaccreditation**

### **Eligibility**

Agencies seeking reaccreditation must satisfy the criteria noted previously in this manual. In addition, the agency must be in Accredited Status at the time application is made for reaccreditation. The timing of the agency's application should allow for completion of the process in order to maintain the agency's continuous Accredited Status. It is advised that the application be submitted nine months prior to the expiration of the agency's current status. If the agency has allowed the preceding accreditation to expire, it again applies the process required of agencies seeking initial accreditation.

Agencies seeking reaccreditation should be able to demonstrate efforts to improve not only upon compliance levels based upon progress on Plans of Action, but also by addressing quality of life, safety and other subjective issues raised in the previous panel hearing.

### **Activities**

As with the initial process, the accreditation process involves an exchange of information and materials between the agency and Performance-Based Standards and Expected Practices Accreditation Department staff. Upon receipt of the signed contract and a completed Organization Summary from the agency, the Performance-Based Standards and Expected Practices Accreditation Department will move forward with the audit.

For agencies seeking a continuation of their three-year Accredited Status, documentation must indicate continuous compliance with the expected practices from the previous audit. Auditors sample records, files, and logs dating back to the previous audit in order to determine if continuous compliance has been maintained.

### **Compliance Reaccreditation Audit**

The agency's request and arrangements for a reaccreditation audit are the same as for agencies proceeding through accreditation for the first time.

The audit format and activities remain basically the same; however, the subsequent audit focuses not only on compliance at the time of the audit, but also on compliance levels throughout the three-year period. During the subsequent audit, Visiting Committee members seek confirmation that the agency has maintained continuous compliance and looks for agency progress in correcting earlier deficiencies in expected practices compliance.

### **Visiting Committee Report (VCR)**

The format and time frames for completing the VCR remain the same as those described earlier in this manual. For audits of agencies seeking reaccreditation, the following information may also be included in the VCR:

- Comments concerning expected practice remaining in non-compliance since the prior audit, including progress on Plans of Action

- An indication of major changes in agency operation or programs affecting applicability or compliance
- Discussion of special issues noted in the previous audit or accreditation period
- Summary of the annual report and any critical incident reports

### **Accreditation Hearing**

For agencies seeking reaccreditation, the same conditions required for initial accreditation apply. In addition, the Commission reviews the agency's progress in achieving compliance with expected practices found in non-compliance at the time of the previous accreditation period. The agency must be able to demonstrate a good faith effort in addressing concerns that may have arisen during an earlier accreditation period.

## **XV. Visiting Committee Roles and Responsibilities**

### **A. Auditor Code of Ethics**

#### **On relationships with clients, colleagues, other professions and the public:**

- I. Auditors will respect and protect the civil and legal rights of all clients
- II. Auditors will serve each case with appropriate concern for the client's welfare and with no purpose of personal gain
- III. Relationships with colleagues will be of such character as to promote mutual respect within the profession and improvement of its quality of service
- IV. Statements critical of colleagues or their agencies will be made only as these are verifiable and constructive in purpose
- V. Auditors will respect the importance of all elements of the criminal justice system and cultivate a professional cooperation with each segment
- VI. Subject to the client's rights of privacy, auditors will respect the public's right to know

#### **On professional conduct and practices:**

- I. No auditor will use the position to secure personal privileges or advantages
- II. No auditor will act in an official capacity in any matter in which personal interest could impair objectivity
- III. No auditor will use the position to promote any partisan political purposes
- IV. No auditor will accept any gift or favor of a nature to imply an obligation that is inconsistent with the free and objective exercise of professional responsibilities. Social events between auditors and facility/agency staff are discouraged.
- V. Each auditor will be diligent in the responsibility to record and make available for review any and all information which could contribute to sound decisions affecting a client or the public safety
- VI. Each auditor will report without reservation any corrupt or unethical behavior which could affect either a client or the integrity of the Association or the Commission
- VII. Auditors will not discriminate against any client, employee or prospective employee on the basis of race, sex, creed, or national origin
- VIII. Each auditor will maintain the integrity of private information; auditors will neither seek personal data beyond that needed to perform official responsibilities, nor reveal information to anyone not having proper professional use for such information.

## **B. Auditor Training and Assignments**

### **Auditor Training**

ACA provides auditor training through several avenues: training at ACA conferences, virtual training, and webinars.

Training is conducted at the ACA Winter Conference and the ACA Congress of Corrections. Association staff may solicit the auditors for training topics and the final agenda is distributed to the auditors via email. Current auditors are required to attend the training at least once in a three-year period to remain in good standing.

Virtual training is also conducted by ACA staff. Webinars are also available on the ACA website and Auditors are encouraged to review them at their convenience. Auditors currently receive training credit for the webinars.

New auditor training is required to be an auditor. The training is broken down into two parts: virtual or classroom training followed by a practical training exercise during an audit. When assigned to their first audits, special care is taken to the team new auditors are given. The Chair and fellow team member are contacted by Association staff with information regarding the new auditor and are expected to mentor them through the audit process.

Webinars are also available on the ACA website and Auditors are encouraged to review them at their convenience. Auditors currently receive training credit for the webinars.

### **Audit Assignment**

As agency audits are scheduled, the ACA Performance-Based Standards and Expected Practices Accreditation Department electronically sends the upcoming weekly audit schedule to auditors listed in the ACA auditor database. The schedule identifies the dates of the audits, but not the location. Auditors available for those dates are asked to reply to the electronic request for auditors. Auditors will be assigned to an audit commensurate to their area of experience (e.g. adult, juvenile, residential facilities). The auditor will be notified of the assignment by email or direct contact from the responsible Accreditation Specialist. If an auditor has committed to an audit and an emergency arises preventing their participation, it is imperative the auditor notify the Performance-Based Standards and Expected Practices Accreditation Department *immediately*. Many factors are considered when choosing auditors including specialty, demographics and location.

### **Audit Assignment for International Audits**

Once the audit schedule is in place, the Accreditation Specialist contacts the auditors to find out if they are available to perform the audit. Auditors will be assigned to an audit commensurate to their area of experience (e.g. adult, juvenile, residential facilities). The auditor will be notified of the assignment by email or direct contact from the responsible Accreditation Specialist. If an auditor has committed to an audit and an emergency arises preventing their participation, it is imperative the auditor notify the Performance-Based Standards and Expected Practices Accreditation Department *immediately*. Many factors are considered when choosing auditors including specialty, demographics and location.

## C. Audit Preparations

### Preparations Prior to Agency Visits

By accepting an assignment for the Association, an auditor agrees to abide by the Association's policies and procedures regarding conduct, time commitments, written reports, deadlines, and expense reimbursements. Prior to each visit, the auditor receives an email from the Accreditation Specialist which includes the audit packet. This packet includes the assignment letter detailing the purpose of the visit, confirmed dates, name(s) and contact information of auditor(s) sharing the assignment (when applicable), and the name, email and telephone number of the agency Accreditation Manager. The letter is accompanied by additional forms and materials relevant to the audit.

Agency staff may contact the auditor(s) in advance of the visit to discuss the basic details of the assignment, location, transportation arrangements, hotel accommodations, etc. If the auditor has additional questions or concerns prior to or during an assignment, they should contact the Audit Chairperson or the Accreditation Specialist. Generally, transportation schedules are coordinated by the auditor and the agency's Accreditation Manager. The agency Accreditation Manager coordinates hotel reservations for each member of the visiting committee, contacts them for their arrival time, and informs them of the hotel accommodations and transportation arrangements. Auditors will make their travel arrangements through the contract services provided by ACA. **Any flight over \$500 requires approval from the appropriate Accreditation Specialist prior to booking the flight.** Auditors should send the chairperson a copy of the flight arrangements. If an auditor wishes to take an alternate form of transportation to the audit site, he must first coordinate with the appropriate Accreditation Specialist. Hotel accommodations are reserved by the facility and paid for by the auditor (and later reimbursed by ACA).

The agency provides ground transportation for consultants between the airport, hotel, and the agency site. ACA accepts no liability from either the auditor(s) or agency and provides no liability, medical, or collision insurance for such a situation. Use of a rental car can only be authorized by the Director of Performance-Based Standards and Expected Practice Accreditation Department.

Each auditor should provide (electronically) the chairperson and agency their flight information, email address and cell phone number.

Confirmed arrangements and schedules made by an agency can be changed only through the Accreditation Specialist with the concurrence of the agency. If the auditor must cancel his/her participation on an assignment, the Specialist *must* be notified *immediately*.

### Apparel

It is imperative that an auditor's attire represent professionalism. Professional business attire is appropriate. An auditor must respect the agency's dress code which could include some of the following clothing restrictions: no low cut or otherwise provocative clothing, no sleeveless tops, or no camouflage attire. Business suits with ties are preferred for men. Business suits with professional blouses and slacks or appropriate length skirts are preferred for women. Shirts and blouses should not be too revealing or see through for either men or women. Appropriate but comfortable shoes should be available as tours may involve a significant amount of walking.

## **D. Visiting Committee Roles and Responsibilities**

The visiting committee chairperson is responsible for ensuring that the Association's policies and procedures for compliance audits are followed.

*Responsibilities of the visiting committee chairperson include:*

- ✓ Contact team members prior to the audit to get acquainted with the visiting team members, flight information, contact numbers, and auditor background to determine division of performance-based standards and expected practices.
- ✓ Contact agency/facility POC prior to the audit to provide team flight information, introduce self, discuss expectations, and put agency at ease. Request information that will be needed during the audit (see Chairperson recommended lists). However, do not request information prior to the audit. ACA provides the agency a list of required items that are to be sent to ACA prior to the audit. Once collected, the Accreditation Specialist will forward this information to the chairperson.
- ✓ Organizing preliminary discussions with team members (usually the evening before the audit) to establish the audit schedule; make preliminary audit assignments, and share and discuss other appropriate information. Audit assignments include the following: chapters of the accreditation manual, where multiple locations are to be audited, and individual audits of specific locations.
- ✓ Ensuring a consistent and accurate application of Association policies, procedures, and performance-based standards and expected practices interpretations.
- ✓ Maintaining the audit schedule. Any significant deviations from the schedule, and rationale, shall be reported to the Accreditation Specialist.
- ✓ Conducting the entrance interview, daily outbriefing and exit interviews (record exit interview).
- ✓ Advising the Accreditation Specialist of questions or problems that occur during the audit. Issues concerning mandatory expected practices must be brought to the attention of the Accreditation Specialist by the end of the first day and addressed with the Director of Performance-Based and Expected Practice Accreditation Department.
- ✓ Keeping the agency administrator informed during the audit of its progress, including findings of compliance and non-compliance, quality of life issues, etc.; alert the Accreditation Manager immediately upon identifying any concerns with an accreditation file to allow for prompt redress.

- ✓ Reviewing all non-compliant and not applicable expected practices. Review Significant Incident Summary and Outcome Measures, requesting additional information if needed, and resolve any discrepancies.
- ✓ Collecting all non-compliant, not applicable checklists, Significant Incident Summary and Outcome Measures sheets from the Accreditation Manager for use in preparing the VCR. Provide a copy of the tally sheet, all non-compliant and not applicable checklists to the agency Accreditation Manager prior to departing the agency.
- ✓ Ensuring the electronic versions of the Significant Incident Summary and Outcome Measure forms are in the appropriate format for inclusion in the VCR.
- ✓ Reviewing the Agency responses to non-compliant expected practices and including them in the VCR prior to sending the report to ACA.
- ✓ Preparing a complete VCR within four (4) weeks of the completion of the audit. (MUST be submitted in Microsoft Word format).
- ✓ Supervising and mentoring visiting committee members.
- ✓ Complete evaluations on visiting committee members.

*Responsibilities of all visiting committee members include:*

- ✓ Alerting the visiting committee chairperson of auditing expertise for appropriate expected practices assignments.
- ✓ Knowing the expected practices, including an understanding of interpretations.
- ✓ Thoroughly examining all documentation provided by the agency and ACA.
- ✓ Reviewing all mandatory expected practices first.
- ✓ Interviewing staff and offenders to support conclusions of compliance with expected practices.
- ✓ Maintaining accurate and thorough notes to document conclusions of non-compliance, non-applicability, and special considerations and providing relevant documentation to the audit chairperson.
- ✓ Auditing the expected practices only; the comments accompanying the expected practices are intended to clarify the expected practices and should not be used to measure compliance.

- ✓ Presenting (at the exit interview) overall comments of areas responsible for during the audit and provide information of those areas to the chairperson at the conclusion of the audit to be used in the report. Exit interview discussions should be brief, to the point and always end on a positive note. The chairperson will identify what areas of the audit process each auditor should briefly note.
- ✓ Maintaining audit time lines to complete assignments on time.
- ✓ Maintaining confidentiality regarding all agency-specific information once the audit is completed.
- ✓ Alerting the chairperson throughout the audit of its progress and of questions and/or problems encountered by the team.
- ✓ Reviewing all non-compliant, and not applicable expected practices. Health care team members are expected to contribute to and assist the chair in writing the health care section of the report.
- ✓ Non-health care team members are expected to contribute to the report by providing the chairperson notes pertinent to the areas they audited.

## **E. Conduct of the Compliance Audit**

The purpose of the compliance audit is to have the visiting committee examine the agency's policies, procedures, and operations in order to evaluate compliance with the expected practices. Determining compliance is based on the documentation provided by the agency and observation by the audit while touring the facility. After completion of the entire audit process, the visiting committee chairperson will submit a written report to the Commission for their review and consideration for initial accreditation or reaccreditation of the agency. ***Accreditation is not determined or awarded by the visiting committee; it is determined by the Commission on Accreditation for Corrections at the conclusion of the panel hearing.*** In order to verify compliance with expected practices the visiting committee:

- ✓ Tours the facility (***visiting all scheduled shifts at some point during the audit***) and conducts an examination of the physical plant.
- ✓ Reviews records, files, and written documentation prepared by the agency of policies, procedures, and practices related to the operations of the agency.
- ✓ Interviews staff, offenders, and others as appropriate. Consume at least one meal at the facility and observe offender program activities.

The amount of time required to complete the audit depends on agency size, number of applicable expected practices, different sites or facilities to be visited, etc.

### **Visiting Committee Team Meeting**

Auditors should plan to arrive at the hotel by 6:00 p.m. the evening prior to the audit to participate in the organizational meeting that is conducted by the chairperson. The meeting is held to determine auditing assignments and to develop a preliminary schedule of activities.

In assigning accreditation manual chapters, the visiting committee chairperson takes into account the strengths of the team members. Auditors should recognize that the audit almost always exceeds the normal eight-hour workday with scheduled evening team meetings and night visits.

During this meeting, the team should review the status of litigation that involves the facility or the staff, previous audit report (as applicable), annual report, and self-assessment (as applicable). The amount of litigation varies widely and sometimes may be generated by one especially litigious person or group. The agency will supply the basic information concerning litigation for the team's review and appropriate staff and offender interviews.

The Performance-Based Standards and Expected Practices Accreditation Department recommends that the Accreditation Manager meet prior to the audit as an introduction to what the agency can expect. During the meeting, the Accreditation Manager briefs the team on the agency's expectations, reviews any recent events that may affect the outcome of the audit, and answers questions regarding the materials received. The team will also have the opportunity to meet privately at the discretion of the chairperson.

An organized approach by the visiting team (under the leadership of the chairperson) toward the process including communication of concerns among the team, to the agency administration, and as determined by the chairperson to the Performance-Based and Expected Practices Accreditation Department (Director or assigned Accreditation Specialist) can facilitate efficiency. While visiting committee activities vary depending on the type of agency being audited, the compliance audit includes, at a minimum, the following basic elements:

- ✓ Entrance interview
- ✓ Agency tour
- ✓ Review of expected practices compliance documentation
- ✓ Interviews with agency staff, offenders, and others
- ✓ Exit interview

### **Dinner with the Facility**

Some agencies/facilities plan a dinner the night before the audit as an ice breaker between the agency/facility staff and the visiting committee. The visiting team should not request a dinner, but if offered graciously accept. The visiting team should spread out amongst the staff during the dinner and not sit together as a group. Put the staff at ease by sharing experiences, asking them about their experiences, and discussing current events. Though it will be a casual event, remain professional and do NOT drink. The cost of the auditor dinner is borne by the auditor, not the agency.

### **Entrance Meeting**

Auditors must be sensitive to their role in the agency or facility. Accreditation and reaccreditation is a voluntary process. Agency staff have worked very hard preparing for the process. Any anxiety they may have can be reduced or mitigated by auditor acknowledgement of the staff, administration preparation efforts, and their pride in the operation of each department and program.

An entrance interview is usually held the first morning of the audit. In addition to the visiting committee, those present include the agency administrator, Accreditation Manager, and other staff determined by the agency administrator. A list of the names and titles of those present should be provided to the chairperson for inclusion in the report. During the entrance interview, team members introduce themselves and provide the agency with a brief summary of their backgrounds and credentials. The chairperson of the visiting committee discusses the goals of accreditation, the purpose of the audit, presents a tentative schedule of the team's activities, and responds to any questions that may arise concerning the conduct of the audit. The chairperson should also stress the Commission for Accreditation makes the final decision on accreditation, and the visiting committee is the eyes and ears of the commission.

During the entrance interview, the agency administrator designates a primary liaison to the visiting committee and introduces all key staff members to the auditors. The designated staff member should be available to the visiting committee at all times during the audit to answer questions, provide additional materials, and serve as liaison between the agency staff and the visiting committee. The facility administrator may also request an additional private meeting (before or following the formal entrance) with the visiting committee.

### **Agency Tour**

Following the entrance interview, the visiting committee tours the agency. Tours work in conjunction with an in-depth evaluation of written documentation to assist the visiting team in assessing compliance for individual expected practices through their observations of the facility during the tour. Auditors may want to prepare a checklist of items to observe (related to their assigned section of expected practices) during the tour.

The length of the tour depends on the size and type of agency being audited. When large residential facilities are audited, the team may split up to cover separate areas of the institution, satellite camps, or support service areas. The tour includes all areas of the agency, and allows visiting committee members to familiarize themselves with the layout of the facility and to meet department heads, supervisors, and program staff. In addition, the visiting committee should be observing compliance with expected practices through checking inventories (tools, sharps, HAZMAT), questioning staff on procedures, interviewing offenders, and observing activities (recreation, medical, education, etc.) during the tour. It is recommended after the tour, the visiting committee take a few minutes to discuss first impressions, observations, and areas of concern from the tour. As they review expected practices compliance documentation, team members may return to different areas of the facility to conduct more thorough inspections of the physical plant, observe agency operations, and interview staff, contract staff and offenders. Auditors return to the site to visit each shift in order to acquire a better understanding of the overall operation and programming of the agency and to verify through observation, documentation reviewed during the day. Agency personnel are notified when visiting committee members intend to return to the facility.

For residential facilities, the visiting committee visits, at a minimum, all living and sleeping areas and other institutional areas related to the health, safety and security of staff and offenders. In cases where agencies receive support services, such as food and medical services from a nearby or adjoining satellite facility that is administered by the same parent agency, a member of the visiting committee visits the satellite facility to ensure compliance with expected practices in these areas. This is arranged prior to the audit with the Accreditation Manager. Auditors are required to visit each shift and eat at least one meal at the facility. The food is expected to be the same meal and quantity as served to the offenders.

Observations made and interactions that occur during this portion of the process are an important part of assessing expected practices compliance, quality of life, and conditions of confinement.

It is important to document the areas visited, the facility staff present on the tour, the names and titles of staff interviewed, and the number of offenders and an overview of their comments made to the team during the course of the tour and audit. The chairperson may request the facility provide a staff person to take notes for the team during the tour.

## **Compliance Review**

Visiting committee members spend much of their time during the audit reviewing the expected practices and documentation folders prepared by the agency to demonstrate compliance.

The agency will provide a room for the auditors to review expected practices folders that provides adequate seating and a table in an environment that affords privacy and an atmosphere conducive to working. The room should contain the expected practices folders and supporting manuals. The visiting committee reviews selected case files, expected practices folders, personnel records, the significant incident summary, and the outcome measures. It may be necessary for the visiting committee to travel to alternate locations to review personnel files, medical records, etc. in order to comply with privacy laws, HIPAA regulations, or institutional policies and procedures.

*It is recommended that the agency be reminded by the chairperson that materials provided to supplement existing documentation in the folders may not be created once the audit has commenced.*

In addition, interviews with individual staff and offenders are conducted as necessary to supplement written evidence of compliance. The visiting committee will inquire whether any staff or offenders have requested to visit with the visiting committee and will make every effort to respond to those requests. The visiting committee will also talk to offenders who have written to ACA if provided such documents. The agency ensures that all appropriate personnel are available to the visiting committee during the audit.

## **Interpretation of Expected Practices**

The auditor must be familiar with and understand the intent of the expected practices. Expected practices interpretation must not be adapted or adjusted to meet the individual characteristics of an agency or local regulations. Expected practices identify what is to be achieved not how to achieve it. The method an auditor's agency utilizes to achieve compliance is not necessarily the only way to reach the same goal. The comments, protocols, and process indicators portion of the expected practices are to provide clarification of the expected practices expectation and examples of possible sources for supporting documentation or process indicators. These sections are not part of the expected practice and are not to be incorporated into compliance expectations. Accreditation manuals contain a glossary which should be utilized to create common understanding of the terms and phrases found in the expected practices. If the visiting committee is unsure of an interpretation of an expected practice the Accreditation Specialist is to be contacted.

## **Determining Compliance**

- ✓ Implementation of existing policy and procedure
- ✓ Implementation of new policy
- ✓ Compliance with physical plant requirements

Verbal confirmation alone is insufficient to establish compliance. Appropriate written documentation and/or observation *must* support verbal reports.

Auditors are restricted to evaluating compliance with the expected practice not the *comment*. The *comment* that accompanies some expected practices is included only to clarify the intent of the expected practice and may provide *examples* of documentation sources to *support compliance*. *Items addressed in the comment that go beyond the expected practice are not binding* on the agency and should not be audited.

The mandatory expected practices folders review begins following the tour and should be completed by the close of the first day of the audit to allow the agency, the visiting committee, and the Performance-Based and Expected Practices Accreditation Department staff adequate time to address questions regarding mandatory expected practices that may arise prior to the end of the audit.

Each team member reviews designated sections of the manual and is authorized to independently determine compliance with all expected practices. The visiting committee's findings for each expected practice are recorded on the same expected practices compliance checklist used by the agency in preparing its self-evaluation report. Where collective decisions are required (non-compliance and non-applicable expected practices), the concurrence of all visiting committee members is indicated by their signatures on the checklist. If not all members agree on a finding of non-compliance or non-applicable, the minority auditor may write a dissenting opinion for that expected practice. The chairperson will attach the dissenting opinion in the report if not prepared on the checklists. The dissenting opinion should also be emailed to the Accreditation Specialist overseeing the audit.

Noncompliance should be found only after the agency has been given the opportunity to present additional documentation (or photographs, architectural rendering, reports) that existed *prior to the start* of the audit and within the audit cycle dates. When non-compliance is determined by the team, the designated agency liaison must be notified. Issues, questions, or expected practices requiring special consideration are discussed by all team members and if necessary, referred to Performance-Based and Expected Practices Accreditation Department staff. If a mandatory expected practice is believed to be non-compliant, the ACA Director of Performance-Based and Expected Practices Accreditation Department must be contacted by the committee chairperson.

It is the agency's responsibility to provide the documentation necessary to demonstrate compliance with each expected practice. In addition, the following principles and guidelines apply for review of documentation by the visiting committee:

- ✓ It is permissible to provide additional documentation should the visiting committee request it, but such documentation must already have been in existence when the audit began. Once the audit is concluded, an agency cannot bring itself into compliance with an expected practice for the purpose of changing the compliance tally unless a re-audit is conducted. Compliance achieved subsequent to an audit is reflected in the agency's annual report, during monitoring visits, and during the reaccreditation.

- ✓ Auditors review a random selection of personnel and offender files to ensure that forms and records are completed properly. ***Personnel and/or offender client records are never copied or removed from the audit site.***
- ✓ Documentation for agencies going through the process for the first time must demonstrate:
  - Continuous documentation of implementation of relevant policies and procedures that were already in place when the agency formally entered into the process is required. Documentation of implementation of policies and procedures that were initiated during the period of audit preparation after formal entry into the process is required from the point of their development. is required

*Remember: it is the agency's responsibility to provide the documentation supporting compliance; it is the auditor's responsibility to request additional information as needed.*

The agency may use photographs to assist the Commission panel in reaching a decision at the time of the hearing. Offenders should not be identifiable in photographs. If it is necessary for photographs to be included in the VCR, the chairperson should request that they are taken by the agency and forwarded following the audit.

Auditors must interpret expected practices objectively and strictly. The auditor's experience is an essential part of the accreditation process but there are many paths to achieving compliance. Auditors must avoid applying their method of reaching a goal as the only road to compliance. If compliance is questionable or an expected practice is not fully documented, the auditor concludes non-compliance. The agency may appeal such findings by the visiting team in its response to the VCR and to the Commission at the time of the hearing. ***The Commission on Accreditation for Corrections renders the final compliance decision.***

Each auditor is responsible for ensuring their review of each expected practice folder assigned to them. It is important that the auditor be able to identify which expected practice folders they have completed (and signed the checklist) as applicable, not applicable, compliant, and non-compliant. Expected practice folders may be submitted to the agency liaison for further information or clarification. At the end of each day, the visiting committee should close out internally to identify which folders are non-compliant, non-applicable, and returned to the agency/facility for additional documentation. Prior to the calculation of the score and the exit interview, every expected practice folder and compliance determination must be accounted for and each checklist identified with the required signatures as ***compliant, non-compliant, or non-applicable.***

If, during the audit, it is determined that a mandatory expected practice is non-compliant or that there are more than ten percent of the applicable non-mandatory expected practices are non-compliant, the Director of Performance-Based Standards and Expected Practices Accreditation Department will be notified. The Director and Chairperson will discuss the next steps. Generally during an initial accreditation, the audit is turned into a technical assistance visit; while during a reaccreditation audit, the audit would continue. This decision will be made in consultation between the agency/facility, visiting committee, and Director of Performance-Based Standards and Expected Practices Accreditation Department. If the audit is turned into a technical assistance visit, the committee will teach and mentor the agency/facility on how to make the non-compliant

expected practices compliant. At no time will auditors promote private consulting.

### **Interviews**

- a. Visiting committee members conduct both formal and informal interviews with all levels of agency staff and offenders during the audit. Interviews provide insight into quality of life and staff morale. The visiting committee selects the individuals to interview and the issues to discuss in order to obtain verbal confirmation of expected practices compliance and clarify problems that may surface during reviews of documentation. ***Offender interviews are voluntary*** as requested or agreed to by the offender. In addition to the voluntary interviews that occur at random, the following guidelines apply in conducting interviews during the audit:
- b. In auditing large institutions and training schools, all department heads should be interviewed. Offenders who have sent correspondence to the Performance-Based Standards and Expected Practices Accreditation Department may be interviewed. The Accreditation Specialist may notify the chair of such requests prior to the audit.
- c. In cases where the facility is under court order or other judicial individuals connected with the case may be interviewed. Independent, qualified sources including the fire marshal, health inspector, and consulting medical personnel may be interviewed or contacted when it is necessary to verify expected practices compliance.
- d. Other individuals who respond to the invitation or comments contained in the posted announcement of the audit may be interviewed, including an institutional ombudsman, members of offenders' families, representatives of public interest groups, etc.
- e. During the initial tour and any subsequent follow-up visits, offenders and staff should be interviewed.
- f. Auditors concluding their file review prior to the scheduled exit interview should spend that additional time conducting further interviews of staff and offenders
- g. Interviews are a tool to reinforce tour observations; documentation reviewed in the folders, and to assess conditions of confinement.

Offenders may be posed with the following suggested questions:

- ✓ Were you aware the visiting team would be here? Do offenders know how to access health care? Do you understand how to file a grievance? Do you feel safe? Are you involved in any programs and what do you think about the program? Do you have an opportunity to practice one's faith? What is the best program/activity the facility provides that will help you not to come back?

- ✓ Security Staff may be posed with the following suggested questions: Do you understand how to protect yourself and others from infectious diseases? Have you had a performance evaluation in the past twelve months? When is the last time you read and signed your post orders? Do you know your post orders? Do you know how to respond to a crisis situation? Do you feel safe? When was the last fire drill you participated in? What are the procedures if a fire alarm sounded? How is the communication between your sections, and with the executive staff?
- ✓ Auditors should discuss significant concerns derived from the interview process with the other members of the visiting committee.

### **Outcome Measures**

The outcome measure worksheet will be included as an attachment to the final audit report as a Word document.

The auditors review the data for the following criteria:

- ✓ Consistency, e.g. is the documented average daily population for the designated period of time consistent throughout the document?
- ✓ Complete? Do all the measures have data entries including *0* when applicable?
- ✓ Are the numerator, denominator, and calculated outcome measure entered on the worksheet?
- ✓ Correct math?
- ✓ Does the data generally correlate with date on the significant incident summary (i.e. number of homicides, assaults, etc.)?

It is recommended that auditors check the math on a sampling of the outcome measures and on calculated outcome measures that appear exceptionally high, e.g. a large percentage and/or number of active tuberculosis or a high percentage and/or number of inmate on staff assaults. Data that seems exceptional and/or is inconsistent must be brought to the attention of agency for explanation for correction.

The chairperson with assistance from other visiting committee members (specifically the medical auditor for health outcome measures) will provide a summary of the outcome measures, highlighting strong and weak outcome measures, and whether the numbers reflected are consistent with observations, interviews, and the facility/agency mission and population.

### **Significant Incident Summary**

The Significant Incident Summary requires agency information regarding assaults, deaths, escapes, disturbances and other significant events. The information must be provided as stipulated

in the policy manual. Agencies being considered for re-accreditation submit a completed Significant Incident Summary to the Performance-Based Standards and Expected Practices Accreditation Department with the required annual report. The visiting committee is required to review the summary and discuss exceptional and/or inconsistent entries with the agency. The Significant Incident Summary is included as an attachment to the final audit report and is summarized in the audit narrative by the chairperson. The audit narrative should include areas that are outstanding and those that raise a concern, and whether the data reflected are consistent with observations, interviews, and the facility/agency overall mission and security level. If the Significant Incident Summary and Outcome Measures are not for the same time period, the report should annotate as such.

### **Daily Out Briefing**

A daily out briefing is held as an assessment of the audit status and to review the plan for the following day. Those usually present at the out briefing are the visiting committee, facility administrator and others as determined by the administrator. The audit chair should provide the warden with the status of the folder reviews and any outstanding questions or requests for further information should be discussed.

### **Exit Interview**

At the conclusion of the audit, the visiting committee meets with the agency administrator, Accreditation Manager, and appropriate staff to discuss the results of the audit. As with the entrance interview, the agency administrator determines the staff and guests who will be present. Prior to the official exit interview, the visiting committee may meet with the agency administrator to discuss the audit and specifics of the findings. It is the agency's responsibility to ensure the exit interview is audio recorded and the recording is submitted to the chairperson at the conclusion of the exit interview. It is recommended that the chairperson remind the agency Accreditation Manager of the need to audio record the exit interview in advance to allow adequate time to ensure a functional recording device is available prior to the exit. The visiting committee reports all findings of non-compliant expected practices, stating the reasons for each decision. Findings reported by the visiting team during the exit interview are preliminary; and the formal results will be presented in writing in the VCR. The following will be discussed by the visiting team members in planning the discussion items during the exit interview:

- ✓ What will be addressed during the exit interview; it is important that the remarks be brief, to the point, and also end on a positive note.
- ✓ The chairperson will identify what areas of the audit process each auditor should briefly note.
- ✓ The agency staffs have invested a lot of time and effort in this process and it is important that their efforts be acknowledged.

The exit interview should not to be conducted before noon unless you have prior permission from the assigned Accreditation Specialist.

At a minimum the exit interview should include:

- ✓ Agency scores
- ✓ Non-compliant expected practices, reason for non-compliance and a review of the agency/facility options for response.
- ✓ Each visiting committee members' assessment of areas reviewed (keep short and positive)
- ✓ Procedures following the audit
- ✓ The role of the visiting committee in assisting the Commission for Accreditation in making final determination for accreditation
- ✓ Thank agency/facility for assistance and hospitality

The exit interview is not a forum for debate on the merits of the expected practices or the visiting team's assessment of agency documentation. The process for resolving disagreements between the agency and the visiting committee occurs through the agency's response to the VCR and at the time of the hearing. All final decisions regarding accreditation rest with the Commission on Accreditation for Corrections.

Significant changes to the audit as scheduled (e.g. early departure requiring altering travel arrangements or extending the audit) *must* be approved by the assigned Accreditation Specialist.

## **F. Visiting Committee Report (VCR)**

Preparation of the VCR is the responsibility of the chairperson. Other committee members are expected to submit relevant information to the chairperson on the areas they were responsible for, and any input on quality of life, and offender and staff interviews. **Health care auditors are required to submit a detailed health care summary to the chairperson.** As the primary source of information regarding the audit and audit findings, the quality of the report is extremely important in the Commission's decision-making process. The Performance-Based Standards and Expected Practices Accreditation Department has established specific time lines for preparation and submission of the report. Reports must be submitted in the format required by the Performance-Based Standards and Expected Practices Accreditation Department. A new VCR template is sent to the chairperson for each audit. Use the VCR template sent for that specific audit to ensure it is the most up to date template and it has not lost its integrity. Efforts to maintain the report schedule assist in the scheduling of and preparation for accreditation hearings.

Each visiting committee member is responsible for submitting *legible* and *thorough* comments on each non-applicable and non-compliant expected practice. Details of the deficiencies of noncompliance or reasons why the expected practice is not applicable should be noted. If a deficiency is found in square footage, for example, the *amount* of square footage must be indicated. Findings should be written in complete sentences. As these comments are the basis for the report, each should provide clear explanations for findings on the expected practices. The chairperson will retain the original non-compliant and not applicable checklists. A copy of all the non-compliant and not applicable checklists will be provided to the agency/facility prior to leaving the audit site. The chairperson, in turn, is required to send these signed checklists to the Association during the reporting period. These checklists are necessary for the chairperson to write the report and they also have, on occasion, been requested for use in legal proceedings. The checklists of those expected practices found in compliance should be retained by the agency in its files.

The chairperson must obtain *current* information from the agency regarding its operations and programmatic description, offender population, and personnel statistics, organization charts, etc., for inclusion in the Agency Narrative section of the report. If multiple sites are visited for community residential or institutional audits, separate reports are required for each audit conducted. A complex or facility with a satellite camp can be done as one report if it was done as a single audit. If done as one report, all sites should be addressed in all areas of the report.

Reports for probation and/or parole field service agency audits follow a different procedure. The results of visits to all field offices audited are combined into one agency report. For purposes of accreditation, if one field office is found in noncompliance with any expected practice(s), the agency (regardless of the number of field offices) is found in noncompliance with the same expected practice(s).

Issues or concerns that may affect the quality of life (conditions of confinement) in a facility, as well as information and impressions obtained during interviews with staff and offenders, are highlighted in the report. The quality of life statement includes consideration of staff training, cell size and time outside of cells, 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, as well as factors that mitigate the consequences

of negative factors.

The quality of life is evaluated by the Commission during the hearing and should be described in sufficient detail to give them a visual picture of the facility.

The Significant Incident Summary and Outcome Measures Form have been provided to the agency as applicable in pre-audit materials. The chairperson ensures that these forms are completed by the agency and submitted to the chair on the first day of the audit to allow the visiting team to review and follow up, as needed, on any concerns. The information contained on these forms is to be summarized in the narrative portion of the VCR, and the forms are to be submitted as an attachment to the final report for review by the Commission during the panel hearing. The chairperson is also responsible for ensuring the electronic versions of the forms are in the Word format initially provided to the agency by ACA.

The litigation summary should be limited to the case number, cause of action and resolution of class action suits and consent decrees. When there is a decree of judgment, information should be detailed and include the scope and specific requirements.

For re-accreditation audits, the report must address the status of all plans of actions approved by the commission for the previous non-compliant expected practices. (The information should also be available in the annual reports available for the audit period). If the facility/agency is compliant, state the agency/facility is now compliant and no explanation is needed. For those remaining non-compliant, status for each step of the plan of action needs to be addressed in the report.

During the Exit Interview, the Chairperson provides the facility with a written copy of the expected practices found in non-compliance including the reason for the non-compliance. The facility is provided two (2) weeks to respond in writing to the non-compliant expected practices utilizing the Response to Non-Compliance form provided to every facility in the Audit Packet materials.

Upon receipt of the Agency Response(s), the Audit Chair copies and pastes them into the VCR and includes the Auditor Response. Auditor responses should include the rationale for agreement or disagreement with the agency response. The Chairperson then has two (2) weeks to make any edits to the report and email the report to the assigned Accreditation Specialist. According to this timeline, the Chairperson has four (4) weeks from the conclusion of the audit to submit a completed VCR to the assigned Accreditation Specialist.

Upon receipt of the VCR, Performance-Based Standards and Expected Practices Accreditation Department staff implement quality assurance procedures which involve formatting and reviewing the finalized VCR prior to sending it to the Agency for review. Should an Agency have questions about their report, they can communicate with their Accreditation Specialist for resolution and the Specialist will contact the chairperson prior to resolving the issue.

### **Non-compliant expected practices**

Compliance with all applicable expected practices designated as *mandatory* is a prerequisite to accreditation. If a facility is found to be non-compliant with a mandatory expected practice during the audit, the only response they may provide is to request an appeal of the finding of non-compliance. Compliance with 90% of all applicable expected practices designated as non-

mandatory is a prerequisite to accreditation. If not provided during the audit, then within two weeks of the conclusion of the audit, the agency is required to respond to each non-mandatory expected practice found in non-compliance. The response to non-compliance can be emailed to the audit chair using the Response to Non-Compliance form (Appendix F). Response is achieved with a *plan of action, request to waive the requirement that a plan of action be submitted, or an appeal.*

### **Plans of Action**

The Commission's policy is to require agencies to take all reasonable and necessary measures to come into compliance with any non-mandatory expected practice that the visiting committee finds the agency in non-compliance with at the time of the audit. When the non-compliance decision is sustained by the Commission, a plan of action must be developed to correct the deficiencies, (unless such requirement is waived by the commission). The plan of action specifies:

- ✓ Statement of deficiencies
- ✓ Description or summary of actions necessary to achieve compliance
- ✓ Task to be completed
- ✓ Responsible agency and personnel from that agency for completing the tasks
- ✓ Timetables to be met

For programs and facilities operating under a parent agency, the plan of action requires both the individual program being audited, (as well as the parent agency if applicable), to list activities that will be required to achieve compliance with a particular expected practice.

In judging the acceptability of plans of action, the feasibility of plans to achieve compliance will be reviewed by the visiting committee and the Commission, including specific tasks, time frames, and resource availability (staff and funding) for implementing the proposed remedies. The visiting committee chairperson will either accept or not accept the plan of action with a brief synopsis why. In addition, the Commission will look at whether the proposed plan of action is of a continuing nature and, if so, whether or not previously established time frames have been met. The Commission does recognize that not all agencies will be able to comply with all non-mandatory expected practices and may waive the requirement that a plan of action be submitted if factors exist to mitigate the effects of such noncompliance.

### **Waivers**

***Compliance with all applicable expected practices designated as mandatory is a prerequisite to accreditation.*** The Commission views ultimate 100 percent compliance with non-mandatory expected practices as a goal. However, it recognizes that when an agency participates in the accreditation process, it may not always be possible for the agency to comply immediately, or at all, with all of the applicable expected practices. While still encouraging progress toward 100 percent compliance with the expected practices over time, the Commission recognizes

circumstances under which the requirement that a plan of action be submitted may be waived.

The burden of proving that a waiver is warranted rests with the applicant agency. The granting of a waiver does not change the conclusion of non-compliance or alter the expected practices compliance tally. The visiting committee chairperson will either accept or not accept the waiver with a brief synopsis why. The Commission renders the final decision relative to the waiver request during the accreditation hearing.

### **Appeals**

Every expected practice in the manual applied to the applicant program/facility is found compliant, non-compliant or non-applicable. The agency has the opportunity at the accreditation hearing to appeal any findings of the visiting committee in an attempt to change the finding of the expected practice. Auditors are trained and required to render the strictest possible interpretations of expected practices during the audits. The visiting committee chairperson will either accept or not accept the appeal with a brief synopsis why. Only the Commission has the authority and discretion to consider appeals by an agency and render interpretations relative to that program.

The agency's opinion relative to the merit of an expected practice is not grounds for an appeal. The agency *may not* present documentation which did not exist at the time of the audit. The agency may provide additional documentation to the Commission which the visiting committee did not review, understanding that the burden of proof that the documentation existed at the time of the audit is on the agency. The result of a successful appeal is a change in the status of the expected practice (compliance or applicability) and recalculation of the agency's compliance tally. If the Commission denies the appeal, the agency may be required to submit a plan of action for the expected practice to the Performance-Based Standards and Expected Practices Accreditation Department, or the panel may consider a request to waive the requirement that a plan of action be developed. During the next accreditation audit, the agency is responsible for meeting the terms of the submitted plan of action, if applicable.

The last part of the report contains final responses of the visiting committee to all comments received, as well as an evaluation of the agency's plans of action and responses to waiver requests and/or appeals received from the agency. The visiting committee comments on the agency's plan of action OR waiver, request must be more than simply "I agree" or "I disagree." The chairperson should give a concise reason as to why they agree or disagree.

## **G. Specialized Audits and Consulting Visits**

### **Pre-Accreditation Assessment**

At an agency's request and expense, the Association will provide one or more auditors to provide on-site assistance prior to the administrator's decision to sign a contract. The Performance-Based Standards and Expected Practices Accreditation Department staff work with the requesting agency in determining the purpose of the visit, selecting an auditor and the visiting date(s), establishing requirements for report writing, and the fee. Following these arrangements, a facility representative contacts the auditor directly to discuss local hotel and ground transportation arrangements.

The agency administrator may request an auditor for assistance in one or more of the following areas:

- ✓ Assess the agency's strengths and deficiencies by the expected practices
- ✓ Measure readiness for application for accreditation and /or
- ✓ Identify steps required to achieve accreditation

The auditor will not return to the agency as a visiting committee member, but may return to conduct technical assistance if the agency requests such a visit.

The auditor conducting a pre-assessment will review the agency's policies and procedures, examine the physical plant, review compliance with all mandatory expected practices, and, if requested, conduct a short staff orientation on the process. Based on interviews with staff and observation and review of operating materials, the auditor will identify areas where the agency appears to meet the expected practices and those in which they are deficient.

The length of the pre-assessment depends on the agency's stated needs and interests.

### **Agency Tour (Pre-Accreditation)**

The auditor takes an in-depth tour of the facility giving particular attention to the mandatory expected practices and to areas the agency considers important. The auditor visits all areas of the facility, indicating areas that appear to be in compliance and those that appear to be deficient. Suggestions for correcting deficiencies may be given, but with the explicit understanding that only the visiting committee has the authority to make compliance decisions. The auditor should review all physical plant expected practices. During the tour, the auditor may speak with agency staff, particularly department heads, and offenders.

### **Review of Policy and Procedure (Pre-accreditation)**

The auditor reviews current policies and procedures. If the agency has extensive policies and procedures, a sampling will serve to determine an agency's understanding of and readiness for entry into accreditation. If policies and procedures are inadequate, agency staff is provided with an explanation of what is required including how and where to obtain assistance in their writing. Also, an explanation of the Association's documentation requirements is provided.

### **Review of Mandatory Expected Practices (Pre-accreditation)**

The auditor will review mandatory expected practices during the tour and the related policies and procedures. The auditor identifies the mandatory expected practices that appear to be in compliance and those that do not. Suggestions to achieve compliance may be given with the understanding that the visiting committee makes the determination for compliance during the audit.

### **Accreditation Orientation for Staff (Pre-accreditation)**

At the agency's request, the auditor provides a brief accreditation orientation for the administrator and other staff the administrator requests to be present. As appropriate, the orientation will include an explanation of the Association's organization and resources, the benefits of accreditation, and the process. The Association will provide training aids (overheads and handouts) to consultants requesting them.

### **Pre-Assessment Report**

The auditor is required to submit a pre-assessment report to the Association within two weeks following the completion of the visit. Accreditation staff review the report and forward a copy to the agency. The content of the report is tailored to the agency's requirements, strengths, and deficiencies. However, the report will cover the following information:

- ✓ Names and positions of agency staff participating in the pre-assessment
- ✓ General and specific physical plant problems that may delay application for accreditation
- ✓ Status of the agency's policies and procedures and estimate of work required to be compliance with the expected practices
- ✓ Suggestions on how to organize agency staff to complete the requirements of accreditation
- ✓ Problems with mandatory expected practices; and
- ✓ Unique aspects of the agency that might affect their entry into the process

The report should contain a detailed narrative of the auditor's findings and an analysis of the agency's readiness for entry into accreditation including, where appropriate, suggested time lines

for correcting problems and signing a contract.

### **Technical Assistance**

While preparing for the audit, the agency may require clarification of policy and procedure, assistance in determining the applicability of particular expected practices to their program, or expected practices interpretations to clarify the meaning and intent of individual expected practices. At the request of an agency, the Performance-Based Standards and Expected Practices Accreditation Department is able to provide on-site assistance to agencies.

The Technical Assistance visit entail an on-visit by a staff member or auditor to an individual facility or program. The purpose of the visit is to provide assistance to the agency in conducting its self-evaluation and preparing expected practices compliance documentation. Technical Assistance visits are encouraged for agencies seeking initial accreditation.

At an agency's request, the Performance-Based Standards and Expected Practices Accreditation Department arranges for an auditor to provide on-site assistance in one or more of the following areas:

- ✓ Explanation of policy and procedure, including audit preparations
- ✓ Interpretation of the applicability of expected practices to specific areas of concern
- ✓ Evaluation of the appropriateness and thoroughness of documents to support expected practices compliance

A Technical Assistance visit typically entails a review of selected expected practices and documentation prepared by the agency.

During the review, the auditor looks for the appropriate application of expected practices to the agency and addresses organization and completeness of documentation files to ensure that the necessary types of documentation are provided. For residential programs, the field auditor tours the facility, checking agency practices for regular physical plant maintenance, facility sanitation and cleanliness, and to determine if the necessary provisions are in place for fire safety as required by the expected practices. For example, the auditor may look for the proper storage and control of flammable, toxic, and caustic chemicals, upkeep on major appliances and machinery, and the currency of inspection reports by the appropriate authorities. Finally, the field auditor reviews policy and procedure and advises the agency of what to expect during the expected practices compliance audit.

The determination of need for an onsite consultation visit is generally made after the agency has started its self-evaluation. If a visit is agreed upon, the activities and schedule are set. The Accreditation Specialist assigned to the agency coordinates the visit. Transportation and lodging arrangements are handled in the same fashion as for other consultations.

In maintaining the integrity of the process, the individual conducting the Technical Assistance Visit is not assigned to the visiting committee performing the expected practices compliance audit.

Details of the auditor's findings are included in a written report submitted to the Performance - Based Standards and Expected Practices Accreditation Department two weeks following the conclusion of the audit. The contents of the report vary according to the agency's specific needs. However, the report usually covers the following information:

- Names and positions of participants
- General and/or specific physical plant problems related to the expected practices
- Problems with the organization regarding expected practices interpretations and/or policy and procedure; and
- Unique aspects of the agency or facility that could affect the outcome of an expected practices compliance audit

If individual expected practices are reviewed for compliance, the report reflects these findings. Likewise, the auditor notes any weaknesses with particular aspects of documentation. These items alert Performance-Based Standards and Expected Practices Accreditation Department staff and the agency to potential problem areas prior to scheduling an expected practices compliance audit. Upon receipt of the report from the auditor, Performance-Based Standards and Expected Practices Accreditation Department staff will review the report and forward copies to the agency.

### **Mock Audits**

At the agency's request, the Performance-Based Standards and Expected Practices Accreditation Department can arrange for a full visiting team to conduct a mock audit to assess the agency's readiness for the actual accreditation audit. This onsite visit is geared less toward training agency staff and more toward assessing compliance with the expected practices. Transportation and lodging arrangements will be handled in the same manner as other Association visits.

In order to assess agency readiness, the team will conduct the following activities:

- Tour the facility
- Review records, files, and completed expected practices compliance folders
- Interview offenders, staff, and others as appropriate
- Prepare a report for the Performance-Based Standards and Expected Practices Accreditation Department for their review and forward copies to the agency of the findings that may include recommendations to facilitate expected practices compliance

## **Re-Audit**

In the event that an agency is found to be in non-compliance with one or more mandatory expected practices or lacks sufficient compliance levels at the time of the original audit, a re-audit may be requested by the agency, for an additional fee. The re-audit is a visit to the agency that entails a re-evaluation of compliance with mandatory and/or other expected practices necessary to meet accreditation requirements. The chairperson or another member of the original visiting committee may return to the agency to audit the appropriate expected practices.

When a re-audit is requested, the agency is responsible for notifying the Performance-Based Standards and Expected Practices Accreditation Department when the deficiencies have been corrected. Arrangements for the re-audit, including scheduling, transportation, and accommodations are handled in the same manner as for the expected practices compliance audit. The agency may also request a re-audit of any expected practices found in non-compliance during the initial audit. The number of expected practices reviewed and the length of the visit are determined in advance by Performance-Based Standards and Expected Practices Accreditation Department staff.

Re-audit activities follow a format similar to those involved in the expected practices compliance audit. Generally, the visiting committee member meets briefly with agency staff and takes a short tour of the facility (residential and institutional programs) before beginning a re-examination of documentation. All basic auditing principles are applicable on a re-audit, i.e., review of documentation, communication with agency personnel, and interviews. Upon finishing the review of expected practices compliance documentation, the auditor meets with the agency administrator and designated staff to report the new findings. The exit interview is conducted in the same manner as that of the expected practices compliance audit, entailing review and explanation of audit findings.

Following the visit, a written report of audit activities is submitted to the Performance-Based Standards and Expected Practices Accreditation Department within two weeks of the completion of the audit. The re-audit report briefly addresses the conduct of the visit, observations made on the tour, the result of interviews, and any changes in compliance findings since the original audit. This report is combined with the original VCR for use by the Commission when considering the agency's accreditation application.

## **Monitoring Visits**

Monitoring visits to agencies in Accredited Status are conducted by an ACA auditor(s) in order to assess continuing compliance with the expected practices. A monitoring visit may be conducted at any time during the accreditation period, with advance notice to the agency. The determination of need for a monitoring visit is based on the following criteria:

- Compliance levels, findings, and recommendations by the Commission on Accreditation for Corrections during the hearing
- Incidents or events reported by the agency in its annual report
- Critical incident reports or other reports received by the ACA or Commission on

## Accreditation for Corrections that require intervention

The length of the visit varies depending on the number of expected practices or special issues that must be addressed during the visit. The visits are conducted similar to expected practices compliance audits, but on a reduced scale

Activities, as a general rule, involve a review of all expected practices found in non-compliance at the time of accreditation, any other concerns identified by the Commission and may include a review of all mandatory expected practices. The visit also involves a tour of the agency and interviews with staff and offenders to ensure maintenance of the requirements of accreditation. It concludes with an exit interview during which the auditor informs the agency staff of the findings of the visit.

Following the visit, the auditor prepares a monitoring visit report that addresses findings of the visit within two weeks of the completion of the visit. The report includes the following information:

- ✓ A list of expected practices reviewed
- ✓ Explanation of non-compliance findings
- ✓ Results of the tour and interviews with agency staff and offenders
- ✓ Discussion of any issues believed to be relevant to the agency's accreditation

The report, as with others prepared by the auditors, is reviewed by the Performance-Based Standards and Expected Practices Accreditation Department and sent to the agency.

When a monitoring visit to the agency reveals deficiencies in maintaining compliance levels that existed at the time of accreditation, or less than 100 percent compliance with mandatory expected practices, or other significant issues, the agency prepares a response providing explanation of the problems indicated in the report.

When the agency has failed to maintain compliance with all mandatory expected practices, or as may be determined by aca staff, the monitoring visit report and the agency response are submitted to the Commission on Accreditation for Corrections for review during the next regular hearing or to the Commission on Accreditation for Corrections Executive Committee. At the discretion of the Commission, the agency may be placed in probationary status and a revisit conducted to determine if deficiencies have been corrected, or accreditation may be revoked.

### **Honorarium and Reimbursement**

Included with the audit materials received by each auditor for their assignment is the "Auditor's Honorarium and Travel Reimbursement form". The auditor must submit the form to ACA upon their return from the audit, and the *form must* be completed and signed in order for the auditor to receive the honorarium and reimbursement. Travel reimbursement covers fees for the hotel room, the allotted daily meal per diem, airport parking, round trip mileage to the airport, round trip

mileage to the audit if driving (prior approval required), and the allotted miscellaneous expense. Failure to sign the reimbursement, name of the facility being audited, missing receipts, illegible handwriting, etc. may result in significant delays in the processing or returned/rejected reimbursements. It is recommended that auditors' staple or paperclip their reimbursement request form to their receipts prior to mailing them to ACA.

The auditor must submit *original receipts* for all expenses *incurred during the audit* except for the meals and miscellaneous expenses. ACA reimburses meals per an allotted daily per diem; therefore, individual food receipts are not necessary. Reimbursement is calculated based on the departure time of day on the beginning date of travel of the audit to the auditor's return time of day to their home at the conclusion of the audit's trip. ACA does not reimburse for room service, pay-per-view movies, dry cleaning, mini-fridge items, etc.

The auditor will receive *one check* for the total amount of the honorarium and expense reimbursement.

Auditors are asked to allow 4-6 weeks for the processing of travel reimbursement. Questions concerning the status of reimbursement should be directed to the appropriate Accreditation Specialist.

ACA does not accept photocopied or emailed reimbursements. They must be mailed to the attention of the appropriate Accreditation Specialist.

## **H. AUDITOR REMINDERS**

- I. REVIEW MANDATORY EXPECTED PRACTICES FIRST!** Reviewing the mandatory expected practices folders first identifies problems early allowing time for potential resolution. If the visiting committee believes a mandatory expected practice is non-compliant, the chairperson should notify and confer with the facility administrator. After meeting with the facility administrator, the chairperson must notify the Director of Performance-Based Standards and Expected Practices Accreditation Department.
- II. REFER TO THE ANNUAL REPORTS AND THE PREVIOUS AUDIT REPORT!** Re-accreditation audits should reference the previous audit and subsequent annual reports, i.e. identify current status of previously non-compliant/non-applicable expected practices, note progress on prior plans of action, note and comment on changes that occurred during the past three years that may have impact on the conditions of confinement and quality of life such as physical plant changes, increased/decreased population, staff/administration turnover, etc.
- III. PROVIDE DETAILED INFORMATION!** On the checklist, auditors must provide detailed information explaining why an expected practice is non-compliant or non-applicable. Physical plant expected practices should include measurements and ratios. State why or how the protocols and process indicators do not meet the expected practice.
- IV. WRITE LEGIBLY!** When completing the expected practices checklists, the visiting team member reviewing the assigned expected practice must make sure their notes are legible and written in complete sentences without abbreviations.
- V. VERIFY THE CONTENTS OF THE AGENCY NARRATIVE!** Verify the population count at the time of the audit, confirm staffing levels, etc.
- VI. KEEP THE AGENCY AWARE OF ANY PROBLEMS!** Don't wait for the exit interview to bring up problems. Keep the agency apprised of the progress of audit process including concerns about expected practices compliance, especially the mandatory expected practices.
- VII. SUBMIT REQUIRED REPORTS/RESPONSES TO ACA IN THE IDENTIFIED TIMELINES!** If you are running late with a report promptly notify your assigned Accreditation Specialist. Failure to do so may negatively impact the number of audits you are selected for.
- XIII. IF YOU MUST CANCEL,** give as much advance notice as possible to the assigned Accreditation Specialist.
- IX. SUBMIT A COMPLETE REPORT!** Make sure the report you (as the chairperson) submit to ACA is clearly written, comprehensive, and includes any required attachments such as the completed non-applicable and non-compliant expected practices checklist. Remember, the report will be read by the agency and the Commission on Accreditation. Be professional, be appropriate, and be clear. **When writing the report, do not cut and paste the agency description from a previous audit report – THINGS CHANGE!**

- X. **FINDINGS ARE CONFIDENTIAL** and must not be discussed with colleagues or associates.
- XI. **AUDITORS ARE THE *EYES AND EARS* OF THE AMERICAN CORRECTIONAL ASSOCIATION AND THE COMMISSION ON ACCREDITATION FOR CORRECTIONS.**
- XII. **CALL THE ACCREDITATION SPECIALIST** if you have any questions or concerns during the audit.
- XIII. **YOU ARE AN INVITED GUEST OF THE AGENCY!** The goal of the accreditation process is to assist agencies in recognizing their accomplishments and assisting them in identifying how they can improve. Be professional, courteous, and respectful of the agency, the administrators, the staff, and the offenders.
- XIV. **COSTS. Limit air travel to the costs and times frames indicated in your assignment emails. Anything over \$500 requires prior approval from ACA staff.**
- XV. **AT NO TIME WILL AUDITORS PROMOTE THEIR PERSONAL INTERESTS, BUSINESSES OR ACTIVITIES.**
- XVI. **No auditor will accept any gift or favor of a nature to imply any obligation that is inconsistent with the free and objective exercise of professional responsibilities.**

## XVI. ACA Awards Program

The American Correctional Association awards excellence in the auditing and accreditation field. These awards are:

- The Dunbar Award
- The Keohane Award
- The Crystal Eagle Award
- The Global Eagle Award
- The Lucy B Webb Hayes

The **Dunbar** and **Keohane** awards are presented annually at the summer Congress of Correction in recognition of superior contributions, professionalism, commitment and leadership to the auditing and accreditation process. Nominations for this award come from the field and are due to the Director of Performance-Based Standards and Expected Practices Accreditation Department, at [acastandards@aca.org](mailto:acastandards@aca.org) eight weeks before the scheduled conference date.

The **Crystal Eagle Award** is presented to county and local correctional agencies or single-state independent organizations operating three or more separate facilities. The award is given in recognition of accrediting every component within the agency's area of responsibility. The Crystal Eagle award represents the highest commitment to excellence in correctional operations and the dedication of these agencies to enhancing public safety and the well-being of those under their responsibility.

The **Global Eagle Award** is presented to state correctional agencies or trans-state independent organizations in recognition of accrediting every component within their area of responsibility. The Global Eagle award represents the highest commitment to excellence in correctional operations and the dedication of these agencies to enhancing public safety and the well-being of those in their care.

The **Lucy Webb Hayes Award** is presented to correctional agencies, trans-state independent or single-state independent organizations operating three or more separate facilities. The award is given in recognition of achieving ACA Accreditation and PREA certification for every component within their area of responsibility. The Lucy Webb Hayes award represents the highest commitment to excellence in correctional operations and the dedication of these agencies to enhancing public safety and the well-being of those in our care.

The Lucy Webb Hayes Award (Gold Level) is presented to State correctional agencies or trans-state independent organizations in recognition of achieving ACA Accreditation and PREA certification for every component within their area of responsibility. The Lucy Webb Hayes (Gold Level) award represents the highest commitment to excellence in correctional operations and the dedication of these agencies to enhancing public safety and the well-being of those in our care.

The Lucy Webb Hayes Award (Crystal Level) is presented to county and local correctional agencies, community corrections, or single-state independent organizations operating three or more separate facilities. The award is given in recognition of achieving ACA Accreditation and PREA certification every component within the agency's area of responsibility.

The Lucy Webb (Crystal Level) award represents the highest commitment to excellence in correctional operations and the dedication of these agencies to enhancing public safety and the well-being of incarcerated individuals.

If you believe your agency qualifies for the Crystal Eagle, Golden Eagle, or Lucy Webb Hayes Awards please contact your ACA Specialist. Notifications are due to your ACA Specialist no later than eight weeks prior to the Winter Conference or Congress of Correction.

## Appendix A

### Compliance File Documentation Guide

There are many successful methods of building compliance files for ACA Accreditation Audits to include electronic folders. While many expected practices are common among all accreditation manuals, 22 manuals do exist and there are a great number of agencies each with their own unique profiles. Simple, concise and clear documentation should ease the review process. In consideration of such variance, the only required folder protocols are as follows:

- ✓ Clearly distinguish between mandatory and non-mandatory expected practices. This can be done with different colored folders or different colored labels – red is the preferred color for mandatory expected practices.
- ✓ Provide sufficient documentation to establish compliance and have available for access further documentation if requested.
- ✓ List primary/protocol and secondary/process indicator documents on the compliance checklist. It is helpful to list documents in the order they appear in the file.
- ✓ Sign the compliance checklist and mark each compliant, non-compliant or non-applicable.
- ✓ Files must include completed documentation for the three years of your audit cycle for reaccreditation audits, and available completed documentation for an initial accreditation audit. For reaccreditation audits, documents should be separated by audit year when feasible. This can be as achieved by simply placing a different colored paper in between each year.
- ✓ Expected practices which require a specific review period such as annual, quarterly, monthly, or weekly must have files which include the identified period requirements. For example, an annual review requirement would have one document illustrating the annual review; once for an initial or once each year of the three-year accreditation cycle. For example, multiple review periods would have three consecutive weekly, and two consecutive monthly or quarterly documents, thus illustrating compliance with the more frequent review requirements. Other weekly, monthly, or quarterly documentation should be available if requested.

The following guidelines are merely suggestions to assist in file preparation.

1. Typically, files are built with the compliance checklist on the left side of the file and with protocols/primary documentation and process indicators /secondary documentation on the right side of the file.
2. Most expected practices should have a written policy which meets the requirements of the expected practice. There are some instances wherein the expected practice is directly impacted by local or state statute in which case there may not be a policy and the statute or

law is place in the file. It is not a problem should your department have a policy directing compliance with statute, in which case both the policy and a copy of the statute would be placed in the file

3. Policy documents should include any revisions which impacted compliance during the accreditation cycle if a reaccreditation audit. The front policy page and any following pertinent pages are sufficient; it is not necessary to have three complete copies of the same policy. Revisions should be easily identified.
4. Should an expected practice be identified as non-compliant, such information can be documented on the compliance checklist itself or in an attachment.
5. Similarly, if an expected practice is identified as non-applicable, information documented on the compliance checklist itself is appropriate to illustrate the rationale for a non-applicable finding, or an attachment may be used.
6. When the expected practices include multiple requirements, compliance documentation should include identification of the individual components utilizing corresponding numbering on process indicators and protocols.

## APPENDIX B

Date Mailed:

Date Posted:



### NOTICE THIS AGENCY IS AN APPLICANT FOR ACCREDITATION

- The Commission on Accreditation for Corrections and the American Correctional Association are private, non-profit organizations directing the accreditation of correctional programs in the United States and other countries.
- Example Facility** is voluntarily seeking accreditation by the Commission on Accreditation for Corrections by demonstrating its compliance with nationally established expected practices.
- The Commission on Accreditation for Corrections will conduct a compliance audit of this agency on **March 17-19, 2018**.
- Information relevant to this agency's compliance with expected practices should be submitted in writing to the American Correctional Association, Performance-Based Standards and Expected Practices Accreditation Department, at least 10 working days prior to the audit. Please send all materials or comments to:

American Correctional Association  
Performance-Based Standards and Expected Practices Accreditation Department  
206 North Washington Street, Suite 200  
Alexandria, Virginia 22314  
(703) 224-0000

## APPENDIX C-1



### ORGANIZATION SUMMARY FOR SECURE RESIDENTIAL FACILITIES

*Revised 5/20/2020*

An Organization Summary is a form completed by the agency applying for accreditation that provides the Performance-Based Standards and Expected Practices Accreditation Department with descriptive information about the program or facility. Please complete a separate summary for each program or facility and return to the ACA. If you have any questions, please contact your Accreditation Specialist. *This form is fillable so you can type directly into the grey boxes.* Upon receipt of this organization summary please contact your Accreditation Specialist to determine the date it needs to be submitted.

INTRODUCTION	
Governing Authority/ Parent Agency:	
Name of Facility/Program:	
Physical Address:	
Mailing Address:	
Primary Facility Telephone Number:	
Primary Contact Person:	
Primary Contact Person's Phone Number:	
Airport Information	1 <sup>st</sup> Preference: Distance from the facility: 2 <sup>nd</sup> Preference: Distance from the facility:

ACCREDITATION AND MANUAL INFORMATION	
ACA Accreditation Status:	<input type="checkbox"/> Initial <input type="checkbox"/> Reaccreditation Date of last ACA Accreditation: _____ Applicable Manual and Edition: _____
Is this agency or facility accredited by any other organization?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide the name of the organization(s) and the date(s) of the most recent accreditation:

--	--

DEMOGRAPHICS	
Current Operational Capacity:	_____ <i>Number of beds or program slots authorized for the safe and efficient operation of the facility/program</i>
Current Population:	Current Population: _____ Average Daily Population for the last 12 months: _____
Characteristics of the Population:	Number of Adults:
	Number of Youthful Offenders: (Under the age of majority, but adjudicated as adults)
	Number of Juveniles:
Average Length of Stay:	Years: _____ Months: _____ Days: _____
Average Sentence Length:	Years: _____ Months: _____ Days: _____

ORGANIZATIONAL INFORMATION	
State the mission of the agency or facility (attach additional pages if necessary)	
Describe any current significant court interventions (i.e. consent decrees or settlement agreements)	
Total Number of Full Time Staff:	
Facility Administrator/Title:	
Telephone Number and Email Address:	
Existing ACA Member? If yes, please include ACA Membership Number.	
Facility Accreditation Manager:	
Telephone Number and Email Address:	
Existing ACA Member? If yes, please include ACA Membership Number.	
State/Regional Accreditation Manager: (if applicable)	
Telephone Number and Email Address:	
Existing ACA Member?	

If yes, please include ACA Membership Number.	
---	--

**PHYSICAL AND OPERATIONAL SECURITY FEATURES**

Date of Facility Construction:	
Date of the Last Renovation: (if applicable)	
Number of Satellite Facilities:	_____ Are these facilities to be included in the accreditation? _____
Name of Satellite Agency or Facility:	
Physical Address:	
Mailing Address:	
Primary Facility Telephone Number:	
Security Level of the Facility:	_____ Maximum _____ Medium _____ Minimum
Number of Offenders by Custody Level:	_____ Maximum _____ Medium _____ Minimum

Signature:

Printed Name:

Title:

Date:

## APPENDIX C-2



### ORGANIZATION SUMMARY FOR NON-SECURE RESIDENTIAL PROGRAMS

*Revised 5/20/2020*

An Organization Summary is a form completed by the agency applying for accreditation that provides the Performance-Based Standards and Expected Practices Accreditation Department with descriptive information about the program or facility. Please complete a separate summary for each program or facility and return to the ACA. If you have any questions, please contact your Accreditation Specialist. *This form is fillable so you can type directly into the grey boxes.* Upon receipt of this organization summary please contact your Accreditation Specialist to determine the date it needs to be submitted.

INTRODUCTION	
Governing Authority/ Parent Agency:	
Name of Facility/Program:	
Physical Address:	
Mailing Address:	
Primary Facility Telephone Number:	
Primary Contact Person:	
Primary Contact Person's Phone Number:	
Airport Information	1 <sup>st</sup> Preference: Distance from the facility: 2 <sup>nd</sup> Preference: Distance from the facility:

ACCREDITATION AND MANUAL INFORMATION	
ACA Accreditation Status:	<input type="checkbox"/> Initial <input type="checkbox"/> Reaccreditation Date of last ACA Accreditation: _____ Applicable Manual and Edition: _____
Is this agency or facility accredited by any other organization?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide the name of the organization(s) and the date(s) of the most recent accreditation:

<b>DEMOGRAPHICS</b>	
Current Operational Capacity:	<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border-bottom: 1px solid black; width: 150px;"></div> <div style="font-size: small; text-align: right;"><i>Number of beds or program slots authorized for the safe and efficient operation of the facility/program</i></div> </div>
Current Population:	Current Population: _____ Average Daily Population for the last 12 months: _____
Characteristics of the Population:	Number of Adults:
	Number of Youthful Offenders: <small>(Under the age of majority, but adjudicated as adults)</small>
	Number of Juveniles:
	Age of Criminal Majority in your jurisdiction:
Average Length of Stay:	Years: _____ Months: _____ Days: _____

<b>ORGANIZATIONAL INFORMATION</b>	
State the mission of the agency or facility <small>(attach additional pages if necessary)</small>	
Describe any current significant court interventions <small>(i.e. consent decrees or settlement agreements)</small>	
Total Number of Full Time Staff:	
Facility Administrator/Title:	
Telephone Number and Email Address:	
Existing ACA Member? <small>If yes, please include ACA Membership Number.</small>	
Facility Accreditation Manager:	
Telephone Number and Email Address:	
Existing ACA Member? <small>If yes, please include ACA Membership Number.</small>	
State/Regional Accreditation Manager: <small>(if applicable)</small>	
Telephone Number and Email Address:	
Existing ACA Member?	

If yes, please include ACA Membership Number.	
---	--

<b>PHYSICAL AND OPERATIONAL SECURITY FEATURES</b>	
Date of Facility Construction:	
Date of the Last Renovation: (if applicable)	

Signature:

Printed Name:

Title:

Date:

## APPENDIX C-3



### ORGANIZATION SUMMARY FOR NON-SECURE, NON-RESIDENTIAL PROGRAMS *Revised 5/20/2020*

An Organization Summary is a form completed by the agency applying for accreditation that provides the Performance-Based Standards and Expected Practices Accreditation Department with descriptive information about the program or facility. Please complete a separate summary for each program or facility and return to the ACA. If you have any questions, please contact your Accreditation Specialist. *This form is fillable so you can type directly into the grey boxes.* Upon receipt of this organization summary please contact your Accreditation Specialist to determine the date it needs to be submitted.

INTRODUCTION	
Governing Authority/ Parent Agency:	
Name of Facility/Program:	
Physical Address:	
Mailing Address:	
Primary Facility Telephone Number:	
Primary Contact Person:	
Primary Contact Person's Phone Number:	
Airport Information	1 <sup>st</sup> Preference: Distance from the facility: 2 <sup>nd</sup> Preference: Distance from the facility:

ACCREDITATION AND MANUAL INFORMATION	
ACA Accreditation Status:	<input type="checkbox"/> Initial <input type="checkbox"/> Reaccreditation Date of last ACA Accreditation: _____ Applicable Manual and Edition: _____
Is this agency or facility accredited by any other organization?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide the name of the organization(s) and the date(s) of the most recent accreditation:

--	--

DEMOGRAPHICS	
--------------	--

Program Slots Available:	
--------------------------	--

ORGANIZATIONAL INFORMATION	
----------------------------	--

State the mission of the agency or facility (attach additional pages if necessary)	
---	--

Describe any current significant court interventions (i.e. consent decrees or settlement agreements)	
---	--

Total Number of Full Time Staff:	
----------------------------------	--

Number of Field or District Offices: (if applicable)	_____
	Are these facilities to be included in the accreditation? _____

Number of Satellite Facilities: (if applicable)	_____
	Are these facilities to be included in the accreditation? _____

Facility Administrator/Title:	
-------------------------------	--

Telephone Number and Email Address:	
-------------------------------------	--

Existing ACA Member? If yes, please include ACA Membership Number.	
---	--

Facility Accreditation Manager:	
---------------------------------	--

Telephone Number and Email Address:	
-------------------------------------	--

Existing ACA Member? If yes, please include ACA Membership Number.	
---	--

State/Regional Accreditation Manager: (if applicable)	
--	--

Telephone Number and Email Address:	
-------------------------------------	--

Existing ACA Member? If yes, please include ACA Membership Number.	
---	--

Signature:

Printed Name:

Title:

Date:

## Appendix D Compliance Checklist

Expected Practice Number: \_\_\_\_\_

<b>SELF-EVALUATION AGENCY PERSONNEL</b>	<b>COMPLIANCE AUDIT VISITING COMMITTEE</b>
Staff Signatures:	Auditor Signatures:
<input type="checkbox"/> Compliant <input type="checkbox"/> Non-Compliant <input type="checkbox"/> Non-Applicable	<input type="checkbox"/> Compliant <input type="checkbox"/> Non-Compliant <input type="checkbox"/> Non-Applicable
List documentation to support compliance or explain non-applicability of expected practices.	List reasons for non-compliance or non-applicability of expected practices.  *Note: List all deficiencies if standard is in non-compliance. Include the square footage, ratios, footcandles, dBAs, etc. Make your complete comments on this page with attachments, if necessary. <b>BE VERY SPECIFIC!</b>
Comments:	

## Appendix E Compliance Tally Sheet

### COMMISSION ON ACCREDITATION FOR CORRECTIONS AND THE AMERICAN CORRECTIONAL ASSOCIATION COMPLIANCE TALLY

Manual Type		
Manual Date		
Facility/Program		
Audit Dates		
Auditor(s)		
	<b>MANDATORY</b>	<b>NON-MANDATORY</b>
Number of Expected Practices/Traditional Standards in Manual		
Number Not Applicable		
Number Applicable <sup>1</sup>		
Number Non-Compliance		
Number in Compliance <sup>2</sup>		
Percentage (%) of Compliance <sup>3</sup>		
<ul style="list-style-type: none"> <li>• Number of Expected Practices minus Number of Not Applicable equals Number Applicable</li> <li>• Number Applicable minus Number Non-Compliance equals Number Compliance</li> <li>• Number Compliance divided by Number Applicable equals Percentage of Compliance</li> </ul>		

**Appendix F**  
**Response to Non-compliance Form**

Traditional Standard/Expected Practice # \_\_\_\_\_

**RESPONSE TO NON-COMPLIANCE**  
**(To be forwarded to the Audit Chair within two weeks of the Audit Closeout)**

Submit one of the following for the non-compliant expected practice referenced above.

**1. Plan of Action**

Please explain completely the corrective action that will be taken to comply.

In the order of anticipated completion dates, list the tasks necessary to achieve compliance, the responsible agency (including parent agency), and assigned staff member.

Task

- a.
- b.
- c.

Responsible Agency

- a.
- b.
- c.

Assigned Staff

- a.
- b.
- c.

Anticipated Completion Date

- a.
- b.
- c.

**RESPONSE TO NON-COMPLIANCE**

**Page 2**

**Traditional Standard/Expected Practice # \_\_\_\_\_**

**2. Waiver Request**

Indicate why the requirement for the submission of a Plan of Action should be waived.

**3. Appeal of the Visiting Committee Finding**

Indicate your reason for disagreeing with the Visiting Committee's finding of non-compliance.

**Agency Representative Signature:**  
**Agency Representative Name and Title Printed/Typed:**

**Date:**



## Appendix G Significant Incident Summary

This report is required for all **residential** accreditation programs.

This summary is required to be provided to the Chair of your visiting team upon their arrival for an accreditation audit and included in the facility's Annual Report. The information contained on this form will also be summarized in the narrative portion of the visiting committee report and will be incorporated into the final report. Please type the data. If you have questions on how to complete the form, please contact your Accreditation Specialist.

This report is for Adult Correctional Institutions, Adult Local Detention Facilities, Core Jail Facilities, Boot Camps, Therapeutic Communities, Juvenile Community Residential Facilities, Juvenile Correctional Facilities, Juvenile Detention Facilities, Adult Community Residential Services, and Small Juvenile Detention Facilities.

Facility Name: \_\_\_\_\_

Reporting Period: \_\_\_\_\_

Incident Type	Months														Total for Reporting Period
	⇒														
Escapes															
Disturbances*															
Sexual Violence															
Homicide*	Offender Victim														
	Staff Victim														
	Other Victim														
Assaults	Offender/Offender														
	Offender/Staff														
Suicide															
Non-Compliance with a Mandatory Standard*															
Fire*															
Natural Disaster*															
Unnatural Death															
Other*															

\*May require reporting to ACA using the Critical Incident Report as soon as possible within the context of the incident itself.

## Appendix G – Page 2

### Significant Incident Summary Glossary



**Assaults:** An altercation which results in serious injury requiring urgent and immediate medical attention and restricts usual activities.

**Disturbance:** Offender action that resulted in loss of control of the facility or a portion of the facility and required extraordinary measures to regain control.

**Escape:** As defined by the jurisdiction reporting.

**Fire:** A fire which results in evacuation of staff or offenders and/or significant damage to a facility or part of a facility structure.

**Homicide:** As defined by the jurisdiction reporting.

**Non-Compliance with Mandatory Expected Practices:** Determination that a condition results in non-compliance with a mandatory standard that is expected to result in sustained non-compliance.

**Natural Disaster:** A natural event such as a flood, tornado, tsunami, earthquake, or hurricane that causes great damage or loss of life.

**Other:** Any significant negative event or distraction that adversely impacts normal operations.

**Serious Injury:** Is a physical injury which creates a substantial risk of death, or which causes serious and protracted impairment of health or protracted loss or impairment of the function of any bodily organ.

**Sexual Violence** (as defined by PREA): A substantiated, non-consensual sexual act includes one or more of the following behaviors:

- Contact between the penis and the vagina or the penis and the anus involving penetration, however slight. It does not include kicking, grabbing or punching genitals when the intent is to harm or debilitate rather than to sexually exploit.
- Contact between the mouth and the penis, vagina, or anus.
- Penetration of the anal or genital opening of another person by a hand, finger, or other object.

**Unnatural Death** – Death of a person in confinement for causes other than suicide, homicide, or accident that is contrary to the ordinary course of nature or otherwise abnormal.

## Appendix H

REPORT NUMBER

(Staff Use Only)



### Performance-Based Standards and Expected Practices Accreditation Department Critical Incident Report

The agency is responsible for notifying Performance-Based Standards and Expected Practices Accreditation Department staff of any critical incident that has the potential to affect expected practice compliance or facility accreditation as soon as possible within the context of the incident itself. This report is applicable to Adult Correctional Institutions, Adult Local Detention Facilities, Core Jail Facilities, Boot Camps, Therapeutic Communities, Juvenile Correctional Facilities, Juvenile Detention Facilities, Adult Community Residential Services and Small Juvenile Detention Facilities.

#### I. INTRODUCTION AND FACILITY INFORMATION

- a. Governing/Parent agency:
- b. Facility Name:
- c. City, State:
- d. Facility Contact Person:
- e. Telephone Number:
- f. Email Address:
- g. Date of Report:
- h. Date of incident:

---

## **II. TYPE OF INCIDENT:**

- Disturbance: Offender action that results in loss of control of the facility or a portion of the facility and required extraordinary measures to regain control.
- Fire: A fire which results in evacuation of staff or Offenders and/or significant damage to a facility or part of a facility structure.
- Homicide: As defined by the jurisdiction reporting.
- Natural Disaster: A natural event such as a flood, tornado, earthquake, or hurricane that causes great damage or loss of life.
- Non-Compliance with Mandatory Expected Practice: Determination that a condition results in non-compliance with a mandatory expected practice and is expected to result in sustained non-compliance.
- Other: Any significant negative event or distraction that adversely impacts normal operations.

---

## **III. SUMMARY OF THE INCIDENT (attach additional documents if necessary):**

## Appendix I

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REPORT NUMBER  
(STAFF USE ONLY)



### PERFORMANCE-BASED STANDARDS AND EXPECTED PRACTICES ACCREDITATION DEPARTMENT ANNUAL REPORT

Each accredited program must submit an annual report to the ACA Performance-Based Standards and Expected Practices Accreditation Department. The Annual Report is due by the anniversary of accreditation. The accreditation date is noted on the Final Accreditation Report and on the Accreditation Certificate that is awarded at the panel hearings.

---

#### I. INTRODUCTION

- a. Governing/Parent Agency:
  - b. Facility/Program Name:
  - c. Date of Audit:
  - d. Date Accredited:
  - e. Contact Person:
  - f. Contact Person's Phone Number and Email Address:
- 

#### II. DEMOGRAPHICS

- a. Current Operational Capacity:  
*(Number of beds or program slots authorized for the safe and efficient operation of the facility/program)*
- b. Average Daily Population/Program Participation for the reporting year:
- c. Average Length of Time Current Population has been assigned to Facility/Program:

---

### III. COMPLIANCE TALLY UPDATE

- a. Current Compliance Level (as defined in Agency Manual on Accreditation)
- b. Changes in Compliance Level Since Last Annual Report (include both “compliance” to “non-compliance” and “non-compliance” to “compliance” changes).
- c. Plan of Action (POA) Update
  - i. Plans of action completed
  - ii. Plans of action in progress (on schedule/proceeding as approved by CAC)
  - iii. Plans of action revision needed/requested
- d. Summary of approved Waivers

---

### IV. ORGANIZATION UPDATES

- a. Major Change in Agency Administration and/or Major Staffing Changes
- b. Mission change or significant program revisions
- c. Significant changes in program participant population.
- d. Major physical plant renovations (including effect on current capacity, if any).
- e. Other Accreditation/Certification Received (i.e. PREA)
- f. Number of Staff Certified as a Certified Correctional Professional (CCP), if available

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V. **SIGNIFICANT INCIDENT SUMMARY** (if applicable) shall be attached as Attachment A.  
Attached

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VI. **Outcome Measures** (if applicable) shall be attached as Attachment B.  
Attached

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VII. **SUMMARY OF CRITICAL INCIDENT REPORTS** (if applicable) shall be attached as  
Attachment C.  
Attached



APPENDIX J.1

## Visiting Team Member Evaluation

This evaluation is provided to each audit chair and is to be completed at the end of their American Correctional Association (ACA) audit. The purposes of obtaining this information are to assist in the improvement of auditor training, and to provide one source of data for administrative evaluation. This document will serve its purpose best if items are answered honestly as you reflect back on each visiting team member.

**Facility Audited:** \_\_\_\_\_ **Audit Date:** \_\_\_\_\_

**Name of Team Member #1:** \_\_\_\_\_

General	Strongly Agree	Agree	Disagree	Strongly Disagree
The auditor was prepared for the audit.				
The auditor made team members feel comfortable.				
The auditor made facility staff feel comfortable.				
The auditor answered staff questions in a courteous manner.				
The auditor treated all staff with respect.				

**Name of Team Member #1:** \_\_\_\_\_

1. Did this team member assist in writing the report?
  - a. If yes, how would you describe their writing skills?
  
  
  
  
  
  
  
  
  
  
  - b. If no, why now?
  
  
  
  
  
  
  
  
  
  
2. List three qualities of this team member that would be a benefit to a visiting team.
  
  
  
  
  
  
  
  
  
  
3. List three areas which you feel this team member needs to improve upon before being considered for participation in the audit chair mentoring program.

**Submitted by:** \_\_\_\_\_



## APPENDIX J.2 Visiting Team Member Evaluation

This evaluation is provided to each audit chair and is to be completed at the end of their American Correctional Association (ACA) audit. The purposes of obtaining this information are to assist in the improvement of auditor training, and to provide one source of data for administrative evaluation. This document will serve its purpose best if items are answered honestly as you reflect back on each visiting team member.

**Facility Audited:** \_\_\_\_\_ **Audit Date:** \_\_\_\_\_

**Name of team Member #2:** \_\_\_\_\_

<b>General</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
The auditor was prepared for the audit.				
The auditor made team members feel comfortable.				
The auditor made facility staff feel comfortable.				
The auditor answered staff questions in a courteous manner.				
The auditor treated all staff with respect.				

**Name of Team Member #2:** \_\_\_\_\_

1. Did this team member assist in writing the report?
  - a. If yes, how would you describe their writing skills?
  
  
  
  
  
  
  
  
  
  
  - b. If no, why now?
  
  
  
  
  
  
  
  
  
  
2. List three qualities of this team member that would be a benefit to a visiting team.
  
  
  
  
  
  
  
  
  
  
3. List three areas which you feel this team member needs to improve upon before being considered for participation in the audit chair mentoring program.

**Submitted by:** \_\_\_\_\_



APPENDIX K

# Audit Evaluation

This evaluation is provided to each facility upon completion of their American Correctional Association (ACA) audit. The purposes of obtaining this information are to assist in the improvement of the audit process, and to provide one source of data for administrative evaluation. This document will serve its purpose best if items are answered honestly as you reflect back on the audit process.

Audit Chair:

Team Member(s):

Audit Date:

Facility Name:

Submitted by:

Upon completion of this evaluation, please send via e-mail to the Director of Standards and Accreditation, David Haasenritter at [davidh@aca.org](mailto:davidh@aca.org).

Thank you!

## GENERAL QUESTIONS

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The audit team was well prepared for your audit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The audit team made you and your staff feel comfortable, to ask questions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The audit team provided Answers to your questions in a professional, courteous manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Strongly Agree	Agree	Disagree	Strongly Disagree
4. Members of the audit team never embarrassed or intimidated staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Members of the audit team interacted appropriately with all staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The audit team's communication was clear and easily understood by all involved in the audit process.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### PROBLEM-SOLVING QUESTIONS

	Always	Almost Always	Sometimes	Almost Never	Never
7. Audit team members responses were clear and concise.	<input type="checkbox"/>				
8. Audit team's members provided alternative explanations when needed.	<input type="checkbox"/>				
9. The audit chair managed time effectively.	<input type="checkbox"/>				
10. The audit team members were readily available for consultation with facility staff.	<input type="checkbox"/>				

11. The audit team graded consistently in accordance with the standards.

<input type="checkbox"/>				
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

12. The audit report was submitted in a timely manner.

<input type="checkbox"/>				
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

13. The audit report was accurate and complete.

14. The audit report was sufficiently detailed to future audits.

<input type="checkbox"/>				
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

15. The audit chair was effective in her/his role.

<input type="checkbox"/>				
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

16. The audit team members (other than the chair) were effective.

<input type="checkbox"/>				
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

**OTHER QUESTIONS:**

17. What factors made a positive impact on you or your staff during the audit process?

18. Were there any occurrences that left you and/or your staff with a negative feeling regarding the audit process? If so, please describe.

19. What did you like about the audit process?

20. What improvements would you like to see made regarding the audit process?

Additional Comments: