Potter Anderson & Corroon LLP

FOURTH SEMI-ANNUAL REPORT OF THE INDEPENDENT MONITOR OF THE MEMORANDUM OF AGREEMENT BETWEEN THE UNITED STATES DEPARTMENT OF JUSTICE AND THE STATE OF DELAWARE REGARDING THE DELORES J. BAYLOR WOMEN'S CORRECTIONAL INSTITUTION, THE JAMES T. VAUGHN CORRECTIONAL CENTER, THE HOWARD R. YOUNG CORRECTIONAL INSTITUTION AND THE SUSSEX CORRECTIONAL INSTITUTION

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EXECUTIVE SUMMARY

This is the Fourth Report submitted pursuant to the MOA[1] and the Monitoring Agreement,[2] covering the period from July 1, 2008 through December 31, 2008. During this monitoring period, the Monitoring Team[3] has visited each of the Facilities[4] on multiple occasions in order to provide technical assistance and conduct monitoring. In order to monitor the State's compliance with the provisions of the MOA, the Monitoring Team conducted interviews of leadership and staff of Delaware Department of Correction ("DOC") and Correctional Medical Services ("CMS"),[5] and inmates housed in the Facilities.[6] In addition, the Monitoring Team has reviewed numerous medical records at each facility. All of these materials, in connection with the observations that the Monitoring Team made while on site at the Facilities, form the basis of the compliance assessments[7] contained in this Report.

The compliance assessments made in this report regarding the State's compliance with the provisions of the MOA are made by consensus of the Monitoring Team, which means that the Monitoring Team reviews the evidence and determines whether the evidence shows substantial, partial or noncompliance with a provision of the MOA. Furthermore, prior to the

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[1] The "MOA" refers to the Memorandum of Agreement between the United States Department of Justice ("DOJ") and the State of Delaware (the "State") regarding the Delores J. Baylor Women's Correctional Institution, the Delaware Correctional Center, the Howard R. Young Correctional Institution, and the Sussex Correctional Institution, which was entered into on December 29, 2006. The MOA is available at http://www.deprisonmonitor.org/pdf/delaware_prisons_moa_12-29-06.pdf.

[2] The "Monitor Agreement" refers to the Agreement between Joshua W. Martin III (the "Monitor") Individually and on Behalf of Potter Anderson & Corroon LLP and the State of Delaware, which was entered into on May 14, 2007 (the "Monitor Agreement").

[3] The Monitor has retained a team of medical and mental health experts. The Monitor, together with the medical and mental health experts and other attorneys, are hereinafter referred to as the "Monitoring Team." Biographies of the members of the Monitoring Team are attached hereto as Appendix I.

[4] The term "Facilities" refers to the Delores J. Baylor Women's Correctional Institution ("Baylor"), the James T. Vaughn Correctional Center ("JTVCC") (formerly the Delaware Correctional Center or DCC), the Howard R. Young Correctional Institution ("HRYCI"), and the Sussex Correctional Institution ("SCI").

[5] CMS is a private contractor that has been providing medical and mental health care services at the Facilities since it took over the prior vendor's contract on July 1, 2005. The CMS website is available at http://www.cmsstl.com.

[6] The Monitoring Team also has received unsolicited information from inmates, their families, advocates, community groups and other external sources.

[7] For those provisions of the MOA for which the Monitoring Team made an assessment, there are three different compliance assessments possible: substantial compliance, partial compliance, and non-compliance. These compliance assessments will be explained at greater length in the introduction to the report.

Monitoring Team's visit to a site, it serves upon the DOC document requests, describing documents that it anticipates reviewing during its visit. The DOC then takes steps to have these documents ready for review upon the Monitoring Team's arrival, if not prior to that date.

Summary of Findings

As highlighted in previous reports, the Monitoring Team continues to be concerned over the lack of stable and effective leadership at the vendor-level. As the Monitoring Team emphasized in previous reports, without stable and effective leadership, the State will be significantly hampered in its attempts to become compliant with the MOA. Specifically, stable and effective leaders will improve the State's performance by taking responsibility for ensuring that those staff members that they supervise are performing adequately. Also, stable and effective leadership will ensure institutional knowledge of appropriate practices according to the State's policies and procedures.

The Monitoring Team is also very concerned about the lack of progress the State has made with respect to its Continuous Quality Improvement ("CQI") program required by the MOA. Paragraph 54 of the MOA requires the State to create a comprehensive CQI program that, among other things, tracks various data and services performed at the Facilities. A comprehensive CQI program would assist the State with coming into compliance with other provisions of this MOA because, by highlighting specific problems the State is having and pointing out why the problems exist, the State can take action to remedy those problems promptly and without supervision. The CQI program in place at the present time is not operating consistently or with predictable results. While the State has performed various CQI studies, the Monitoring Team finds that the methodology used to select and audit records needs improvement. Specifically, the methodology is flawed at times because the sample is not targeted for the specific indicator being examined in a particular study. For example, a study might be commissioned to examine medication noncompliance issues and the State will pull 50 charts of inmates at random to examine this issue, but only five of the charts are relevant to the study. Instead of selecting charts at random, the State should target the specific issue being examined in the particular study. The Monitoring Team has discussed with the State its concerns with the sample size and methodology during both its visits to the Facilities, and during previous reports.[8]

The State has continued to attempt to maintain areas of improvement that were highlighted in the Third Report. Specifically, the overall timeliness of certain screening processes is fairly good, although the State has had some difficulty in maintaining the performance highlighted in the Third Report at all of the Facilities. In addition, sanitation efforts have improved, although some problem areas remain with respect to that issue. Finally, the State has continued to take action to remedy some of the issues surrounding the availability and use of space needed for the provision of health-related services.

[8] *See* Third Report at pg. 215-221.

Summary of State's Compliance

The MOA contains fifty-five provisions which apply to Baylor, and fifty-four provisions which apply to each of the other three Facilities. The Monitoring Team's assessments of the Facilities are as follows:

- The Monitoring Team found that Baylor is in substantial compliance with 10 of the provisions; in partial compliance with 43 of the provisions; and in non-compliance with 2 provisions.

- The Monitoring Team found that JTVCC is in substantial compliance with 10 of the provisions; in partial compliance with 37 of the provisions; and in non-compliance with 7 provisions.

- The Monitoring Team found that HRYCI is in substantial compliance with 7 of the provisions; in partial compliance with 43 of the provisions; and in non-compliance with 3 provisions. The Monitoring Team deferred making an assessment with respect to one provision, as there was nothing to monitor.

- The Monitoring Team found that SCI is in substantial compliance with 11 of provisions; in partial compliance with 40 of the provisions; and in non-compliance with 3 provisions.

As compared to the Third Report, overall, the number of provisions which the State is in substantial compliance with has increased slightly from 37 to 38. More importantly, the number of provisions which the State is not in compliance with has decreased from 22 to 15. With respect to the majority of provisions with which the State has been assessed as being in partial compliance, as is discussed in the Introduction, a partial compliance rating covers a wide range of performance. It should be noted that, although the State may have received partial compliance ratings in consecutive reports, that does not indicate that the State has failed to make any progress. To the contrary, in many situations, the State has made progress, but still has some work to do before achieving a substantial compliance rating. In order to gain a complete understanding of the progress made by the State, the reader must look past the assessment itself and review the findings made for each provision by the Monitoring Team.

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INTRODUCTION

The First Semi-Annual Report of the Independent Monitor for the State of Delaware Department of Correction was published on June 29, 2007, and represented a preliminary overview of the Monitor's duties, and summaries of the Monitor's first observations regarding the State's compliance with the MOA.[9] The Second Semi-Annual Report (the "Second Report") was published on January 31, 2008. This report represented the Monitoring Team's first opportunity to conduct and report on monitoring of the Facilities and was designed to serve as a baseline against which the State's future improvement will be compared. The Third Semi-Annual Report (the "Third Report"), which was published on July 29, 2008.

In this Fourth Semi-Annual Report (the "Fourth Report"), the Monitoring Team continues to report on its monitoring of the Facilities. As was the case in the Third Report, this report takes note of improvements made by the State since the last report and describes the significant hurdles the State must overcome to come into full compliance with the MOA.

The organization and components of this Fourth Report are the same as those in the Third Report. The organization of the report consists of a review of each MOA provision, followed by the Monitoring Team's assessment of the State's compliance with that MOA provision at a given Facility, findings made by the Monitoring Team regarding that MOA provision at that Facility, and recommendations, if any, to assist the State in reaching substantial compliance with a given provision of the MOA. For purposes of this report, the Monitoring Team used a consensus approach to determine the State's level of compliance with a given MOA provision.

During this monitoring period, the Monitoring Team's visits to the Facilities occurred between August and December 2008. The Monitoring Team visited each Facility; the medical and nursing experts visited a given Facility once to monitor the provision of medical and nursing services, and the mental health experts visited a given Facility once to monitor the provision of mental health services at the Facility. Each visit lasted two to five days.

The Monitoring Team is not, and cannot be, a constant presence at each of the Facilities. Thus, it is important to note that the findings and assessments made in this report are made as of the date of the Monitoring Team's visit to that Facility to monitor a particular provision of the MOA. Therefore, the findings and assessments are not necessarily an indication of the current state at each of the Facilities but rather are a "snapshot" of the state of affairs at the time of the Monitoring Team's visit. This report does contain some updates, however, under circumstances when it was possible to obtain and verify such an update.

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[9] Previous reports can be found on the Monitor's website, at the following address: www.deprisonmonitor.org. The website contains an overview of the Monitor's role, and links to press releases and reports. All future reports will be posted on the website.

Definition of Assessment Ratings

Pursuant to paragraphs 71 and 72 of the MOA, the Monitor is required to review and report on the State's implementation of, and assist with the State's compliance with, the MOA. The Monitor must determine whether the State has successfully complied with each requirement contained in the MOA at each of the Facilities. In order to make that determination, the parties must agree upon appropriate measurements and standards against which the State's performance will be compared. The following are the assessment ratings used by the Monitoring Team:

- The term "substantial compliance" shall mean that the State has satisfied the requirements of all components of the assessed MOA provision. If the State has sustained substantial compliance with all provisions of the MOA for a period of one year, then the State may submit a written request to the DOJ for early termination of the MOA. *See* MOA ¶ 60. The DOJ will determine whether the State has, in fact, maintained substantial compliance for the one year period. *Id*. Otherwise, the MOA is designed to terminate after three years from December 29, 2006. *See* MOA ¶¶ 59 and 60. Non-compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance will not constitute failure to maintain substantial compliance. *See* MOA ¶ 60. At the same time, temporary compliance during a period of sustained non-compliance shall not constitute substantial compliance. *Id*.

- The term "partial compliance" shall mean that the State has achieved less than substantial compliance with all of the components of a rated provision of the MOA, but has made some progress toward substantial compliance on most of the key components of the rated provision. A partial compliance rating encompasses a wide range of performance by the State. Specifically, a partial compliance rating can signify that that the State is nearly in substantial compliance, or it can mean that the State is only slightly above a non-compliance rating.

- The term "non-compliance" shall mean that the State has made negligible or no progress toward compliance with all of the components of the MOA provisions being assessed.

For the purposes of this Fourth Report, the Monitoring Team has reviewed the information available to it, and assessed the level of the State's compliance with each MOA provision at each of the Facilities based upon a consensus approach. This means that for each provision, the Monitoring Team reviews the evidence and determines whether the evidence shows substantial, partial or no compliance with a provision of the MOA.

Overview of Fourth Report

The Fourth Report, like previous reports, generally follows the format of the MOA, which is organized into three distinct substantive areas: (1) Medical and Mental Health; (2) Suicide Prevention; and (3) Quality Assurance.[10] The Fourth Report mirrors that format, and

[10] *See* MOA ¶ 65 (defining Sections III through V as the "Substantive Provisions" of the MOA).

contains individual sections devoted to each of these three areas. Each MOA provision is listed by paragraph number and is followed by some or all of the following:

- a summary of the particular MOA requirements;
- discussion, as appropriate, of any applicable generally accepted professional standards which relate to the MOA provision;[11]
- key findings made by the Monitoring Team;
- an assessment of the State's compliance with the relevant provision;
- recommendations, if any, to assist the State in achieving substantial compliance with the provision.[12]

[11] In this report, the monitor has cited in some cases to two separate NCCHC standards (or other appropriate standards). For informational purposes, this report cites to the NCCHC standards that were in effect at the time the parties entered into the MOA. The NCCHC published a revised version of its standards in 2008. For information about the 2008 Revisions, including summaries of the major changes to the NCCHC Standards please see http://www.ncchc.org/resources/2008_standards/intro.html. The 2008 Revisions do include some substantive changes. For instance, P-E-04 now permits certain facilities to not conduct an initial health assessment on all new intakes, and instead provides an alternative. However, this revision does not comport with provision 12 of the MOA, which requires all newly admitted inmates to receive health assessments within one or two weeks of intake, depending upon whether they have a chronic illness.

[12] Recommendations included in this Report are in the nature of technical assistance and do not represent an obligation of the DOC pursuant to the MOA. The Monitoring Team believes, however, that if the State is able to enact its recommendations, the State's success in achieving substantial compliance with the MOA will be enhanced.

MEDICAL AND MENTAL HEALTH CARE

1. Standard

A. Relevant MOA Provision

Paragraph 1 of the MOA provides:

> The State shall ensure that services to address the serious medical and mental health needs of all inmates meet generally accepted professional standards.[13]

This provision of the MOA requires that the State provide services in all of the areas set forth in the MOA according to generally accepted professional standards, including but not limited to, the standards promulgated by the National Commission on Correctional Health Care ("NCCHC") for prisons and for jails. The Facilities are all used both as jails[14] and as prisons.[15] For the most part, the NCCHC standards for jails and prisons are the same; however, there are some notable differences based upon the different functions served by a jail versus a prison, especially with regard to intake procedures. (*See e.g.*, discussion of provision 10) As the

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[13] According to section II.C. of the MOA, "generally accepted professional standards" means:

> [T]hose industry standards accepted by a significant majority of professionals in the relevant field, and reflected in the standards of care such as those published by the National Commission on Correctional Health Care (NCCHC). DOJ acknowledges that NCCHC has established different standards for jail and prison populations, and that the relevant standard that applies under this Agreement may differ for pretrial and sentenced inmates. As used in [the MOA], the terms "adequate," "appropriate," and "sufficient" refer to standards established by clinical guidelines in the relevant field. The Parties shall consider clinical guidelines promulgated by professional organizations in assessing whether generally accepted professional standards have been met.

[14] A "jail" is, "a detention facility where accused persons are detained until their alleged crime is adjudicated before a jury or judge." Joseph E. Paris, Ph.D., M.D., CCHP, FSCP, *Interaction Between Correctional Staff and Health Care Providers in the Delivery of Medical Care, in Clinical Practice in Correctional Medicine* (Michael Puisis, D.O. ed., 2006). Thus, "[f]or the most part, persons in jails are not yet convicted of a crime, although some jails also house those serving misdemeanor terms (1 year or less) as well as those serving county jail time as condition of felony probation." *Id*.

[15] A "prison" is a "facilit[y] where persons are incarcerated as punishment for crimes for which they have been convicted." Joseph E. Paris, Ph.D., M.D., CCHP, FSCP, *Interaction Between Correctional Staff and Health Care Providers in the Delivery of Medical Care, in Clinical Practice in Correctional Medicine* (Michael Puisis, D.O. ed., 2006).

DOJ has acknowledged in the MOA, the NCCHC has adopted separate standards for prisons and for jails.[16]

B. Assessment

The Monitoring Team found that the State is in partial compliance with this provision of the MOA.

C. Findings

The Monitoring Team notes that each of the Facilities has demonstrated and sustained some improvement, but each Facility has certain challenges that remain to be met. For the specific findings regarding the provisions of the MOA, see the remainder of this report.

The Monitoring Team also believes that it might be helpful to the State to evaluate the infirmaries within the Facilities as a unit. Thus, the following is a summary of findings relating specifically to the infirmary units of each of the Facilities; the topics that are covered within these findings relate to numerous provisions of the MOA, including 3, 10, 12, 13, 15, 16, 22, 24, 25 and 27.

1. Baylor

At the time of the Monitoring Team's visit, the infirmary had several patients who had been there for relatively long periods of time. Four out of five of the patients had been in the infirmary for over 24 hours. A new infirmary log has been developed and is in use, but is not always completely filled out. A review of the patients' health records resulted in the following findings:

- Three of the five patients' records had a nursing intake note.
- Four out of five patients' records had intake orders.
- All patients' records had frequent nursing progress notes.
- Two out of five patients' records had daily provider notes.
- Three out of five patients' records had a discharge note.
- Four out of five patients' records had discharge orders.
- None of the patients' records had nursing transfer notes.
- One patient's record had no nursing intake note, no intake orders, no discharge note, no discharge order and no transfer note. Only by the infirmary log could the Monitoring Team ascertain that she was post-partum. The only documentation in the record were four nursing progress notes for one date, after the last of which the inmate was released back to general

[16] Unless otherwise noted, all references in the format of "J-__-__" shall refer to standards from the *Standards for Health Services in Jails*, National Commission on Correctional Health Care (2003). Likewise, unless otherwise noted, all references in the format o "P-__-__" shall refer to standards from the *Standards for Health Services in Prisons*, National Commission on Correctional Health Care (2003).

population. The nursing progress notes did not document how many days post-partum the inmate was.

- One patient had been followed closely by several different providers; however, there was a break in the continuity of the notes without explanation. From other communications, it appeared that she had been readmitted to the hospital from a follow-up outpatient consult appointment, had surgery for a ventral hernia repair and returned. There was no nursing readmission note.
- One patient had been in the infirmary for nine days with only three provider notes (on day one, day four and day nine). Although she suffered from new neurological symptoms, no neurological examination was performed. Finally, at the insistence of a member of CMS leadership staff, she was sent to a hospital where she remained eight days later, when the Monitoring Team's review took place.

2. JTVCC

The Facility Medical Director is responsible for patient care in the infirmary. Although her responsibility as a primary care provider in the clinic has been removed, she still has many other duties, including oversight of the maximum security unit, supervision of the associate medical director, and participation in frequent meetings. Additionally, she does not have an office in which to perform chart reviews, audits and other quality assurance activities. The State is in the process of building this office space, but although recommended during the prior monitoring period, a temporary space for her to use has not been designated. The result of this lack of protected space is that she is interrupted constantly by both nursing staff and inmates, which causes difficulty for her in completing her work efficiently.

The Monitoring Team reviewed seven records of infirmary patients. Four of the records represented inmates who had been admitted to the infirmary for acute problems, and three of the records represented inmates who were chronically ill and needed to be housed in the infirmary because their medical needs could not be met elsewhere in the facility. The latter are designated as housing patients and comprise the majority of infirmary patients.

Specific findings based upon the Monitoring Team's record review are as follow:

- All records had nursing intake notes. Five of the seven intake notes were on forms specifically created for this purpose; however, most forms were filled out incompletely. Two intake notes were documented in the progress notes.
  - Four of the five notes using the form did not have an admitting diagnosis listed.
  - There was no documentation of physician notification on three of the forms.
  - On one of the admissions, no vital signs were recorded.
- There were frequent nursing notes in all records; however, when an acute change in status occurred and was documented, a physician was not notified.
- Admitting orders could not be found for two patients.
  - In one case, the physician was not notified that the patient was in the infirmary for two days, and the physician was not aware that it was a new patient because he was placed in the same bed as a discharged patient with the same name. This patient appeared to have received prescribed medications without an order.

- In the other case, there were some undated orders in the record which were not cosigned by a physician until several weeks later.

- Intake notes occurred on the next business day in only three of six patients. The seventh patient had arrived the weekend prior to the audit, and the chart was pulled before the physician had arrived at the facility on Monday.
- Provider notes of rounds occurred more frequently than in the previous audit, but none of the patients' records contained daily notes. Many notes stated "late entry" and were written the day after the patient was seen.
- Although housing patients only require a provider note once a week, most of these patients had notes more frequently.
- Two patients with acute problems were admitted over the weekend prior to the Monitoring Team's visit, and documentation of the admittances had not yet occurred when the audit was performed on Monday.
- Two of the records selected for audit had discharge orders written on November 14, 2008; however, the inmates remained in the infirmary as of November 17, 2008.
  - The Monitoring Team learned that discharged patients frequently remain in the infirmary a week or more after discharge because security personnel do not move them. This issue is problematic because, as long as the patient remains in the infirmary, medical charting must continue in accordance with infirmary policy even if the medical needs do not warrant it. This creates additional work for an already overextended medical staff, and detracts from the care of the sicker patients. It also creates problems when a new admission needs a bed that is not available. At the exit briefing,[17] DOC administrative staff acknowledged the problem, and stated that there was a solution that was anticipated to be in place the week following the Monitoring Team's visit.
- Discharge notes were present on both patients discharged.

3. HRYCI

A new medical director who had primary responsibility for infirmary care began work one week before the Monitoring Team's visit. To give a fair picture of the effect of this transition, charts were selected randomly from the patients who were in the infirmary at the time of the Monitoring Team's visit. A total of five charts were audited: three records of patients who had been admitted to the infirmary with acute problems, and two records of patients who had been admitted to the infirmary for housing because their medical needs could not be met in general population.[18]

There has been significant improvement in infirmary care. In fact, there are many more inmates moving to and from the infirmary, as indicated by the need for a third correctional

[17] At the conclusion of each visit to a facility, members of the Monitoring Team, and CMS and DOC leadership meet to discuss the Monitoring Team's findings during that particular visit. These exit briefings provide an opportunity for the State and CMS to gain immediate feedback, and begin to act on that feedback with greater expediency.

[18] The review was performed in the infirmary so as not to remove active charts that might be needed from the area as well as to observe the activity in the infirmary.

officer to be assigned to assist in the infirmary during times of peak activity.[19] The addition of a correctional officer should assist with the timeliness and overall access to care in the infirmary.

Patient care had also improved, as the following findings reveal:

- All but one patient's records had a nursing intake note; however, except in one case, these were written in the progress notes rather than on the nursing intake form.
- All patients with acute problems had a provider intake note in their records on the day of admission to the infirmary. One of the housing patients had a provider intake note in his record the day of arrival and the other within 48 hours of arrival.
- All patients had intake orders written the day of arrival.
- Patients with acute conditions had daily progress notes written in their records, which notes addressed the status of the acute problems.
- Although notes on housing patients are required weekly, these patients had notes written in their records between 2 to 3 times per week.
- Since all patients were currently in the infirmary, the Monitoring Team was not able to assess discharge notes and orders.
- The only problematic area was the state of the medical records, which tended to be disorganized. The Monitoring Team was informed that medical records staff does not come into the infirmary to initiate and organize the records.

4. SCI

The Monitoring Team reviewed medical records of five patients who were or had been in the infirmary. Of these five patients, three had been in the infirmary for housing, one for an acute problem, and one for a short-term observation. The Monitoring Team's findings are as follow:

- All patients' records had a nursing intake note. Three of these were on the form created for this purpose and two were in the progress notes.
- All patients' records had intake orders written on the day of admission.
- All patients' records had a provider intake note written within 24 hours of admission.
- Two of the three patients for whom it was appropriate had provider notes in their records in accordance with the recommended schedule.
  - One patient should have had daily rounds but did not.
  - One additional patient was admitted for observation two days prior to the Monitoring Team's audit and on the day of the audit, was requesting to return to population, stating that all of his symptoms had resolved. The provider had not completed rounds yet at the time of the audit, so the Monitoring Team does not know the outcome of that situation.
- Only two of the five patients had been discharged from the infirmary.

[19] The Monitoring Team noted that interaction of the officers with inmates was empathetic and helpful.

- Both patients' records had discharge orders.
- One patient's record had a provider discharge note and one did not.

- While housed in the infirmary, one patient was sent to the hospital for an acute event.
  - There was no note in the record about sending the patient to the hospital or documentation of an order out. (This was discussed with the medical director, who stated that he was contacted in this case and did give the order to send to the hospital.)
  - There was a return from the hospital note.
- One patient initially admitted for a seizure subsequently developed tachycardia and alteration in mental status. He was referred to mental health without an assessment by a medical provider. Although he was a heavy drinker, after an initial Clinical Institute Withdrawal Assessment of Alcohol score of 0, no further assessment for alcohol withdrawal occurred.
- One patient housed in the infirmary for complicated medical problems had multiple physicians overseeing his case, resulting in fragmented care.

2. Policies and Procedures

A. Relevant MOA Provision

Paragraph 2 of the MOA provides:

> The State shall develop and revise its policies and procedures including those involving intake, communicable disease screening, sick call, chronic disease management, acute care, infection control, infirmary care, and dental care to ensure that staff provide adequate ongoing care to inmates determined to need such care. Medical and mental health policies and procedures shall be readily available to relevant staff.

This provision of the MOA requires that the State have policies[20] and procedures[21] in place to address vital procedural steps in providing appropriate medical and mental health care for inmates, and is meant to ensure that these policies and procedures are readily available to relevant staff. According to NCCHC standards, policies and procedures should be facility-specific. J-A-05; P-A-05.

The Monitoring Team finds that the State is in partial compliance with this provision of the MOA. The State previously had a substantially complete set of policies which had been approved by the DOJ as of November 6, 2007. In the Third Report, the Monitoring Team stated its belief that the absence of local operating procedures in each of the Facilities contributes to continued systemic problems, such as substantial delays in inmate access to

[20] A "policy" is defined by the NCCHC as "a facility's official position on a particular issue related to an organization's operations." J-A-05; P-A-05.

[21] A "procedure" is defined by the NCCHC as "describ[ing] in detail, sometimes in sequence, how a policy is to be carried out." J-A-05; P-A-05.

advanced level providers,[22] and the processing of medications. The Monitoring Team had received a rough draft of facility-specific operating procedures to be used to implement the State's policies at each of the Facilities. At the time of the Third Report, those procedures required a great deal of revision, however. The State and CMS submitted working drafts of the local operating procedures to the Monitoring Team and the DOJ for review, comment, and approval. The following is a facility-specific review of the local operating procedures by Facility.

At Baylor, the Monitoring Team found that the facility was still in the process of drafting local operating procedures based on the State's policies. The Monitoring Team had not received the draft local operating procedures, which reportedly had been drafted by staff at Baylor, and reviewed by the Office of Health Services ("OHS").

At JTVCC, the Monitoring Team reviewed a draft set of local operating procedures. They had been drafted by CMS' regional management staff. The Monitoring Team identified several inconsistencies between these draft procedures and the State's policies. Thus, the local operating procedures need to be revised to conform to the State's policies. The Monitoring Team was informed that there was a plan to revise them early in December 2008. The Monitoring Team looks forward to evaluating a resubmission of the draft local operating procedures after those revisions have been completed.

At HRYCI, the Monitoring Team completed a review of approximately 15 of the local operating procedures that had been drafted for HRYCI, and identified several that needed to be revised to add various components. The Monitoring Team discussed those local operating procedures with the Facility leadership team, which agreed to make recommended changes. The Monitoring Team will continue reviewing local operating procedures during the Monitoring Team's next site visit.

At SCI, as with the other institutions, staff was in the process of drafting local operating procedures. Those local operating procedures are to be submitted to the OHS prior to the Monitoring Team's review, so that the State can have appropriate input to the procedures. Then the Monitoring Team will review the local operating procedures and provide any necessary technical assistance.

With respect to mental health-related policies and procedures at all of the Facilities, the Monitoring Team was informed that two policies had been drafted or revised since its last visit in Spring 2008. One policy is entitled "Non-Emergency Involuntary Medication Administration" and has been implemented at the facilities. The Monitoring Team believes this policy is appropriate and meets applicable standards.

The other policy is a revised policy regarding segregated inmates and requires inmates who are in isolation and are also on the mental health caseload be seen three times per

[22] The term "advanced level providers" refers to physicians, physicians' assistants, and nurse practitioners.

week while in isolation. A mental health progress note must be written once per week for each of these inmates. Implementation of this policy as well as staff training relevant to this policy have not yet occurred. Specifically, the policy requires mental health to screen within 24 hours any inmate placed on isolation who is also on the mental health caseload to insure there are no factors present suggesting isolation would be harmful to the inmate. Additionally, the policy requires that a disciplinary assessment be conducted for these inmates to see whether there are any mitigating circumstances, due to the inmates mental health condition, which warrant the inmate's removal from isolation. Neither the screenings nor the assessment are routinely performed.

F. Recommendations

At all Facilities, the Monitoring Team recommends that the State implement the policy relating to segregated inmates and conduct appropriate training of staff regarding this policy. The OHS should re-review the local operating procedures at each institution to insure that those procedures conform to the DOC policies.

At Baylor, the Monitoring Team recommends the State submit the operating procedures to the Monitoring Team for review, technical assistance, and assessment.

The Monitoring Team recommends that JTVCC proceed with the plan to revise the draft procedures, insuring that they are completely consistent with the approved DOC policies.

At HRYCI, the Monitoring Team recommends that those operating procedures that have been reviewed and approved should be implemented after appropriate training is provided and monitoring of performance should become part of the CQI program.

3. Record-Keeping

A. Relevant MOA Provision

Paragraph 3 of the MOA provides:

> The State shall develop and implement a unitary record-keeping system to ensure adequate and timely documentation of assessments and treatment and adequate and timely access by medical and mental health care staff to documents that are relevant to the care and treatment of inmates. A unitary record-keeping system consists of a system in which all clinically appropriate documents for the inmate's treatment are readily available to each clinician. The State shall maintain a unified medical and mental health file for each inmate and all medical records, including laboratory reports, shall be timely filed in the medical file. The medical records unit shall be adequately staffed to prevent significant lags in filing records in an inmate's medical record. The State shall maintain the medical records such that persons providing medical or mental health treatment may gain access to the record as needed. The medical record should be complete, and should include

information from prior incarcerations. The State shall implement an adequate system for medical records management.

This provision of the MOA contains several key elements. First, the State must develop and implement a unitary record-keeping system. According to the MOA, a unitary record-keeping system consists of a system in which all clinically appropriate documents for an inmate's treatment are readily available to each clinician, and should include information from prior incarcerations. Although the amount and type of documentation that should be in an inmate's health record is determined by the individual inmate's medical history and condition, an inmate's health record normally should contain the following categories of documents:

- identifying information (*e.g.*, name, identification number, date of birth, gender);
- problem list containing medical and mental health diagnoses and treatment as well as known allergies;
- receiving screening and health assessment forms (*see* discussion of provisions 10 and 12 of the MOA);
- progress notes of all significant findings, diagnoses, treatments, and dispositions;
- provider orders for prescribed medication;
- medication administration records ("MARs");
- reports of laboratory, x-ray, and diagnostic studies;
- flow sheets;
- consent and refusal forms;
- release of information forms;
- results of specialty consultations and off-site referrals;
- discharge summaries of hospitalizations and other inpatient stays;
- special needs treatment plan, if applicable;
- immunization records, if applicable;
- place, date, and time of each clinical encounter; and
- signature and title of each documenter.

J-H-01; P-H-01. A health record of this magnitude will not always be established for every inmate; however, any health intervention after the receiving screening will require the initiation of a record containing some or all of the foregoing documents. *Id*.

The MOA also requires that the State ensure that adequate staffing is maintained to support medical records filing. Specifically, the State should maintain sufficient staffing so that appropriate medical records are filed properly, and quickly enough so that staff can access relevant information as needed. One requirement implicit in this provision of the MOA is that the staff performing medical record-keeping functions be adequately trained to do so.

The Monitoring Team evaluated compliance with this provision of the MOA by reviewing the following health record components: (a) the format of the health record to ensure a unified document; (b) the quantity and elapsed time frame of health records to be filed; (c) the use and functionality of tracking systems to document the receipt of laboratory, diagnostic and consultation reports; (d) health record filing and retrieval systems; and (e) the adequacy of health record staff necessary to perform health record activities in a timely manner. Each member of the Monitoring Team made observations regarding record-keeping while evaluating other provisions of the MOA, and the Monitoring Team collaborated to determine the assessments regarding record-keeping by consensus.

As discussed in prior reports, the DOC uses a paper medical records system, rather than electronic medical records. However, some information generated for the paper record is initially recorded in the Delaware Automated Correctional System ("DACS"). DACS contains multiple "modules," and is used by the DOC for many non-medical tasks. Although DACS contains a medical module, the DOC reports that it was not designed to be (and has not been) used as an electronic medical record. Until recently, the DACS medical module was used mostly for certain intake and scheduling tasks.

As reported in the Second and Third Reports, the State needs a credentialed statewide medical records director to supervise and oversee medical records services at the Facilities. The Monitoring Team believes that the lack of a person in this capacity has had a negative impact on the State's ability to be in substantial compliance with this provision of the MOA, because a statewide medical records director can help to ensure that the Facilities are training medical records personnel appropriately, and that these employees are receiving appropriate supervision and guidance.[23]

The State has made efforts to hire a medical records director. In fact, the State had hired someone to fill this position who was to begin working in October 2008. Only days before this person was to start, she decided to take another job. Thus, this position remains vacant.

[23] Although the State is not required to implement the recommendations offered by the Monitoring Team, the Monitoring Team believes that this recommendation is especially important for the State to follow in order to ensure compliance with this provision of the MOA.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring team evaluated compliance with this provision of the MOA by reviewing the following health record components: (a) the format of the health record to ensure a unified document; (b) the quantity and elapsed time frame of health records to be filed; (c) the use and functionality of tracking systems to document the receipt of laboratory, diagnostic and consultation reports; (d) health record filing and retrieval systems; and (e) the adequacy of health record staff necessary to perform health record activities in a timely manner.

Appropriateness of Format and Organization of Health Records

Consistent with previous visits, the Monitoring Team found that both in policy and practice there is a unified health record, which contains medical, dental and mental health information. However, the Monitoring Team found that patient records are maintained in "temporary files" for one to two months before a permanent file is established. Temporary files contain only loose information, which is not organized using appropriate dividers. These are appropriate to use on a truly temporary basis, but not for longer than seven days, by which time a permanent file should be established. Storing patient health records in temporary files for a longer period of time makes health information difficult for the user to locate. The Monitoring Team also found that, as reported in the Third Report, archived health records are bulky and should be purged in accordance with professional standards.

Timeliness of Health Record Filing

The Monitoring Team found that there were significant delays in the filing of health records. For instance, at the time of the Monitoring Team's visit in August 2008, the MARs had not been filed since the end of April 2008. In addition, the Monitoring Team found that laboratory reports were not printed, reviewed and filed in a timely manner, if at all.

Adequacy of Facility and Staff

The medical records staff continues to work in a room that contains two desks and is very cramped. There are tentative plans to move medical records to another area when the medical unit expands into an area across the hall from its present location. There is also a separate medical records archive room in another part of the facility that is used to store other records, including those that are "to be filed."

There are two staff members dedicated to management of health records. One is scheduled for the day shift and one for the evening shift. The Monitoring Team notes that CMS

previously had provided staff on a temporary basis to eliminate backlogs in filing. However, backlogs in filing continue to occur, suggesting that this allocation of health record staffing may be insufficient to maintain contemporaneous filing. In addition, as mentioned above, the Monitoring Team found that the State has not yet been able to hire a credentialed medical records director to supervise and oversee medical records services at the Facilities.

Adequacy of Tracking Systems

The facility uses an "outguide" system to track the location of health records, and it appears that staff members have been using the outguide effectively.[24] However, Baylor still does not have an adequate tracking system for laboratory and diagnostic test results, or adequate supervision of the existing system. (*See also* discussion of paragraphs 4 and 13 of the MOA). Specifically, the Monitoring Team found several records in which there were orders for a laboratory test, but the corresponding laboratory test results were not in the inmate's health record.[25]

To schedule patients for laboratory tests, staff members use both a paper log and DACS, but neither tracking system contains all the information that needs to be tracked and monitored. Specifically, the paper log that staff members use usually reflects the patient's name, tests ordered, and the date the patient is scheduled to have the laboratory specimen drawn. However, staff members do not document on the paper log the actual date the laboratory specimens are drawn, or the date the resulting report was received. Staff members also use DACS to schedule patients for tests, but DACS does not specify the types of laboratory specimens to be drawn and also does not indicate when the State received the laboratory test report. This should be tracked because staff members need to monitor whether laboratory tests that are ordered by a clinician have been performed by the laboratory, and the results received in a timely manner. Thus, there is no unified system to document the ordering, scheduling, completion and return of laboratory results at the Facility.

Record-Keeping Issues Relating to the Mental Health Caseload

The Monitoring Team observed that its recommendation that the State hire a professional medical records staff to provide leadership, supervision and standardization to medical records policies and procedures has not been implemented. The mental health clerk, referenced in the Third Report, has helped to reduce the backlog of mental health filings significantly. At the time of the Monitoring Team's visit, the backlog was estimated to be less than one week. However, a review of records indicated that no MARs had been filed from

[24] An outguide is a system that is used to account for the health records that have been taken out of the files or filing area for use.

[25] One factor that complicates the tracking function at all of the Facilities is that the State uses two different laboratories for tests: a state laboratory is used for all communicable diseases (*e.g.* syphilis, HIV antibody testing), and a reference laboratory for other types of tests (*e.g.* kidney and liver function). Thus, staff members need to ensure that the tracking system accounts for laboratory reports from both laboratories.

August 2008 through late October 2008, the time of the Monitoring Team's visit. Additionally, very few MARs from July 2008 had been filed either.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

At JTVCC, the Monitoring Team found that the State maintains a unitary record-keeping system that contains medical, dental and mental health information.

Timeliness of Health Record Filing

The Monitoring Team found persistent backlogs in health record filing. There were approximately 10 to 12 inches of documents to be filed, which included documents dating back to July 2008. Some of these documents included original consultation and abnormal laboratory test reports that a clinician had not signed as having been reviewed.

As noted in the Third Report, many health-related documents, such as laboratory test results, must be reviewed by a clinician before they are filed. Thus, a clinician failing to review documents on a timely basis can delay filing. On the other hand, if documents are not maintained in a manner so that clinicians are aware of and can find such documents, clinicians cannot review such documents on a timely basis. There should be systems in place to insure that clinicians are aware of the receipt of laboratory test results, and review them in a timely fashion.

The Monitoring Team's record reviews showed that there continues to be a delay in clinician review of laboratory and consultation reports from outside appointments. Often, there were delays of seven to 10 days once the laboratory report was available. The lack of timely review and filing creates a risk that patients with serious medical conditions will not be diagnosed and treated in a timely manner. In speaking with staff members, the Monitoring Team learned that the system for filing records is that each staff member is alphabetically assigned a portion of records. Some members of the team may file records contemporaneously, but if another staff member is on leave or fails to file his or her assigned records, backlogs occur.

Adequacy of Tracking Systems

There is a tracking log for laboratory test, diagnostic, and consultation reports, but it does not include the date that the Facility receives a report. There is an Inpatient Transition Coordinator, who is responsible for scheduling on-site services (*e.g.*, radiology, ultrasound, physical therapy), and tracking the resulting reports. In addition, there is an Outpatient Transition Coordinator, who is responsible for scheduling off-site appointments (*e.g.*, surgery, off-site consultations and CT/MRI procedures), and tracking those reports. Once the report is

received, the respective coordinator is responsible for placing the report in the health record and providing the record to the clinician who ordered the test.

Adequacy of Facility and Staff

The medical records area is essentially unchanged since the Monitoring Team's last visit. The area where staff congregates in the back is cramped and the floors are dirty. The organization of the shelves where medical records are stored pending filing has improved somewhat, but the shelves are not labeled as to the types of records they contain. Upon entering the medical records area, there is a room with two cubicle-like spaces that appears to be relatively underutilized.

Since the Monitoring Team's last visit, medical records coverage has been expanded to the evening shift so that staff members are available from approximately 3:00 a.m. until 11:00 p.m. Staff members report that this additional coverage has been very helpful with respect to file accountability and accessibility. This is a positive change.

Adequacy of Health Record Retrieval Systems

There is an "outguide" system for tracking the location of health records, but staff members reported to the Monitoring Team that it is not used consistently. The Monitoring Team also learned that health records are often not returned to the medical records area in a timely manner.

Record-Keeping Issues Relating to the Mental Health Caseload

In the Third Report, the Monitoring Team expressed concerns that mental health staff members had reported frequent problems with gaining access to records of inmates in the Security Housing Unit ("SHU"). During its most recent visit to JTVCC, the Monitoring Team observed that this problem has been resolved. The improved access is due to training that has been provided to medical records staff members as well as improved staffing of the medical records department.

Unfortunately, while access to medical records in the SHU has improved, staff members now report that access to medical records for inmates in the T1 Special Needs Unit has become problematic. Although the reasons for these problems are unclear, the results are that mental health staff members are required to walk to the medical records department in order to obtain records.

Finally, in the Third Report, the Monitoring Team noted a problem in that records and medications were not following transferred inmates in a timely manner. The Monitoring Team recommended that the State conduct a CQI study in order to address this issue. The State has not yet conducted this CQI study and the Monitoring Team notes that the problem continues.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team believes that, once the State is able to fill the statewide medical records director position, it will be important for this person to oversee a series of standardized procedures so that the record-keeping staff members at each of the Facilities are performing their record-keeping tasks uniformly and consistently. However, with or without a statewide medical record director, each of the Facilities needs to ensure that it has dedicated medical records personnel to file and maintain health records, rather than assign filing duties to personnel who are not trained in record-keeping and have other duties. In fact, the Monitoring Team found that medical assistants and others at HRYCI had been delegated the responsibility to manage the medical records in addition to their regular duties. The result of this was lack of timeliness of filing as well as terrible inconsistency in the location of documents in the records.

Appropriateness of Format and Organization of Records

The Monitoring Team found that the records at HRYCI are extremely disorganized, to the point that the average provider would not have the time to attempt to locate critical documents that are not in the required section or filed chronologically within the given section. It took the Monitoring Team lengthy periods of time to identify critical information in several records.

The Monitoring Team also learned that the health records of released inmates are not being maintained in an organized fashion, but rather are kept in bins. As a result, those health records may be functionally non-retrievable. This lack of organization may create a danger to inmates who return to the system, or who have critical information that could be conveyed to them post-release for treatment.

Timeliness of Filing

In the west side of the facility (housing pre-trial detainees), the Monitoring Team was informed that all filing had been brought up to date on the day of the Monitoring Team's visit. The Monitoring Team does not know the extent to which the filing being up to date was a reflection of a recent extraordinary effort or whether, had the Monitoring Team reviewed the records a week earlier, filing would have been up to date. On the other hand, on the east side of the facility (the area housing the sentenced inmates), the Monitoring Team found approximately six inches of unfiled documents, dating back through July and August 2008. Thus, the backlog in this area is on average 10 to 12 weeks. The Monitoring Team learned that on the east side of the facility a clerk had been added for the prior two weeks, and that this additional staffing had begun to improve the filing, although a two to three month backlog remained.

Record-Keeping Issues Related to the Mental Health Caseload

As indicated in the Third Report, mental health staff members do their own filing and chart access is adequate. However, there is a backlog of records needing to be filed which ranges from a few days to several weeks.

Additionally, problems resulting from the use of "out guide" sleeves still exist. As discussed in the last report, when a record is not available, the unfiled notes are placed in an "out guide" sleeve. These unfiled notes are usually returned to the mental health office for filing rather than the medical records clerk entering them when the medical record is returned to their area. This process is problematic because it sometimes results in lost entries, filing in incorrect sections of the record, and significant delays in filing essential material.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team's review of record-keeping at SCI showed that there have been some improvements in this area, although some aspects of the Monitoring Team's findings remain unchanged from the Third Report.

Adequacy of Facility and Staff

As referenced above, the Monitoring Team learned that CMS had hired a statewide medical records director, but this person took another job just prior to when she was to start, thus the position is still vacant. The State did have a statewide medical records director from another state come to SCI to perform an assessment and provide recommendations. According to the health services administrator ("HSA") at SCI, he made several recommendations regarding space, staffing, filing and how to develop an adequate medical records system.

At the time of the Monitoring Team's visit, there were two new staff members dedicated to medical record-keeping, both of whom work during the day shift. One is in the pre-trial area, and the other in the Maximum Security Building ("MSB"). In addition, there is a temporary employee, whom the HSA calls upon three days a week as necessary to remain current in medical records filing.

In the MSB, the health clinic medical records continue to be stored in unlocked filing cabinets in the main clinic where inmates and officers circulate. There are also open desks

in this area in which medical records await to be filed. This does not ensure confidentiality of health records.

Timeliness of Health Record Filing

According to medical records staff members, health record filing was up to date. However, as on previous visits, the Monitoring Team found that MARs of patients with Keep on Person ("KOP") medications are not filed in the record in a timely manner. These records may not be filed for over a year. As a result, clinicians are unable to determine whether there is continuity of medication with respect to that patient.

Adequacy of Tracking Systems

The facility has an outguide, but staff members reported that this system is not used consistently, and it is difficult to maintain control over records since they are stored in unlocked cabinets in the main clinic area.

As noted in the Third Report, the Monitoring Team found that there is a laboratory test log that tracks laboratory tests sent out to a reference laboratory, but staff does not complete the section documenting receipt of laboratory reports.[26] A review of records showed that there were often delays from the time a laboratory report was received until it was signed as being reviewed by a clinician. It appears that this problem is due, at least in part, to laboratory reports not being given to clinicians on the day that the report is available. Instead, when laboratory reports become available, a nurse or other staff member triages the laboratory reports and places them in the respective inmate's health record in the filing cabinet. Twice a week these records are retrieved and given to the clinician for review. Thus, the system developed for review of laboratory reports has a built in delay in the process. Staff members advised the Monitoring Team that the reason for this system is that there is insufficient room in the clinician's office on a daily basis to store all the medical records with laboratory test reports requiring review.

As reported in the Third Report, SCI does not have an adequate system for tracking consultation, procedure or hospital reports from services provided offsite. The consultation tracking log used to have a column for tracking the date the report is received, but it was eliminated. The Monitoring Team also found instances in which hospital and procedure reports were filed in an inmate's health record without being reviewed. This lack of review presents a risk that clinicians will be unaware of patients with abnormal diagnostic or laboratory findings and delay diagnosis and treatment.

[26] In order for the laboratory test log to be sufficient, it should document the date the clinician made the order for the laboratory test, the date staff drew the laboratory sample, the date the Facility received the laboratory report containing test results, and the date on which a clinician reviewed the laboratory report.

Record-Keeping Issues Related to the Mental Health Caseload

At the time of the Monitoring Team's visit in late October 2008, the backlog of records that needed to filed had been eliminated. This improvement most likely is due to the hiring of new employees, and the use of a contractor on an "as needed" basis. Additionally, MARs were filed by the sixth of each month.

There was a backlog of laboratory filings in September 2008. However, two certified nursing assistants were credentialed to draw blood, which has corrected this problem.

F. Recommendations

In general, the Monitoring Team recommends that the State fill the statewide medical records director position with a person who has appropriate medical records credentials and who can oversee the medical records program at each of the Facilities. This is a vital step that the State and CMS can take to assist with the State's compliance with this provision of the MOA. The State has informed the Monitoring Team that this position has been made a part of the contract amendment between CMS and the DOC, which was signed on July 1, 2008. The State and CMS are taking action to fill this position.

At Baylor, the Monitoring Team recommends that health care leadership establish and monitor systems to ensure that the tracking, clinical review and filing of all health records occurs in a timely manner. All tracking systems (*e.g.*, laboratory, diagnostic and consultation) should document not only when the procedure was done, but when the facility receives the report. Additionally, clinicians should continue to actively update inmates' problem lists following the receipt of these reports.

At JTVCC, the Monitoring Team recommends the State do the following:

- Ensure that the medical records room is routinely cleaned and reorganized to optimize the use of space and enable better tracking and filing of health record documents;
- Establish and monitor systems to ensure the tracking, clinical review and filing of all health records (*e.g.* laboratory and diagnostic reports) in a timely manner;
- Ensure that logs include the date that laboratory test reports are received;
- Consider ongoing consultation with a medical records consultant to assist with reorganization and development of medical record systems;
- Conduct a CQI study to address the issue described in both this and the Third Report concerning records not being transferred in a timely manner; and
- Take steps to identify why mental health staff is having difficulties accessing records in the SNU and take steps to rectify this problem.

At HRYCI, the Monitoring Team repeats its recommendation from the Third Report that the State address the problems associated with its use of "out guide" sleeves. The Monitoring Team also recommends that the State take the following actions:

- Ensure that *dedicated*[27] staff is responsible for managing the medical records in each area of the correctional institution; and
- Develop a program that manages the documents of individuals who have been released from the system responsibly.

At SCI, the Monitoring Team recommends that, when the medical unit is renovated, a dedicated and secure medical records room of sufficient size is built to accommodate health records and staff associated with medical record maintenance. The health care leadership (HSA, Director of Nursing and Medical Director) should ensure that the health record tracking system is utilized by all staff. Health care leadership should change the clinical report review process to ensure more timely review and filing of laboratory, diagnostic and hospital reports. The clinicians should review laboratory, diagnostic and hospital reports in a timely manner and document appropriate action including scheduling patient encounters as clinically indicated. MARs for nurse-administered medications should be filed monthly so they are available to clinicians for review. MARs for KOP medications should be filed at least quarterly.

4. Medication and Laboratory Orders

A. <u>Relevant MOA Provision</u>

Paragraph 4 of the MOA provides:

> The State shall develop and implement policies, procedures, and practices consistent with generally accepted professional standards to ensure timely responses to orders for medications and laboratory tests. Such policies, procedures, and practices shall be periodically evaluated to ensure that delays in inmates' timely receipt of medications and laboratory tests are prevented.

The MOA requires that the State develop policies, procedures, and practices consistent with generally accepted professional standards to ensure timely responses to orders for medications and laboratory tests. The State has adopted policies consistent with this requirement of the MOA. *See* State Policy D-02 and D-04. The State has not yet completed its facility-specific procedures, although the State has made progress with respect to its Facility-specific procedures (*see* paragraph 2). The implementation of this policy should ensure that inmates do not experience unnecessary delays and interruptions to care due to physician orders for medications and laboratory tests not being timely performed. *See* J-E-12; P-E-12. Finally, the MOA requires that the policies, procedures, and practices be periodically evaluated to ensure that delays in inmates' timely receipt of medications and laboratory tests are prevented. The Monitoring Team recommends that the State include this periodic review as a part of the CQI Program. (*See* discussion of provision 54 of the MOA).

[27] This means that the staff member(s) given this assignment should have this responsibility, not as an add-on to their regular assignments, but as a major focus of their work.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated compliance with this provision by reviewing 11 records selected from various service areas (*e.g.*, sick call, chronic disease management, medication administration) to determine whether medications and laboratory orders are accurately transcribed and implemented in a timely manner.[28] The Monitoring Team also noted during its review of 23 records of patients with chronic diseases (*see* discussion of paragraph 22) whether laboratory tests that had been ordered were obtained, reviewed, and filed in a timely manner.

The Monitoring Team found that, in 10 of 11 records, clinician orders were complete, which means that they contain the medication name, dosage, frequency, route of administration, duration, and number of refills.[29] In seven of 11 records, the clinician dated and timed the order, and four of 11 records lacked the time the order was written. The Monitoring Team noted that the nurse practitioner ("NP") did not write physician orders for laboratory tests she had already completed during an examination (*e.g.*, gonorrhea and Chlamydia cultures). A consequence of this practice is that by not writing the order, there is no mechanism to track that particular test (*i.e.*, the nurse does not transcribe the order and note the laboratory test on a tracking log). The Monitoring Team found several records in which the cultures were documented as being performed, but there was no test result in the record. Thus, clinicians should write orders for all procedures, tests, medications, etc., to be performed on the patient, and the completion of the orders should be tracked and documented.

With respect to nursing transcription of orders, the Monitoring Team found continued problems in this area. Only three of 11 clinician orders were transcribed the same day. The remaining eight orders were transcribed one to four days after the order was written, or the date of transcription was not documented. In four of 10 records, medication orders were accurately transcribed onto the MAR. In two of 10 records, the order was not accurately transcribed, and, in four out of 10 records, there was no MAR filed in the record to evaluate transcription accuracy due to a backlog in MAR filing.

As described above with respect to record-keeping, the Monitoring Team found continued problems with obtaining laboratory test results. This problem is due in part to inadequate tracking systems and supervisory monitoring of this function.

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[28] The Monitoring Team reviewed clinician orders that were written after the date of the Monitoring Team's last visit, which ranged from May 1, 2008 until August 15, 2008.

[29] The term "clinician" includes physicians or nurse practitioners.

In a review of 23 records of chronic disease patients, the Monitoring Team found instances where ordered laboratory tests were not obtained, or were obtained but not reviewed and addressed in a timely manner.

Issues Related to the Mental Health Caseload

Administrative staff members reported that the problems associated with obtaining laboratory results in a timely manner have been resolved. However, the Monitoring Team found this information is not consistent with information obtained from the psychiatrist at Baylor or recent audits conducted by the State. Additionally, the psychiatrist indicated to the Monitoring Team that problems continue to exist with obtaining laboratory results in a timely manner.

The Monitoring Team conducted its own review of a sample of charts and found that in 11 out of 12 charts (92%), the appropriate laboratory test was ordered by the psychiatrist in a timely fashion. This audit indicates a more favorable outcome than either of the State's studies. This might simply be due to the period of time studied, but the range of results of these studies supports a conclusion that the State has not fully remedied this problem.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found that JTVCC is in partial compliance with respect to mental health services and not in compliance with respect to medical services.

2. Findings

The Monitoring Team reviewed medication and laboratory orders written between July and October 2008 to assess the timeliness of order transcription, and implementation of the orders. In general, the Monitoring Team found continued problems with both the timeliness of transcription and implementation of these orders.

For example, of 14 orders reviewed, only eight (57%) were transcribed on the day the order was written. In the majority of cases, the clinician wrote a complete order; however, three of 14 orders lacked the time the orders were written. Three orders were verbal orders given telephonically to a nurse that were not cosigned by the ordering clinician.[30]

With respect to the accuracy of medication order transcription, eight (61%) of 13 medication orders were transcribed accurately (one MAR could not be located to evaluate the

[30] After a clinician gives a verbal order, he or she should review and sign off on the order when he or she returns to the Facility. The "sign off" indicates that what is written is an accurate transcription of the clinician's verbal order.

accuracy of the transcription). In one record, the nurse transcribed an order for a blood thinner but then crossed it off, so the patient did not receive the medication. In another record, the nurse initialed the order as having been transcribed, but a pharmacy-printed MAR reflects that the pharmacy did not receive the order. In another case, the nurse did not transcribe a new order onto the MAR but simply continued the old order, resulting in incorrect order dates. In another case, the nurse inaccurately transcribed the discontinuation of a medication on the MAR, and, as a result, the patient continued to receive the medication for another five days.[31]

With respect to the timeliness of receipt of medications, seven records reflected problems related to delay, failure to receive, or failure to document receipt of medications. In three cases, it took seven days for the patient to receive ordered medications. In two of the cases, the inmate did not receive the prescribed medication at all. In the other two cases, staff members could not locate the MAR to verify that inmates had received the medications.

With respect to the implementation of laboratory orders, the Monitoring Team found several cases in which orders either were delayed significantly, or not implemented at all. For instance, in one case, the clinician ordered a culture on July 2, 2008, which was not completed until September 11, 2008. In addition, there were several cases in which the clinician ordered tests that were not taken at all. Finally, in another case, a patient had monthly tests ordered to test medication levels, which were not completed as ordered.

The Monitoring Team also noted that chest x-rays typically are completed one week from the order date. The radiology reading of the x-rays is produced one week later. The report is reviewed seven to 10 days following receipt of the radiology report. Thus, the typical turnaround time for a routine chest x-ray is three weeks. This period of time is too long, particularly for patients whose tuberculin skin tests (TST) are positive.

Issues Related to the Mental Health Caseload

The State has conducted an audit with respect to this provision, but there are serious problems with this audit regarding both the sample sizes and methodology used. In its audit, the State examined too few charts, and also uses too few indicators to be able to consider their audit meaningful in terms of tracking the quality of care. For instance, the State only looked at the presence or absence of a result in the records, and did not assess whether those results were obtained in a timely manner.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

[31] The Monitoring Team found that, in several of these records, MARs dating back to June and July 2008 were not filed in the record.

2. **Findings**

The Monitoring Team evaluated compliance with this provision by reviewing a sample of 15 patient records from both the east and west sides of the facility, which contained physician orders written from July to November 2008. For each order, the Monitoring Team evaluated the completeness of the order, the timeliness of transcription, and implementation of the order. This area was assessed to be in partial compliance, however significant improvement is required to obtain substantial compliance.

The Monitoring Team found that only eight (53%) of 15 physician orders were complete. In the remaining seven (47%) orders, the route of medication administration (*i.e.* by mouth, intramuscularly) was missing. In nine (60%) of 15 orders, the clinician legibly dated, timed and signed the order. Of the remaining six records, in three cases the clinician did not sign or cosign the order, and, in three cases, the order was not timed. In only five (33%) of 15 records was the order transcribed in a timely manner (the overall range was 1 to 27 days). For example, in one case, the NP wrote orders for a patient with a chronic disease that were not transcribed by a nurse. This was not noted until a follow-up visit six weeks later, during which the time the patient was not receiving appropriate care.

Ten (67%) of 15 orders were accurately transcribed. In the other five records, it appears that the inaccurate transcriptions included: incorrect medication start date, incorrect dosing frequency, and failure to transcribe the order altogether. In one case, staff members could not locate the MAR to evaluate accuracy.

With respect to timeliness of medication administration, eight (53%) of 15 records showed that the medication was received in a timely manner (the overall range was 2 to 7 days). In one case, a chronic care patient told the nurse upon his arrival in September 2008 that he took medication for his chronic disease. The nurse did not refer him to a clinician upon arrival, and DACS automatically scheduled him for a chronic disease visit one week later. Thus, he was not evaluated for chronic disease medications until a week after his arrival. The physician ordered laboratory tests for this patient, but they were not performed. In another case, an NP ordered medications for a different patient with a chronic disease whose disease was under poor control. The patient did not receive his medications for seven days after they were ordered.

With regard to the application of this provision of the MOA to mental health services, the Monitoring Team conducted a review of twenty-one charts and found that, in 15 of those charts, laboratory orders were made in a timely fashion. Additionally, at the time of the Monitoring Team's August 2008 visit, HRYCI had added a laboratory technician who was responsible for the daily coordination of the laboratory report review and chart placement. This addition should help the State with obtaining results in a timely manner. Finally, log books used by the State relevant to this provision have been enhanced. These enhancements will aide the State in tracking relevant data so that it can monitor the ordering of labs.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

Consistent with the findings of the Third Report, the Monitoring Team found persistent problems with the timely transcription and implementation of physician orders, including those for medications and laboratory tests. Typically there are three primary care providers and a psychiatrist writing orders on a daily basis. Discussion with health care leadership revealed that there may be insufficient staff to transcribe all of the resulting orders and therefore all licensed staff, including the Director of Nursing ("DON") and HSA, transcribe orders.

The Monitoring Team reviewed 19 physician orders that were written between August and October 2008. Of these orders, only four of 19 were transcribed by a nurse on the day the order was written. The delay in order transcription has resulted in delays in obtaining medications and laboratory tests, and, in some cases, a failure to obtain medications or tests at all. The range of time of transcription of the remaining 15 orders ranged from one to nine days. In the month prior to the Monitoring Team's visit, a new procedure for order transcription had been developed and implemented. The new procedure included primary care physicians writing medication orders on the Pharmacor[32] ordering sheet, which is faxed to the Pharmacor pharmacy each day at 11 a.m. and 3 p.m.

As found during the Monitoring Team's previous visit, nurses do not consistently transcribe new orders onto the MAR for nurse-administered medications. For example, if a physician wrote an order for a medication the patient was already receiving, the nurse often crossed out the old dates on the MAR, and overwrote the new dates on the MAR. This defaces a previous order and should not be done. This practice has also resulted in transcription and resulting medication errors. For example, in February 2008, a physician who was concerned about the kidney function of a patient with a chronic disease, decreased the patient's medication from daily dosing to administering the medication every other day. The nurse did not transcribe the new order onto the MAR. Instead, she crossed out the dates of the old order and, as a result, the patient erroneously continued to receive the daily dosing of the medication from February until August 2008.[33]

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[32] Pharmacor is the pharmaceutical provider used by the State.

[33] A possible contributing factor to this medication error is that the physician used abbreviations instead of documenting in longhand how the medication should be given. In this case the old medication order read "Viread 300 mg. po qd" (*i.e.* daily) and was changed to "Viread 300 mg po qod" (*i.e.*, every other day). It is likely that the nurse did not recognize that a change in dosing had been made due to the similarity in the order. To minimize these types of errors, the Joint Commission on Accreditation of Health Care Organizations (JACHO) recommends that physicians completely write out orders (*e.g.*

From a review of another patient record, the Monitoring Team found that the physician, who normally documented each medication on a separate line on the physician order sheet, added a medication to an HIV regimen on the same line as another medication. The nurse did not note the addition of the medication and it was not transcribed onto the MAR. One might anticipate that the MAR printed by Pharmacor with the complete order would provide a check and balance to the accuracy of physician order transcription by the nurse. This is not always the case, however, because Pharmacor does not send a new MAR with each new medication order. Pharmacor only prints MARs at the end of each month. Thus, the Pharmacor-printed MARs cannot be relied upon as a mechanism to identify errors in nursing transcription.

With respect to the implementation of laboratory orders, the Monitoring Team found that the laboratory tracking log is not completed on a consistent basis with the date the test was ordered and the date the final report is returned. The Monitoring Team also found that ordered laboratory tests consistently were not obtained in a timely manner or at all. For example, in August 2008, a physician ordered a type of test for medication levels, which requires a blood draw to be performed every other day over a 10 day period. Only three of the five blood draws were completed. In addition, only two of three tests completed were initialed as having been reviewed by a physician within 5 to 7 days after the tests were obtained.

In another case occurring in August 2008, another patient's initial laboratory test results were reviewed two weeks after the results were available. Those test results led the physician to order a hepatitis panel. The order was transcribed, but the test was not completed.

In September 2008, the physician ordered a different kind of test for a patient whose initial test results for a disease were equivocal. There was no follow-up test result in the record, and it was unclear whether it was performed or not. The inmate requested follow-up regarding the inmate's status and a repeat test was obtained, but not the type of test that the physician ordered. The patient's record reflected that he has been not counseled regarding his test result. Thus, the physician ordered test was not performed in a timely manner and the patient has not been counseled regarding his test result in a timely manner.

With respect to mental health-related laboratory tests and medication orders, the Monitoring Team observed significant improvement with respect to this provision. The Monitoring Team found that in 13 of 15 charts reviewed, appropriate laboratory tests were ordered by a psychiatrist in a timely fashion.

The Monitoring Team notes that the State has conducted its own audit with respect to this provision, but the Monitoring Team found significant problems with both the sample size and methodology of these audits. The State's audit demonstrated a wide range of

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Viread 300 mg po (by mouth) give one tablet daily). It would also be useful for physicians' medication changes for a given patient to document "Change Viread 300 mg po from once daily to once every other day". This alerts the nurse to the new dosing and may help minimize errors.

compliance between the June and September 2008 results. However, these rates are based on a review of a total of six charts. Additionally, the methodology of these audits was problematic as it was unclear whether the State had examined the timeliness of laboratory tests being ordered or simply measured compliance based on the fact that charts indicated a laboratory test was ordered, regardless of the timeliness.

F. Recommendations

At Baylor, the Monitoring Team recommends the following:

- The HAS or DON should implement a system to insure timely transcription of physician orders and a mechanism to track the implementation of all physician orders.
- The HAS or DON should implement a CQI study to improve the accuracy of medication order transcription (including the services provided by Pharmacor).
- Clinicians should write a physician order for any medication, treatment, laboratory or diagnostic test the patient is to receive to establish a tracking and accountability mechanism for implementation of the order. If the order has already been completed, the clinician should document this as well.
- The HAS or DON should develop, implement and monitor a more reliable system for tracking the completion of laboratory tests and diagnostic procedures.

At JTVCC, the Monitoring Team recommends the following:

- Health care leadership should implement CQI studies to evaluate the effectiveness of a recently revised procedure for transcription of physician orders, as well as the system for implementation of physician orders.
- Health care leadership should also ensure that laboratory, diagnostic and consultation reports are received, reviewed, and filed in at timely manner.

At HRYCI, the Monitoring Team recommends that:

- The State implement a system to ensure timely transcription of physician orders and a mechanism to track the implementation of all physician orders.
- The State evaluate the process for implementation of medication orders beginning with the timeliness of transcription, providing medication from stock supplies until the medication arrives, and or delivery of the dispensed medication to the patient.

At SCI, the Monitoring Team recommends that:

- The HSA, DON, and Medical Director continue to develop and monitor a system to ensure that all clinician orders are transcribed and implemented in a timely manner.
- Training be provided for staff and the system monitored on a daily basis until issues associated with order transcription and implementation are resolved.
- Nurses transcribe each new order completely, including order start and stop dates, and refrain from crossing out dates on a previous order.

- Ongoing CQI studies be performed regarding the timeliness and accuracy of physician order transcription.
- The State establish a monitoring system to ensure that all ordered labs are obtained, reviewed and filed in a timely manner with appropriate patient follow-up.

STAFFING AND TRAINING

5. Job Descriptions and Licensure

A. Relevant MOA Provision

Paragraph 5 of the MOA provides:

> The State shall ensure that all persons providing medical or mental health treatment meet applicable state licensure and/or certification requirements, and practice only within the scope of their training and licensure. The State shall establish a credentialing program that meets generally accepted professional standards, such as those required for accreditation by the National Committee for Quality Assurance.

The first component of this provision of the MOA requires that all persons providing medical or mental health services meet applicable state licensure and/or certification requirements and practice only within the scope of their training and licensure. In addition, the MOA requires that the State establish a credentialing program such as those required for accreditation by the National Committee for Quality Assurance.

The State uses both Registered Nurses ("RNs") and Licensed Practical Nurses ("LPNs") to perform nursing tasks within the Facilities. The Monitoring Team is required to make a determination regarding whether the RNs and LPNs at the Facilities are practicing within the scope of their licensure. In particular, the Monitoring Team is concerned that LPNs are practicing beyond the scope of their licensure and/or not receiving appropriate supervision from RNs by performing such tasks as conducting independent sick call evaluations. Pursuant to Delaware law, LPNs are permitted to provide various nursing services, "at the direction of a registered nurse or a person licensed to practice medicine, surgery, or dentistry." 24 *Del. C.* § 1902 (m). As clarified by the Delaware Board of Nursing Regulations, LPNs may "participate in" or "contribute to" assessments, nursing diagnoses, and evaluations, but, unlike RNS, LPNs may not independently perform those tasks. *Compare e.g.*, DE ADC 24 1900, § 7.3.1.1 *with* DE ADC 24 1900, § 7.4.1.1; DE ADC 24 1900, § 7.3.1.2 *with* DE ADC 24 1900, § 7.4.1.2; DE ADC 24 1900, § 7.3.1.3 *with* DE ADC 24 1900, § 7.4.1.3; and DE ADC 24 1900, § 7.3.1.5 *with* DE ADC 24 1900, § 7.4.1.5.

The Monitoring Team examined the job descriptions for RNs and LPNs in the course of conducting a review of this provision of the MOA. The Monitoring Team took the position that the job descriptions needed to be revised because the descriptions for RNs and LPNs essentially were identical, which does not reflect the differentiation in the scope of the licensure of RNs and LPNs. The Monitoring Team requested these revised job descriptions several times beginning in February 2008 and received the draft revised job descriptions on June 30, 2008. After reviewing the revised job descriptions, the Monitoring Team found that it would

be helpful to revise them further, to reflect exactly what an LPN may not do.[34] The State further revised the job descriptions to the Monitoring Team's satisfaction.

As discussed in the Third Report, with respect to mental health clinicians, Delaware law requires only those who hold themselves out as licensed mental health professionals to hold licenses. *See* 24 *Del. C.* § 3030. Thus, if one does not hold him or herself out as being licensed, no license is required, but he or she can still provide counseling services. However, the Monitoring Team believes that with respect to unlicensed mental health clinicians, some supervision is required of these individuals. Since the publication of the Third Report, the parties have agreed upon the appropriate level of supervision required for these unlicensed clinicians and the State has memorialized this agreement in a policy.

At each of the Facilities, the Monitoring Team reviewed personnel files of relevant staff members. The Monitoring Team found that the staff who undisputedly are required to have licenses are licensed and in good standing. Moreover, the Monitoring Team has reviewed the credentialing programs at the Facilities, and finds that these programs are appropriate. As noted above, the Monitoring Team has found that certain staff members are practicing outside the scope of their licensure. Therefore, the Monitoring Team finds the Facilities are in partial compliance with this provision of the MOA. Facility-specific findings are listed below.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA. For informational purposes, Baylor is almost in substantial compliance with this provision of the MOA with respect to medical services.

2. Findings

In addition to the job description for LPNs, the Monitoring Team has reviewed the job descriptions for other positions and finds them to be sufficient.

With regard to licensure, the Monitoring Team reviewed the credential files of the licensed staff and found that all licensed staff had their licenses reviewed and signed off as up to date. For a discussion of whether staff members are practicing within the scope of their licensure, please see the discussion of paragraph 19 of the MOA.

With respect to mental health staff, at the time of the Monitoring Team's visit to the facility in October 2008, no formal supervision of unlicensed mental health clinicians was taking place as required by the recently enacted policy.

[34] Job descriptions are important on a practical level because they are used to assign schedules and tasks to employees.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that the job descriptions that it reviewed are consistent with the understanding of the parties. In addition, in reviewing licensure status of all of those requiring a license the documents were completely up-to-date.

With respect to mental health staff, the Monitoring Team was informed during its December 2008 visit to the facility that supervision of unlicensed mental health clinicians was occurring in accordance with the policy. However, there is no documentation that such supervision is actually occurring.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that LPNs are still conducting sick call, which is beyond the scope of their licensure. The Monitoring Team also found that licensed staff members have appropriate credentials.

With respect to mental health staff, at the time of the Monitoring Team's August 2008 visit, supervision of unlicensed mental health clinicians was not occurring.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the job descriptions and licensure for all individuals for whom a license is required. The documentation is complete in both areas. For a

discussion of whether staff members are practicing within the scope of their licensure, see discussion of provision 19 of the MOA.

With respect to mental health staff, the Monitoring Team was informed during its October 2008 visit to the facility that supervision of unlicensed mental health clinicians was occurring in accordance with the policy. However, there is no documentation that such supervision is actually occurring.

F. Recommendations

At all of the Facilities, the Monitoring Team recommends that the State fully implement the policy regarding supervision of unlicensed mental health clinicians. The State should maintain some documentation to serve as a record that this supervision is occurring in accordance with the policy.

At Baylor, the Monitoring Team recommends the following:

- The sick call policy needs to be modified to restrict the performance of sick call to RNs only.
- The vendor needs to reconfigure staffing so that only RNs perform sick call.

At JTVCC, the Monitoring Team recommends the following:

- The State, in collaboration with CMS, should conduct a staffing analysis at JTVCC.
- Health care leadership should assign RNs the responsibility for nurse sick call.
- The State should provide sufficient LPN staffing to enable staff to administer medications in a timely manner and in accordance with standards of nursing practice (See medication administration).

At HRYCI, the Monitoring Team recommends that the State revise nursing assignments so that only licensed RNs are performing the sick call service.

6. Staffing

A. Relevant MOA Provision

Paragraph 6 of the MOA provides:

> The State shall maintain sufficient staffing levels of qualified medical staff and mental health professionals to provide care for inmates' serious medical and mental health needs that meets generally accepted professional standards.

One way to evaluate the adequacy and effectiveness of a facility's staffing plan is the facility's ability to meet the health needs of the inmate population. J-C-07; P-C-07. Various factors can be examined to determine the number and type of health care professionals required at a facility, such as the: (i) size of the facility; (ii) types and scope of health services delivered; (iii) needs of the inmate population at the particular facility, and (iv) organizational structure of

the facility. *Id*. In addition, two other factors of significance in evaluating the sufficiency of staffing levels are whether a prescribing provider[35] is available for a sufficient amount of time so as to avoid any unreasonable delay in patients receiving necessary care, and if physician time[36] is sufficient to meet both clinical[37] and administrative responsibilities.[38] *Id*.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

With respect to nursing, the Monitoring Team found that the nurses are not appropriately assigned responsibilities in accordance with their level of education and training. The Monitoring Team reported this problem in the Third Report, and it continues. For example, LPNs are performing sick call when the charge nurse is absent, conducting intake screening, and managing the chronic care clinic. These responsibilities involve nursing assessment and educational skills and are more appropriately assigned to an RN. In addition, as discussed elsewhere in this report, the Monitoring Team found continued problems with medication administration, including the duration of each medication pass. Although the Monitoring Team believes that staffing contributes to these problems, it does not believe that all deficiencies are staffing-related; some are performance related. A more detailed discussion of staffing is included below.

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[35] A "prescribing provider" is defined as "a licensed individual, such as a medical doctor, doctor of osteopathy, nurse practitioner, or physician's assistant, authorized to write prescriptions. J-C-07; P-C-07.

[36] Typically, 3.5 hours of physician time per 100 inmates housed at a facility is regarded as the minimum acceptable physician time. J-C-07; P-C-07. Nurse practitioners or physician's assistants may substitute for a portion of the physician's time seeing patients, but must do so under the supervision of a physician. *Id*.; *see generally*, 24 *Del. C.* § 1772.

[37] Clinical responsibilities include conducting physical examinations, evaluating and managing parties in clinics, monitoring other providers by reviewing and co-signing records, reviewing laboratory and other diagnostic test results, and developing individual treatment plans. J-C-07; P-C-07.

[38] Administrative responsibilities include reviewing and approving policies, procedures, protocols, and guidelines, participating in staff meetings, conducting in-service training program, and participating in quality improvement and infection control programs. J-C-07; P-C-07.

Advanced-Level Provider Staffing

Staffing at Baylor is the same as reported in the Third Report. Currently, Baylor is allocated and has 2.0 clinical full time equivalent ("FTE") positions. This includes a 1.0 FTE Medical Director and a 1.0 FTE NP. The Monitoring Team finds this allocation to be adequate.

In addition to the 2.0 clinical FTEs, there is also a part-time OB/GYN NP who comes to the facility on a weekly basis, and an HIV specialist who comes to the facility periodically.

Nurse Staffing

As reported in the Third Report, excluding the DON, there are 5.2 FTE RNs to cover 24 hours per day, 7 days per week. There are two RNs on the day shift (a charge nurse and infection control nurse), one RN is assigned to cover the evening shift, and one RN is assigned to cover the night shift. The remaining 1.2 RNs are assigned to cover the weekends. The facility is using "as needed" (PRN) staffing for relief coverage. As noted above, the Monitoring Team found that LPNs are conducting sick call and intake screening, which the Monitoring Team believes are functions that should be performed by an RN. Therefore, the Monitoring Team believes that additional RN positions are necessary during day and evening shifts to adequately perform these functions.

There are 7.8 LPN positions to cover 24 hours per day, 7 days per week. This is a 1.6 FTE increase since the Monitoring Team's last visit. These additional resources have been allocated to medication administration duties. There are 3.4 LPNs assigned to the day shift. Their duties include managing the chronic care clinic, medications, intake screening, and other duties such as providing treatments (*e.g.*, blood pressure checks, administering insulin). There are three LPNs assigned to the evening shift, and 1.4 LPNs assigned to the night shift. The addition of the LPN positions has been helpful; however, the increase still does not allow for dedication of 2 LPNs for medication administration during days and evening shifts (*see* discussion of paragraph 24 of the MOA).

Other Staffing

There have been no changes to the medical assistant staffing levels at Baylor from the staffing levels reported in the Third Report. There are 2.0 FTE medical assistant positions. One medical assistant provides support to the physician and NP on the day shift, and the other medical assistant is assigned to the night shift. The Monitoring Team finds this level of staffing to be sufficient.

There are three administrative support positions. One individual is designated as the consultation coordinator, the other is an administrative assistant. In the Third Report, the Monitoring Team found this level of staffing to be sufficient, but during the Monitoring Team's most recent visit, the Monitoring Team questions the sufficiency of the adequacy of health records staffing (*see* discussion of paragraph 3 of the MOA).

Mental Health Staffing

With respect to mental health staffing, during Summer 2008, there was one mental health staffing vacancy at Baylor, and the mental health director was providing coverage to another institution, which created a partial functional vacancy at Baylor. These changes were in addition to the FTE mental health clinical position being removed from Baylor prior to the Monitoring Team's April 2008 visit.

In September 2008, a full time mental health clinician was hired and assigned to the Harbor House[39] program. Prior to this hiring, group meetings in Harbor House had not been scheduled due to staffing vacancies. Services for general population inmates also had been negatively affected as individual routine monthly mental health sessions were provided on an as needed basis instead of being regularly scheduled.

In the Third Report, the Monitoring Team noted that it was unable to assess the long term impact of the decrease in mental health positions at Baylor. The Monitoring Team now can conclude that current staffing at Baylor is not adequate. This assessment is based, in part, on the fact that clinical contacts have significantly decreased following the loss of the position at Baylor to JTVCC. For instance, in 2007, the average number of routine mental health visits ("RHMVs") was 124 per month. In 2008, the average number of RHMVs through April (when the position was reallocated) was 188 per month. From May 2008 through the time of the Monitoring Team's visit in October 2008, the average number of RHMVs had decreased to 91 per month.

Another major problem observed by the Monitoring Team is the fact that one of the clinicians spends approximately 95% of the time with the Harbor House program. The problem with this arrangement is that if the general population mental health clinician is on vacation, all programming on Harbor House ceases as the Harbor House clinician has to cover intakes and sick call requests for the general population.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

[39] Harbor House is the housing area for inmates with special mental health needs. Harbor House is a housing unit for women with serious mental health illnesses and women who have been court ordered to this program for various reasons related to their mental health issues.

2. **Findings**

Advanced-Level Provider Staffing

The clinical staffing for the facility is 5.0 FTE. This includes three physicians and two NPs. The Monitoring Team finds that this staffing allocation most likely is adequate.

Nurse Staffing

The Monitoring Team is are concerned that the facility still has insufficient numbers of both RNs to conduct sick call and LPNs to administer medications in a timely manner (*see* discussion of paragraph 24 of the MOA). Both RNs and LPNs perform sick call, however sick call should be assigned only to properly trained RNs. (*See also* discussion of paragraph 19 of the MOA).

Mental Health Staffing

The Monitoring Team observed that staffing allocations are unchanged from prior site visits. At the time of the Monitoring Team's December 2008 visit, there were 2.0 FTE clinical mental health staffing vacancies, and a vacant 1.0 FTE director of mental health position.

The Monitoring Team continues to believe, as it did in the Third Report, that the current mental health staffing allocations are inadequate. This opinion is based upon its review of health care records and information obtained from staff and inmates.

D. HRYCI

1. **Assessment**

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. **Findings**

Advanced Level Provider Staffing

The Monitoring Team found that HRYCI most likely has adequate clinical staff, but, as discussed below, has insufficient numbers of RNs to conduct sick call, and LPNs to administer medications in a timely manner.

At the time of the Monitoring Team's visit. HRYCI had allocated 4.6 clinical FTEs: a 1.0 FTE Medical Director, 1.6 FTE physician, and 2.0 FTE NPs. The Medical Director position was vacant.

Nurse Staffing

At the time of the Monitoring Team's visit, there were a total of nine RN positions, excluding the DON position, which had been filled shortly prior to the Monitoring Team's visit. The allocations were as follows: 1.0 FTE RN supervisor on days and evenings seven days per week, a 1.0 RN FTE on each shift seven days per week. There is now an RN assigned to the night shift. There is a RN designated as an infection control coordinator, and a QA/chronic care case manager.

Although the Monitoring Team was advised that RNs now conduct sick call, the Monitoring Team's record review reflected that this does not occur consistently. Instead, as noted elsewhere in this report, this responsibility predominantly is assigned to LPNs, who should not be performing independent nursing assessments. In order for RNs to perform the activities that require independent assessments, it is likely that more RN positions are required. The alternative is to have an NP or physician conduct sick call.

With respect to LPN staffing, there are a total of 12.2 FTE LPN positions. A significant portion of these nurses are assigned to pass medications; however, staff currently are unable to administer medications in a timely manner and in accordance with standards of nursing practice. The Monitoring Team attributes these problems to inadequate staff assigned to this function. Although redistribution of assignments might free up additional LPNs to perform medication administration, more LPNs are likely to be needed.

Mental Health Staffing

At the time of the Monitoring Team's August 2008 visit, several mental health clinician vacancies had been filled. For the three months prior to the visit, there had been 3.5 FTE mental health clinician vacancies at HRYCI. Three 1.0 FTE positions were filled, which left only a 0.5 FTE position vacant.

With respect to coverage by psychiatrists, most of the psychiatrists start their work later in the day. The Monitoring Team was informed that a plan was in place to have two psychiatrists provide the bulk of the psychiatrists' hours in a manner that includes a predicable schedule. At the time of the Monitoring Team's visit, one psychiatrist provided coverage to the infirmary, including weekend coverage. However, there was not daily coverage in the infirmary as there should have been.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. **Findings**

The Monitoring Team evaluated this area by reviewing budgeted staff allocations assigned to the facility, vacancy rates, and overall compliance with the requirements of the MOA as well as the State's own policies and procedures. As stated in earlier reports, from a physical plant perspective, SCI is two separate facilities; one for pre-trial detainees and one for sentenced inmates. Each side has a separate medical clinic requiring dedicated nursing and ancillary staff. The institution is staffed as a single facility, which does not reflect the need for dual coverage for each type of task. The Monitoring Team found that staffing essentially is unchanged since the Monitoring Team's last visit, and likely to be insufficient with respect to clinical, nurse and ancillary staff.

Advanced-Level Provider Staffing

With respect to clinical staffing, the CMS contract requires 3.0 clinical FTE positions for SCI and SVOP.[40] The Monitoring Team already has noted that this arrangement creates a situation in which SCI really receives approximately 1.5 FTEs. Given the identified clinical issues, the Monitoring Team found this allocation to be insufficient.

At the time of the Monitoring Team's visit, the Medical Director and other providers were listed collectively as 2.6 FTEs; however, this did not reflect the reality of the clinical coverage. The Medical Director (1.0 FTE) is pulled to other Facilities to provide assistance in infectious disease care as well as to provide vacation coverage. NPs also are pulled to cover other sites. This problem is compounded by the fact that coverage for SCI provider vacations and leave taken pursuant to the Family Medical Leave Act has been extremely limited, resulting in a significant backlog of chronic disease clinic and sick call appointments. Record reviews confirmed significant problems with access to a physician (*see* discussions of paragraphs 19 and 22 of the MOA). Additionally, the Medical Director has had insufficient time to provide adequate supervision of the mid-level practitioners and other site physicians.

Nurse Staffing

There are insufficient numbers of RNs to perform sick call and provide coverage in both MSB and pre-trial areas. For example, during the Monitoring Team's visit there were only LPNs assigned to the pre-trial area. Therefore there are no RNs readily available and qualified to perform independent assessments for routine and urgent visits, or for new intakes requiring an immediate assessment.

With respect to LPN staffing, as noted in prior reports, a significant number of LPNs are assigned to pass medications. However, at the time of the Monitoring Team's visit, staff members were unable to administer medications in a timely manner and in accordance with standards of nursing practice. The Monitoring Team believes that this is due in part to inadequate numbers of staff members assigned to this function (*see* discussion of paragraph 24 of

[40] SVOP (Sussex Violation of Probation Center) is not covered by the MOA.

the MOA). Although redistribution of assignments may free up additional LPNs to perform medication administration, the Monitoring Team believes that more LPNs are likely to be needed.

Mental Health Staffing

At the time of the Monitoring Team's visit in late October 2008, the State had filled the last of the vacancies for mental health clinicians at the facility. During Summer 2008, the facility had as many as 3.5 FTE vacant positions.

Additionally, mental health staff members indicated that the previously recommended systemic staffing analysis is under way, but is not yet completed.

F. Recommendations

At JTVCC and HRYCI, the Monitoring Team repeats its recommendation that the State conduct a systemic analysis to adequately assess the necessary level of mental health staffing allocations at the facility.

At Baylor, the Monitoring Team recommends the following:

- The State and CMS should reassess and adjust RN staffing to permit RNs to conduct sick call, intake screening, urgent/emergent evaluations, and any other responsibility that requires nursing assessment skills.
- The State and CMS should reassess and adjust LPN staffing to allocate two LPNs to medication administration on day and evening shifts, 7 days per week.
- With respect to mental health, the State should examine its staffing levels, especially in light of the apparent effect the decrease in allocations of mental health staff has had.

At HRYCI, the Monitoring Team recommends the following:

- The Medical Director be given the responsibility for allocation of clinician staffing, including ensuring adequate clinical coverage;
- Health care leadership should assign registered nurses the responsibility for nurse sick call;
- Provide sufficient LPN staffing to enable staff to administer medications in a timely manner and in accordance with standards of nursing practice.

At SCI, the Monitoring Team recommends the following:

- The State should reassess clinical and nurse staffing to ensure adequate coverage for both the pre-trial and MSB areas;
- Health care leadership should assign RNs the responsibility for nurse sick call and intake screening and provide additional RNs to enable this to occur;
- The State should provide sufficient LPN staffing to enable staff to administer medications

in a timely manner and in accordance with standards of nursing practice;

- The State should add ancillary staff (medical records clerk) to facilitate the timely health record filing and transcription of medication orders.

7. Medical and Mental Health Staff Management

A. Relevant MOA Provision

Paragraph 7 of the MOA provides:

> The State shall ensure that a full-time medical director is responsible for the management of the medical program. The State shall also provide a director of nursing and adequate administrative medical and mental health management. In addition, the State shall ensure that a designated clinical director shall supervise inmates' mental health treatment at the Facilities. These positions may be filled either by State employees, by independent contractors retained by the State, or pursuant to the State's contract with a correctional health care vendor.

According to NCCHC Standards for both jails and prisons, each of the Facilities should have a designated health authority responsible for health care services and, as provided in the MOA, each of the Facilities should have another responsible health authority for mental health services. J-A-02; P-A-02. According to the State's Action Plan, positions that the State plans to fill in order to meet this requirement are a statewide full-time medical director, statewide director of nursing, a statewide full-time mental health director as well as additional administrative management staff to assist the foregoing state-level positions. *See* Section 7 of the State's Action Plan. In addition, there is a position allocated at each of the Facilities for a clinical director of mental health, an HSA, medical director and DON. For a Facility to be in substantial compliance with this provision of the MOA, the Monitoring Team needs to find that there has been stable and quality leadership at the Facility. Thus, simply hiring a person to fill a position will not be adequate.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. <u>Findings</u>

In comparison with the Monitoring Team's previous visit, Baylor has suffered a setback with respect to this provision of the MOA. The medical director who had been onsite for several years, and who had been characterized by the Monitoring Team as providing very conscientious services, has left Baylor. A new onsite medical director began about one week before the Monitoring Team's most recent visit. In addition, the site HSA had only been in place for three months and the site DON position was vacant at the time of the Monitoring Team's

visit. Thus, the problem of instability in medical leadership positions persists at Baylor. The Monitoring Team believes that, in all likelihood, a connection exists between the observed deterioration in clinical performance in some areas and the recent changes in these key positions.

With respect to mental health staff management, the statewide mental health director resigned effective November 26, 2008. In addition, a new regional director of psychiatry was hired by CMS in August 2008. This regional director meets with all the psychiatrists on a monthly basis.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The leadership team at JTVCC continues to turn over. Although the Medical Director has been in place for three years, at the time of the Monitoring Team's visit, the HSA had been in that position for three months, the Assistant HSA position was vacant, the DON had been in that position for two months, and the Assistant DON had been in that position for one month. Thus, with the exception of the Medical Director, the remainder of the leadership team is relatively new to their positions and are clearly continuing to be oriented to the unique issues faced at JTVCC.

Although the leadership team is appropriately credentialed, the Monitoring Team continues to remain concerned about the frequency of the turnover in these leadership positions. It is very difficult to implement stable processes when leadership is turning over as rapidly as the Monitoring Team has seen at some of the Facilities, including JTVCC.

With respect to mental health staff management, the statewide mental health director resigned effective November 26, 2008. In addition, a new regional director of psychiatry was hired by CMS in August 2008. This regional director meets with all the psychiatrists on a monthly basis.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that there continues to be a lack of a stable

leadership team at HRYCI. The DON had left two weeks before the Monitoring Team's visit, and the state DON was filling in at that time. In addition, the site medical director had begun work at the facility only one week before the Monitoring Team's visit.

The Monitoring Team hopes that the new site medical director works out well and will be in place at the time of the Monitoring Team's next review. In addition, it must be a priority to fill the DON position. The HSA had been onsite a year and a half at the time of the Monitoring Team's visit, and that was positive. Since the time of the Monitoring Team's visit, however, the Monitoring Team has learned that the HSA has resigned.

The Monitoring Team has been encouraged historically by the individuals brought into the leadership positions. For a variety of reasons, however, they have departed. In order to progress at an acceptable pace, there must be sustained leadership in all of the key positions.

With respect to mental health staff management, the statewide mental health director resigned effective November 26, 2008. In addition, a new regional director of psychiatry was hired by CMS in August 2008. This regional director meets with all the psychiatrists on a monthly basis.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The facility has had continuity with respect to health care leadership. They have not yet been able to stabilize the implementation of the relevant policies and procedures, nor have they been able to provide, on a consistent basis, supervision of staff, which would result in sustained, improved performance. Although there have been improvements in areas such as intake screening and chronic disease management, other areas such as access to care, specialty consultation, as well as the special needs program, still need improved supervision and improved performance.

The Medical Director has clinical responsibilities at other facilities. Thus, the amount of time devoted to SCI is a less than full time position. This does not permit the Medical Director to devote sufficient time to fulfill administrative duties associated with the role of Medical Director, such as peer review and CQI activities.

With respect to mental health staff management, the statewide mental health director resigned effective November 26, 2008. In addition, a new regional director of psychiatry was hired by CMS in August 2008. This regional director meets with all the psychiatrists on a monthly basis.

F. Recommendations

At all of the Facilities, the State must work to maintain a stable, competent leadership team that is necessary to implement policies, and monitor and improve all service areas.

8. Medical and Mental Health Staff Training

A. Relevant MOA Provision

Paragraph 8 of the MOA provides:

> The State shall continue to ensure that all medical staff and mental health professionals are adequately trained to meet the serious medical and mental health needs of inmates. All such staff shall continue to receive documented orientation and in-service training in accordance with their job classifications, and training topics shall include suicide prevention and the identification and care of inmates with mental disorders.

Adequate training for medical and mental health staff includes an immediate basic orientation[41] and all full-time staff must complete a formal in-depth orientation[42] to the health services program at a facility. J-C-09; P-C-09. In reviewing this provision of the MOA, the Monitoring Team also reviewed whether medical and mental health staff have received suicide prevention training, as required by provision 43 of the MOA.[43]

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[41] A "basic orientation" is one that "is provided on the first day of employment, includes information necessary for the health staff member (*e.g.*, full-time, part-time, consultant, per diem) to function safely in the institution." J-C-09-; P-C-09. At a minimum, the basic orientation should include relevant security and health services policies and procedures, response to facility emergency situations, the staff member's functional position description, and inmate-staff relationships. *Id*.

[42] An "in-depth orientation" should occur within 90 days of employment, and includes "a full familiarization with the health services delivery system at the facility, and focuses on the similarities as well as the differences between providing health care in the in community and in a correctional setting." J-C-09-; P-C-09. Specifically, at a minimum, the curriculum of the in-depth orientation should include all health services policies and procedures not addressed in the basic orientation, health and age-specific needs of the inmate population, infection control including use of standard precautions, and confidentiality of records and health information. *Id*. In addition to these essential topics, a formal orientation program could include the following topics: (i) security, including classification of inmates; (ii) health care needs of the inmate population; (iii) the inmate social system; (iv) the organization of health services at the facility; and (v) infection control. *Id*. For nursing staff, topics could also include: (i) assessment and sick-call triage; (ii) emergency triage and management; (iii) resource utilization outside the facility; (iv) procedures for release of information; (v) expected documentation practices; (vi) isolation procedures; and (vii) professional boundaries. *Id*.

[43] The required contents of suicide prevention training are contained in provision 42 of the MOA.

The MOA requires that all newly hired people be trained by January 31, 2008. The MOA was silent on the timeline for newly hired people to receive their training after January 31, 2008. The Monitoring Team raised this issue with the parties for resolution. The parties agreed that this provision of the MOA should be interpreted to require training for newly-hired medical and mental health staff members to be completed within six months of the date that they begin their employment. Therefore, the Monitoring Team will use an employee's start date to determine if the employee has completed training on a timely basis.

In addition, with respect to the requirement that staff members receive suicide training, the Monitoring Team recommended that psychiatrists be required to take a two-hour course as opposed to the normal eight-hour course that other medical and mental health staff members are required to take. The reason for this recommendation is that psychiatrists already have the qualifications necessary to deal with suicidal inmates. The two-hour training should focus on the State's suicide-related policies and procedures as well as risk factors unique to correctional settings. The parties agreed to implementation of this recommendation.

The State prepared this two-hour training module several months ago. After some time had passed, the DOJ had approved the State's proposed training module, with the exception of one suggested change. As a result of the time it took to receive approval for the training module, the DOC had not yet had the opportunity to implement this training at the time of the Monitoring Team's last visit. The Monitoring Team looks forward to reviewing this training during the next monitoring period.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the training records of 52 health care staff members. All but three of the staff members had completed their training. Thus, the percentage of staff whose training was complete was over 90%.

The psychiatrists, however, had not yet completed their training, which is the reason for the partial compliance rating. If the State is able to maintain its current level of staff training, and complete psychiatrist training, the Monitoring Team believes that the State will be in substantial compliance with this provision of the MOA.

C. JTVCC

1. Assessment

The Monitoring Team found JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the new employee training requirements and the records for those employees who had been employed at JTVCC for greater than six months. The Monitoring Team found that there were 101 required training sessions missing, more than 50 of which were suicide training sessions. In addition, the Monitoring Team found non-compliance in the areas of refresher OSHA training. Also, there were some employees who were missing both NEO1[44] and NEO2,[45] or just NEO2. In sum, approximately 20% of the required training sessions had not been completed, which is the largest percentage among the Facilities.

The Monitoring Team was told that the new leadership team is going to be focusing on accomplishing this required training prior to the Monitoring Team's next visit. In addition, CMS and the OHS will have to work together to insure that the required training with regard to suicide is offered frequently enough for all of the employees who still need it to be able to attend before the Monitoring Team's next visit.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

With regard to the medical staff, the Monitoring Team found about 15 individuals out of all of those who are required to receive this training, whose records reflected that they lacked one or more elements of the required training. There were six individuals who lacked CPR training but were scheduled for the training. Other individuals lacked either NEO1 or NEO2.

With regard to the psychiatrists, they will receive an abbreviated two hour suicide prevention training program, focusing on suicidality in a correctional setting, and the State's policies and procedures regarding suicide prevention. The State is in the process of

[44] NEO1 is a non-clinical training program required of medical staff.

[45] NEO2 is a clinical training program required of medical staff.

implementing this training.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the files of all employees who are required to receive the training. With the exception of the required suicide training to be received by the psychiatrists, the staff at SCI generally has completed their required training elements.

SCI is assess as being in partial compliance because the psychiatrists had not yet completed the suicide training. If the State is able to maintain its current level of staff training, and complete psychiatrist training, the Monitoring Team believes that the State will be in substantial compliance with this provision of the MOA.

9. Security Staff Training

A. Relevant MOA Provision

Paragraph 9 of the MOA provides:

> The State shall ensure that security staff members are adequately trained in the identification, timely referral, and proper supervision of inmates with serious medical or mental health needs. The State shall ensure that security staff members assigned to mental health units receive additional training related to the proper supervision of inmates suffering from mental illness.

Adequate training for security staff should occur at least every two years, and include, at a minimum, the following topics: (i) the administration of first aid; (ii) recognizing the need for emergency care and intervention in life-threatening situations (*e.g.* a heart attack); (iii) recognizing acute manifestations of certain chronic illnesses, intoxication and withdrawal, and adverse reactions to medications; (iv) recognizing signs and symptoms of mental illness; (v) procedures for suicide prevention; (vi) procedures for appropriate referral of inmates with health complaints to health staff; (vii) precautions and procedures with respect to infectious and communicable diseases; and (viii) CPR. J-C-04; P-C-04. At any given time, at least 75% of the security staff present should be current with their health-related training. *Id*. The Facilities should maintain a certificate or other evidence of security staff's training, and an outline of the course content and the length of the course for the Monitoring Team's review to assess the appropriateness of the health-related training. *Id*.

While reviewing the State's compliance with this provision of the MOA, the Monitoring Team also reviewed whether security staff members had received the training required by provisions 32 and 43 of the MOA.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed 35 randomly-selected records of security staff members employed at Baylor. Approximately 90% of staff members received the required training. A few security staff members needed a refresher course in first aid or suicide training.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed a sample of employee records for 35 of the 648 custody officers. Of the officers whose records the Monitoring Team reviewed, there were two officers who lacked CPR, AED and First Aid training, and one officer who lacked CPR and AED training. Nonetheless, the State has achieved a 90% compliance rate and this satisfies the Monitoring Team's requirement for substantial compliance.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the records of 30 officers selected at random. The Monitoring Team found that all but one of the correctional officers was up-to-date with training. This is greater than 90% compliance and is consistent with the Monitoring Team's previous finding.

As reported in the Third Report, with regard to the officers working on the mental health inpatient unit, the weekday officers had completed special training, but the weekend officers had not completed such training. The State was to submit documentation of the completion of this training, but the Monitoring Team has not received it.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the records of 30 security staff members, selected at random. The Monitoring Team found that the all but one of the correctional offers was up-to-date with training.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State insure that the relevant staff receives the refresher first aid training or the suicide prevention training where indicated.

SCREENING AND TREATMENT

10. Medical Screening

A. Relevant MOA Provision

Paragraph 10 of the MOA provides:

> The State shall ensure that all inmates receive an appropriate and timely medical screening by a medical staff member upon arrival at a facility. The State shall ensure that such screening enables staff to identify individuals with serious medical or mental health conditions, including acute medical needs, infectious diseases, chronic conditions, physical disabilities, mental illness, suicide risk, and drug and/or alcohol withdrawal. Separate mental health screening shall be provided as described in Paragraph 34 [of the MOA].

According to NCCHC standards, timely receiving screening[46] means that the screening is performed on inmates immediately[47] upon arrival at the respective intake facility, and is performed by a qualified health care professional or a health-trained person. J-E-02; P-E-02. The policies adopted by the State provide that such receiving screening will be initiated within two hours of arrival into a facility and will be the responsibility of the nursing healthcare staff. *See* State Policy E-02. This policy is adequate. If a receiving screening is completed within three to four hours of arrival to a Facility, the Monitoring Team believes that is reasonable.

The MOA requires that the State ensure that the receiving screening, "enables staff to identify individuals with serious medical or mental health conditions, including acute medical needs, infectious diseases, chronic conditions, physical disabilities, mental illness, suicide risk, and drug and/or alcohol withdrawal." In order to comply with this requirement, the State should ensure that receiving personnel are making consistent and complete inquiries and

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[46] A "receiving screening" is

> [A] process of structured inquiry and observation designed to prevent newly arrived inmates who pose a threat to their own or others' health or safety from being admitted to the facility's general population, and to get them rapid medical care. It is intended to identify potential emergency situations among new arrivals to the facility, and also to ensure that those patients with known illnesses and currently on medications are identified for further assessment and continued treatment.

J-E-02; P-E-02. In sum, the purpose of a receiving screening is to (i) identify and meet any urgent health needs of those admitted; (ii) identify and meet any known or easily identifiable health needs that require medical intervention before the health assessment (*see infra*); and (iii) identify and isolate inmates who appear potentially contagious. *Id*.

[47] NCCHC standards do not clarify what is meant by "immediately." As stated above, the Monitoring Team believes that three to four hours is reasonable.

observations. Reception personnel should use a checklist to ensure that they inquire about the following important information:

- current and past illnesses, health conditions, or special health requirements (*e.g.* dietary needs);
- past serious infectious disease(s);
- recent communicable illness symptoms (*e.g.* chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever, night sweats);
- past or current mental illness, including hospitalizations;
- history of or current suicidal ideation;
- dental problems;
- allergies;
- legal and illegal drug use (including the last time of use);
- drug withdrawal symptoms;
- current or recent pregnancy; and
- other health problems that the State should decide to include on its form.

J-E-02; P-E-02. In addition, reception personnel should note on the receiving screening form observations about newly arrived inmates such as:

- appearance (*e.g.* sweating, tremors, anxious, disheveled);
- behavior (*e.g.*, disorderly, appropriate, insensible);
- state of consciousness (*e.g.*, alert, responsive, lethargic);[48]

[48] Persons who are unconscious, semi-conscious, bleeding, mentally unstable, or otherwise urgently in need of medical attention upon arriving at a Facility should be referred immediately for care. J-E-02; P-E-02. Such an immediate referral upon arrival at a Facility should be noted on the receiving screening form. *Id*. In addition, if the inmate is referred to a community hospital for care of the emergency condition and is returned to the Facility, the Facility should require a written medical clearance from the community hospital. *Id*.

- ease of movement (*e.g.* body deformities, gait);

- breathing (*e.g.* persistent cough, hyperventilation); and

- skin (*e.g.* lesions, jaundice, rashes, infestations, bruises, scars, tattoos, and needle marks or other indications of drug abuse).

Id. The disposition of the inmate (*i.e.*, if the inmate was immediately referred for medical care, or placed in general population, etc.) should be indicated on the receiving screening form. *Id*. Once the receiving screening form has been completed, it should include the date and time of completion, and the signature and title of the person completing the form. *Id*. Finally, the receiving screening should allow for all immediate health needs to be identified and addressed, and potentially infectious inmates to be isolated. *Id*.

As noted above, the State has created a policy stating that a receiving screening will be initiated within two hours of arrival to a Facility. (*See* State Policy E-02). This policy further provides that inmates will be screened in a manner consistent with the NCCHC standards cited above. *Id*. Also, the State will record the findings of the screenings in DACS, and the screenings will include a history and observations based on a health screening form. *Id*. The screening form supplied by the State is adequate, but will require some progress notes to be attached and cross-referenced in the case of positive answers to questions that require follow-up.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2 <u>Findings</u>

The Monitoring Team found that there has been deterioration in the performance with regard to both timeliness and completeness of medical screenings at Baylor from the last monitoring period.

<u>Timeliness of Intake Screening</u>

The Monitoring Team reviewed 10 records, which were selected at random from a group of individuals who had been identified as having health problems during the initial screening process. Of those records, four of 10 had not been screened within four hours.

<u>Adequacy of Intake Screening</u>

In eight of the 10 records, the intake screening form lacked necessary detail. More specifically, when a nurse conducts an intake screening, she must provide detail after an inmate has responded affirmatively to a question. For example, if an inmate responds that she is

on medication, then there should be detailed information such as the name of the medication that the inmate takes on the form. In addition, in four of the 10 records, the chart did not contain a TST.

Intrasystem Transfers

With respect to the intrasystem transfer process, the Monitoring Team reviewed eight records of inmates who transferred to Baylor between May 1 and July 21, 2008. In general, the Monitoring Team found that the process for transferring these inmates is not working well, either for newly arriving or transferring patients.

Five of the eight inmates reviewed had been transferred to Baylor within a day or two of arriving at SCI as new to the Delaware correctional system.[49] Thus, a complete medical screening process should have been performed on them. In five out of these five inmates' records, a nurse had initiated the receiving portion of the intrasystem transfer form, but the intake was inadequate. In one record, the intrasystem transfer form had not been printed from the computer, so it was not located in the record, and, in a second record, the nurse did not note the patient's significant medical history on the intrasystem transfer form. Both of these inmates had health problems of significant concern.

In addition, three of the five records reflected that the inmates had refused a physical examination, and had received no further evaluation. Two of these inmates had serious medical and/or mental health concerns; at least one of the inmates reported that she was on medication when she came into the facility. Additionally, one of the inmates had refused TB skin testing; inmates who have not been screened for active TB pose a risk to staff, other inmates, and the public health. Such patients should be referred to a clinician for a review of the patient's medical and mental health history, and a discussion of the reasons why the inmate refused care.

Three of the eight inmates had been transferred from another facility, and were not new to the system. All three of these records were problematic. Although two of the three patients had the intrasystem transfer form completed in a timely manner, the intrasystem transfer forms were not completed with sufficient detail, even when the inmate reported significant health problems. One inmate required medication, but her medications were not continued nor was she seen by a clinician. Another inmate with a significant medical and mental health history, including substance abuse problems, had not had a physical examination prior to her arrival at Baylor. She had been transferred from SCI to Baylor on August 7, 2008, for medical reasons, and, although an intrasystem transfer form was completed, the nurse did not identify that the patient required further evaluation and completion of the medical reception process. On August 12, 2008, this patient became ill, and was subsequently admitted to the infirmary and later to the hospital.

[49] Female inmates are taken into SCI at times, but they are moved to Baylor within 24 hours.

A general concern that arose from the review of all eight of the intrasystem transfer records is that when patients transfer into Baylor, nurses do not obtain physician orders to continue medications. Although a medication order from a prior facility may still be valid, the nurse should take steps to continue the medications at the facility to prevent disruptions in medication continuity.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed 20 records of individuals who entered the JTVCC facility as new arrivals between September and October of 2008.

Timeliness of Intake Screening

Nineteen out of 20 inmates received an intake screening within less than four hours of intake.[50] This is an excellent performance.

Adequacy of Intake Screening

In 17 of the 20 records reviewed, the intake screen was performed by an RN. This is a positive step forward. However, none of the screens performed by LPNs were countersigned by an RN, and the screening quality was not adequate. Specifically, one diabetic patient had a substantially elevated blood pressure and the intake screening noted "vital signs within normal limits." In addition, one screening was missing a TB skin test. Finally, the documentation of one screening indicated that the patient had no chronic problems, but a progress note written by the same LPN who performed the screening indicated that the patient has both hypertension and diabetes.

Intrasystem Transfer

The Monitoring Team also reviewed the records of five inmates who had been transferred to JTVCC. In four out of five cases, appropriate follow-up care was not scheduled because the RN performing that function misunderstood how to use DACS. This problem has been remedied.

[50] The one individual whose screen was more than four hours after intake was screened in 4.5 hours.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found substantial compliance with respect to the timeliness of medical screenings, partial compliance with respect to the appropriateness of the medical screenings, and in partial compliance with respect to intrasystem transfers.

2. Findings

Timeliness of Intake Screening

The Monitoring Team reviewed the health records of 20 newly-arrived inmates. In each case, the inmate received a timely medical screening. This was also confirmed by DACS-generated reports. The process with regard to timeliness of the intake process is working very well.

Appropriateness of Intake Screenings

The Monitoring Team found that LPNs are performing all of the intake screenings. If LPNs are going to conduct intake screenings, then RNs must be reviewing and countersigning all LPN-generated intake screenings. The Monitoring Team found RN countersignatures on only 50% of the records reviewed.

In addition, when a patient provides a positive answer to a question, such as "do you have any medical problems," the screener is to detail the specifics of the positive answer in a text space in the computer. In 50% of the records, such detail was missing on one or more questions.

Intrasystem Transfers

The Monitoring Team reviewed five records of patients who had been transferred from other facilities. Two out of the five records did not document the inmate's vital signs. In three of the five records, there was not a progress note in the medical record to document the patient's problems, medications and pending appointments.[51]

The Monitoring Team found that the TB screening was sufficient in all of the records, except for one in which the patient had a history of a past positive skin test and required a chest x-ray, which had not yet been obtained.

[51] Although information regarding inmates received through intrasystem transfers is entered into DACS, there should be a brief corresponding progress note in the inmate's health record.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance (nearly substantial compliance) with this provision of the MOA.

2. Findings

There has been a significant improvement in the timeliness and quality of medical screenings.

Timeliness of Intake Screening

The Monitoring Team reviewed the medical screening of 15 individuals who entered SCI between September 1 and mid-October, and five records of individuals who transferred into the institution within the same time frame. The screening occurred on average in less than two hours.

Adequacy of Intake Screening

The Monitoring Team found that the DACS software has a problem that impacts the completeness of the intake screening. The DACS screens require that, for each new inmate screened, the nurse must enter his or her name at the beginning of the documentation of the medical screen. If the nurse fails to enter his or her name, then text boxes for details of positive answers do not appear. Thus, when an inmate answers "yes" to a health-related question, a text box prompting the nurse to fill in the details regarding the health-related issue does not appear. In general, nurses also documented the intake screening with a written progress note in the medical record, and the Monitoring Team found that those notes did contain many of the problems which were not detailed in the DACS printout.

In addition, all but five of the 20 records demonstrated screening by an RN, or when screening was performed by an LPN, there was a countersignature. Thus, 75% were in compliance and 25% still lacked a documented RN review.

F. Recommendations

At Baylor, the Monitoring Team recommends the following:

- Medical staff and custody staff need to work together to insure that all screens occur within four hours. As a practical matter, the Monitoring Team encourages the use of the State's policy of a two-hour time frame. This time frame creates a greater sense of urgency with regard to completion of the screenings.
- Staff must be retrained with regard to providing elaboration on "yes" answers elicited from the patients during screenings.
- Nursing supervisory staff should be reviewing intake timeliness and performance on a

daily basis in order to improve performance. Once performance is improved, the intensity of the supervising nurse's monitoring may diminish in frequency.

- When an LPN performs an intake, an RN should review the information within one shift, and bring in the patient if necessary to correct any existing deficiencies.
- Nurses should complete intrasystem transfer forms for all transferring patients within 4 hours of arrival at the facility. The nurse should elaborate on all positive responses and develop an individualized treatment plan based on a patient's needs.
- Nurses should refer patients with acute or chronic medical problems to a clinician within three business days of arrival, and contact a clinician to arrange for continuation of essential medications and other necessary care.
- Although the Monitoring Team understands that the DACS system is supposed to schedule patients for necessary medical activities, nurses should ensure that the proposed schedule is timely with respect to the patient's medical needs and override DACS if necessary.
- Clinicians should review the health records of all newly arriving patients to ensure that patient medical conditions have been noted and addressed.

At JTVCC, the Monitoring Team recommends that the State:

- Insure that when an LPN performs a screening it is reviewed timely by an RN who countersigns the record and insures that the necessary information is available.
- Insure that RNs provide feedback to the LPNs when their performance is not up to standard.

At HRYCI, the Monitoring Team recommends that the State:

- Insure that RNs countersign all screenings performed by LPNs, and should monitor this process through the CQI program.
- Insure that RNs provide feedback to the LPN who performed the screen, so as to improve the performance on an ongoing basis.
- Monitor the quality of the screens as part of a CQI program.
- Monitor the intrasystem transfer process by the CQI program, specifically with reference to the provision of vital signs, as well as the documentation in a progress note for each patient of their problems, medications and pending appointments.

At SCI, the Monitoring Team recommends that the State:

- Insure that all screens not performed by RNs are reviewed and countersigned by an RN.
- Fix the software glitch so that nurses successfully document the specific medical problems in response to a "yes" answer.

11. Privacy

A. Relevant MOA Provision[52]

Paragraph 11 of the MOA provides:

> The State shall make reasonable efforts to ensure inmate privacy when conducting medical and mental health screening, assessments, and treatment. However, maintaining inmate privacy shall be subject to legitimate security concerns and emergency situations.

The MOA requires that the State make "reasonable efforts" to ensure inmate privacy when conducting medical and mental health screening, assessments, and treatment, subject to legitimate security concerns and emergency situations. This provision of the MOA differs somewhat from the NCCHC standards, which provide for clinical encounters[53] to be conducted in private, without being observed or overheard by security personnel unless the patient poses a probable risk to the safety of the health care provider or others. J-A-09; P-A-09.[54] The MOA does not require an individual correctional officer to make an independent assessment of the security risk of an individual inmate. Rather, the State can set the procedures for correctional officers to follow to ensure that privacy is afforded in accordance with this provision of the MOA.

The policies adopted by the State call for healthcare to be provided with consideration of inmate dignity and feelings. *See* State Policy A-09. Further, healthcare encounters are to be carried out in a manner and location that promotes confidentiality within the dictates of security and safety. *Id*. The State's policy calls for security staff or interpreters who may be present during healthcare encounters to be informed and educated regarding the need for confidentiality. *Id*. Finally, the State's policy provides for a female escort to be provided for encounters with a female inmate by a male healthcare provider. *Id*.

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[52] Additional, related observations regarding clinic space and equipment can be found in the discussion of provision 18 of the MOA below.

[53] "Clinical encounters" are defined as "interactions between inmates and health care providers that involve a treatment and/or an exchange of confidential information." J-A-09; P-A-09.

[54] Further, NCCHC standards provide that, in cases in which it is necessary for security personnel to overhear clinical encounters, security personnel should be instructed regarding the maintenance of confidentiality of health information. *Id*. Such privacy is not feasible under all circumstances, such as instances in which health staff is dealing with an inmate's health concern at the inmate's cell, or in Facilities in which space issues do not allow for privacy as described above. Under such circumstances, if safety is a concern and full visual privacy cannot be afforded, the NCCHC recommends that alternative strategies for partial privacy, such as a privacy screen, be used. *Id*.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated compliance with this provision by touring clinic spaces, interviewing staff and inmates, and observing clinical encounters. The Monitoring Team's findings during this review are largely unchanged from the Third Report. Clinicians and nurses continue to conduct sick call in examination rooms with privacy. However, because of insufficient clinic space, nurses continue to conduct encounters (*e.g.*, chronic disease visits) in the main hallway, with other inmates circulating in the area. The Monitoring Team also observed staff asking patients questions in the presence of other inmates.

The Monitoring Team also met with a group of eight inmates who had been at the facility from two to 17 years. The inmates believe that there is a lack of adequate medical privacy. The inmates stated that, in addition to staff discussing their medical conditions in front of other inmates, health records and loose filing were on hallway desks in the clinic. Because there is no correctional officer posted in the medical clinic to provide supervision to inmate-patients or sanitation workers, inmates are free to walk unescorted around the clinic and view this confidential information. Further, inmate janitors walk into treatment rooms that have medical equipment and supplies unattended by any staff member.

On a positive note, plans are underway to expand medical services across the hallway, which would increase space and permit all clinical activities and patient encounters requiring medical confidentiality to be performed in a closed room.

Privacy in the Context of Mental Health Services

The Monitoring Team observed little change with respect to the State's performance under this provision. The Monitoring Team found no changes with respect to the adequacy of office space since the previous site visit, and notes there continues to be insufficient clinic space which results in nurses being forced to conduct clinical encounters in the main hallway, with other inmates circulating in the area.

Additionally, available space on some housing units for private encounters has been a problem. This results in initial mental health assessments and other encounters routinely being performed at a table in the common area. The Monitoring Team was informed that an additional interviewing room will be available for mental health assessment/treatment purposes following completion of the pharmacy and medical administrative offices project. However, private space will remain an issue, especially if psychiatry time at the facility is increased in the future.

In addition, the Harbor House mental health office cannot be secured despite the presence of a deadbolt lock. Security has not provided the key to this lock to mental health staff despite requests that it be made available. All officers in the facility currently have a key that unlocks this room. As a result, mental health staff is unable to secure private treatment notes and materials stored here. In addition, the phone in the office does not allow access outside the facility and there is no computer access either. As a result, staff must leave the unit and use the equipment in the main mental health office, thereby decreasing time efficiency.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated compliance with this provision by touring clinic space, interviewing staff, and observing clinical encounters.

The Monitoring Team found that initial efforts have been made to provide privacy. However, the standard is not yet met. Medical assistants who weigh patients and take vital signs have three separate stations in a back hallway. This is an area of frequent inmate and correctional officer traffic, and the arrangement does not provide adequate auditory privacy.

As found at the Monitoring Team's last visit, none of the three clinical examination rooms in use have a door, and clinical staff does not utilize privacy curtains. A patient sitting on an exam table in one room can observe and hear a patient sitting on an examination table across the hall. The hallway also has frequent officer and inmate traffic, which negatively affects patient privacy. Moreover, the area is very noisy and the lack of examination room doors makes it difficult to perform examinations that require a quiet environment (*e.g.* listening to heart, lung and bowel sounds).

On a positive note, a nursing sick call room has been established in the same area and it does have a door that provides privacy.

Privacy in the Context of Mental Health Services

Since the Monitoring Team's last visit, office space has been created in the back of the infirmary for both mental health and medical staffs, however, this space has not yet been opened for use as the furniture is still being delivered. Mental health Psychiatric Close Observation I status ("PCO") assessments are still being done at the cell front.

The main medical clinic area no longer is being used for mental health appointments except with the psychiatrists due to space issues in the waiting room. Staff indicated the only available office space within the compound for mental health treatment

purposes was in the pre-trial area (B), and S1 (the lieutenant's office). In the other seven compound housing units, the day rooms were used for assessment and treatment purposes. The dayrooms do not provide adequate sound or site privacy.

The Monitoring Team also visited housing Unit C which is an old linear series of cells that reportedly are similar to other units on the compound. Upon entering the unit there is a small security office that houses all the officers. The DOC counselor has a small office and the lieutenant's office is an empty room that was locked and described as intolerable because of the excessive heat and lack of ventilation throughout the year.

Mental health staff uses a large dayroom that is no longer used by inmates for dayroom purposes. It is separated from the hallway by a door. Within that space were two picnic tables, coolers for ice, a supply closet and the staff kitchen area. Contact with an inmate is visible to anyone in the hallway through several large windows. Staff reported that there are frequent interruptions by staff and inmates accessing supplies, ice and food in the area.

Staff reported adequate office space in the SHU and in the SNU within the compound. Despite the availability of adequate office space, psychiatric follow-up encounters in the SHU occur in front of a cell

Adequate space was also not available for programming within either of the SNUs. In addition, the "dayroom" used in housing unit T1 for community therapy purposes had an inadequate number of chairs to accommodate the inmate participants.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated compliance with this provision by touring clinic space, interviewing staff and observing clinical encounters. Observations in this section are also noted in the discussion of provision 18 of the MOA relating to clinic space and equipment.

During this visit, the Monitoring Team noted that patient encounters generally are not provided in private settings. For example, the Monitoring Team witnessed a physician examining a patient in the infirmary examination room with a correctional officer in the room. As stated above, the MOA requires the State to make "reasonable efforts" to ensure inmate privacy when conducting medical and mental health screening, assessments, and treatment, subject to legitimate security concerns and emergency situations. The MOA does not require an individual correctional officer to make an independent assessment of the security risk of an individual inmate. Rather, the State can set the procedures for correctional officers to follow to ensure that privacy is afforded in accordance with this provision of the MOA.

In the case of HRYCI, the DOC has expressed overall security concerns, and implemented a policy which requires a correctional officer to accompany inmates at all times in the infirmary. The Monitoring Team does not find that such a blanket policy constitutes a reasonable effort to maintain inmate privacy, even in light of security concerns. Therefore, the Monitoring Team recommends that the State examine whether it is feasible to implement a policy to afford more privacy in certain situations.

In the east side medical clinic, there is only one examination room and staff members advised the Monitoring Team that both the clinician and nurse conduct sick call in the clinic room at the same time, which does not permit adequate privacy. Consideration should be given to converting the old medication room into another examination room.

In the west side clinic, the exam room is used simultaneously to draw laboratory specimens and to perform physical examinations. Although there is a partition in the room, it does not permit adequate auditory and visual privacy. The radiology room is used as a multipurpose room and is also used by physical therapy, but neither activity occurs daily. Consideration should be given to equipping and supplying this room to perform clinical examinations. This would entail adding a sink in this area.

Inmates in the booking area are still required to stand outside the medical screening room at a half-door while a nurse conducts medical intake screening.

Privacy in the Context of Mental Health Services

The facility's infirmary has 14 cells, but only two of these have large windows and are appropriate for housing inmates on PCO. Only seven of the infirmary cells are used for PCO patients. At present, no interview room is available for seeing inmates on PCO status. Mental health staff, including psychiatrists, interview patients either in the dayroom area, when other inmates are off the floor, or cellside. Generally, neither of these locations are appropriate from a privacy standpoint.

In the Third Report, the Monitoring Team discussed the State's plans to move the pharmacy to another area of the facility, in order to create space for interviews in the infirmary. The pharmacy has been moved and an exam room has been created, but is not yet in use. The room is furnished and ready for use except that it is without a computer line.

Adequate office space (*i.e.*, office with sound privacy) for interviewing purposes in the east side dormitory housing units for the mental health clinicians is not available. The space that is used is problematic because of a lack of privacy. For instance, within the dorms used to run substance abuse groups, there is no sound absorbing material which results in lots of reverberation. There are some soft-sided office cubicles for the substance abuse counselors and the mental health staff use those areas for interviewing. The cubicle is comprised of two or three partitions and is fairly exposed to anyone walking around or entering the units. As a result, there is no sound privacy or visual privacy for inmates being seen by mental health staff.

The psychiatrists can use the east side medical clinic during the day shift. If they work late hours, they too do not have access to a private interview setting. The other housing units do have adequate office space.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found that SCI is not in compliance with respect to mental health services and in partial compliance with respect to medical services.

2. Findings

Since the Monitoring Team's last visit, the DOC has made some improvement with respect to clinic space, which, in turn, has enhanced privacy. However, until planned renovations take place, the clinic area remains suboptimal.

Construction has resulted in the addition of an examination room, and the DOC made changes to an existing examination room which provides greater privacy than before. Two other rooms have been constructed for nurses to perform sick call. However, these rooms resemble booths more than examination rooms, and, although they provide auditory privacy, they have no medical equipment or supplies to perform clinical assessments and would not provide any visual privacy should an examination be required.

In addition, nurses continue to interview patients and provide treatment at a long open table in the center of the clinic with other inmates and officers circulating nearby. Inmates and officers alike are able to overhear conversations and observe any examinations or treatments that take place.

As noted in the record-keeping section, medical records are stored in unlocked cabinets and health record documents sit on desks in the clinic where inmates and officers circulate. This does not provide adequate privacy of health records.

Mental Health Issues

The Monitoring Team found that the State has yet to implement the physical plant changes which were discussed in the Third Report. The Monitoring Team was informed at the time of their October 2008 visit that a bid for construction of the commercial trailer has been accepted and a site study was underway.

As a result of these changes not having been implemented, the problems discussed in the Third Report still exist. There are still significant problems with housing units not having any private or confidential space for clinical encounters.

F. Recommendations

At Baylor the Monitoring Team recommends the following:

- Health care staff should refrain from discussing confidential health information in the presence of other inmates or non-health care staff.
- Health records and other loose filing containing confidential medical information should not be left unattended on open desks.
- A correctional officer post should be established in the medical clinic to provide supervision to inmate janitors and prevent inmates from circulating freely in the clinic.
- At Baylor, the Monitoring Team recommends that the State complete the above described renovations. Additionally, the mental health office in Harbor House needs to be secured with access restricted to health services and supervisory security staff.

At JTVCC, the Monitoring Team recommends the following:

- Clinical examination rooms in the main clinic should be retrofitted with a door that has a Plexiglas window that provides a quiet environment to interview inmates and perform examinations, and permits officers to monitor the safety of staff. In the meantime, clinical staff should use privacy curtains to provide the patient privacy during physical examinations.
- The process of interviewing inmates, and taking vital signs and finger-stick blood sugars should be conducted in a manner that provides auditory privacy.
- At JTVCC, the Monitoring Team recommends that the lack of adequate office space for assessing and treating mental health caseload inmates be remedied. Additionally, unless dictated by emergent needs or absolute lack of space, psychiatric appointments should occur in a private setting.

At HRYCI, the Monitoring Team recommends the following:

- In general, clinical encounters and discussion should occur in private, and the State should make reasonable efforts to have security personnel present only if the patient poses a probable risk to the safety of health care professionals or others.
- In the booking area, the medical interview should be conducted as any normal patient encounter would be conducted: with the patient in the room sitting in a chair. Consideration should be given to installing cameras or a Plexiglas window enabling security to provide visual security.
- In the east side clinic, consideration should be given to creating an examination room where the medication room was located to enable the nurse and NP to independently evaluate patients.
- In the west side clinic, the establishment of an examination room in the infirmary (and potentially the radiology room) should provide expanded space and eliminate the need for labs and physical examinations to be performed in the same room.

At SCI, the Monitoring Team recommends that clinicians and nurses examine patients in a setting that affords visual and auditory privacy and encourages thorough examinations. (*See* recommendations regarding MOA Provision 18). Health records should be stored in a secure area with limited access by inmates and non-health care personnel.

12. Health Assessments

A. Relevant MOA Provision

Paragraph 12 of the MOA provides:

> The State shall ensure that all inmates receive timely medical and mental health assessments. Upon intake, the State shall ensure that a medical professional identifies those persons who have chronic illness. Those persons with chronic illness shall receive a full health assessment between one (1) and seven (7) days of intake, depending on their physical condition. Persons without chronic illness should receive full health assessment within fourteen (14) days of intake. The State will ensure that inmates with chronic illnesses will be tracked in a standardized fashion. A readmitted inmate or an inmate transferred from another facility who has received a documented full health assessment within the previous twelve (12) months, and whose receiving screening shows no change in health status, need not receive a new full medical and mental health assessment. For such inmates, medical staff and mental health professionals shall review prior records and update tests and examinations as needed.

The MOA provides for timely and adequate medical and mental health assessments[55] to occur. NCCHC standards differ with respect to timeliness of a health assessment (*compare* J-E-04 and P-E-04 (stating that health assessments in jails take place "[a]s soon as possible, but no later than 14 days…" and in prisons, "[a]s soon as possible, but no later than 7 days…")), but the MOA requires that the State adhere to the standard for jails, which is 14 days.[56] An adequate health assessment should include at least:

- A review of receiving screening results;
- The collection of additional data to complete the medical, dental, and mental health histories;
- A recording of vital signs;

[55] A "health assessment" is defined as "the process whereby the health status of an individual is evaluated, including questioning the patient regarding symptoms." J-E-04; P-E-04.

[56] The State's policy adopts the 7-day standard applicable to prisons for timeliness of health assessments. *See* State Policy E-04.

- A physical examination (an objective, hands-on evaluation of an individual, involving the inspection, palpation, auscultation, and percussion of a patient's body to determine the presence or absence of physical signs of disease);

- Laboratory and/or diagnostic tests for communicable diseases including sexually transmitted diseases;

- A test for TB; and

- Initiation of therapy and immunizations when appropriate.

Id. The hands-on portion of the health assessment should be performed by a physician, physician assistant, or NP, and the health history and vital signs should be collected by a qualified health care professional.[57] *Id*. When significant findings are present as the result of the hands-on portion of the health assessment, and it is done by a health professional other than a physician, the physician should document his or her review of the health professional's health assessment in the inmate's medical record.

With respect to mental health assessments, this MOA provision requires that mental health professionals review inmates' records and update tests and examinations for those inmates who have either been readmitted or transferred from another facility and have received a documented full health assessment within the previous twelve months.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed 10 records for timeliness and appropriateness of health assessments. As opposed to the records reviewed in relation to the Third Report, which reflected both timely and appropriate health assessments, the Monitoring Team found that there had been a dramatic deterioration in performance, and found a problem with regard to patient refusals.

Out of the 10 records reviewed, three reflected that the health assessments had taken place beyond the seven-day requirement, three reflected that the patient had refused the health assessment altogether, and one reflected that the patient had not received a health

[57] The hands-on portion of the health assessment may be performed by an RN when (i) the nurse completes appropriate training, approved or provided by the responsible physician; and (ii) the responsible physician documents his or her review of all health assessments. J-E-04; P-E-04.

assessment since coming in several months ago. The State is, for the most part, meeting the 14-day requirement where it is applicable.

Based on the Monitoring Team's prior visits, it is uncommon to find refusals of physicals at Baylor.[58] It is incumbent on the medical services to obtain as much health information regarding a patient within as short a period of time as is reasonably possible after arrival. Every patient who refuses the health assessment must be seen by an advanced level clinician who must document the effort to convince the patient to participate.

The Monitoring Team also found at least three cases in which there were significant delays in patients receiving their medication, and an absence of the use of stock medications to bridge a patient over until the medications are received as the result of a clinician's order. This issue also needs to be reviewed with staff so that their performance in this area improves.

Finally, the Monitoring Team identified four patients who were in urgent need of follow-up and conveyed that information to the leadership group.

With respect to mental health assessments, the Monitoring Team found that mental health staff is not reviewing the records of readmitted inmates as required by this provision, despite the fact that the Monitoring Team has discussed this failure in the last two reports. Surprisingly, when the Monitoring Team discussed this requirement with mental health staff they seemed surprised at the requirement despite the fact that it has been discussed with them during prior visits. If not for this lack of review by mental health staff, the State would be in substantial compliance with this provision with respect to mental health.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed 20 records of patients who entered the institution in either September or October of 2008. Of those 20 records, seven reflected delayed health assessments if measured against the State's 7-day policy, although the assessments generally fell

[58] The Monitoring Team finds this upsurge in patient refusals particularly troubling, given that it does not arise solely in the context of initial health assessments. The Monitoring Team found this problem in the context of chronic care and elsewhere. Yet, the staff at Baylor seemed to be unaware that there had been a significant upsurge in refusals. The Monitoring Team believes that the current system causes staff to consider the process completed when a nurse received a signed refusal form from a patient. In fact, when a patient refuses care, staff ought to attempt to determine the reason for the refusal and to provide counseling to the patient regarding the potential outcome of a refusal of care.

within the 14-day requirements when applicable. Another three of the 20 records reflected that the inmate had not received a health assessment at all. Seven of the 20 records reflected inadequate health assessments.

The common problems with the health assessments included not using the correct form, so that the health assessment lacked an adequate history that was specific to the problems that the patient responded to as part of their history.[59] In addition, there were instances in which the chronic care visit did not include an assessment of the degree of control of the specific chronic disease and instances in which the assessment of the degree of control was inconsistent with the available data.[60] There were also a few instances in which the treatment plans were not appropriate to the available data.

The Monitoring Team reviewed five records of patients who transferred to JTVCC from another facility within the 60 days prior to the Monitoring Team's visit. The Monitoring Team found that the RN who was responsible for these transfer screenings did not know how to use the computer system properly, resulting in a disruption to the continuity of care for patients who entered JTVCC with medical problems. This is a training issue, which the OHS reports that it has addressed.

Regarding mental health assessments, the Monitoring Team found that mental health staff is not reviewing the records of readmitted inmates as required by this provision, despite the fact that the Monitoring Team has discussed this failure in the last two reports. If not for this lack of review by mental health staff, the State would be in substantial compliance with this provision with respect to mental health.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed 20 records of patients who had entered the system with some identifiable problem, almost all of whom suffer from chronic illness. Seven of

[59] Use of appropriate forms is vital to the system functioning properly on a consistent basis. By using the appropriate form correctly, the medical staff member will insure that the appropriate information is collected and documented in the inmate's medical record. For individuals with chronic diseases who are new to the system or have never had an initial chronic disease database performed for their chronic diseases, the assessment must be either on the general health assessment form or on the chronic disease initial database. If the general health assessment form is used then a complete initial chronic care database must be completed within the first 30 days of incarceration.

[60] The State may substitute an initial chronic care assessment for the health assessment as long as it is done within the appropriate time period.

the 20 records reflected that the inmate did not receive a health assessment within the required timeframe. Of those seven inmates, one had not received a physical exam at all. The degree of lateness of those which were performed varied from 2 to 40 days late.

The initial chronic care visit should occur within the first seven days of intake for those inmates who enter with an identified chronic disease, and this initial chronic case assessment will serve as the health assessment as well. The Monitoring Team found two cases in which the patient received both a health assessment and then an initial chronic care visit. This created an unnecessary duplication of effort.

In addition to the lack of timeliness of the health assessments, the Monitoring Team found that the health assessments were not adequate. For instance, the Monitoring Team did not find problem lists on consistent basis.[61] In addition, the records of health assessments did not reflect elaboration regarding positive responses in the patient's medical history.

Regarding mental health assessments, the Monitoring Team found that mental health staff is not reviewing the records of readmitted inmates as required by this provision, despite the fact that the Monitoring Team has discussed this failure in the last two reports. If not for this lack of review by mental health staff, the State would be in substantial compliance with this provision with respect to mental health.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed 15 records of patients who entered the institution between September 1 and October 17, all of whom suffered from chronic diseases. The State continues to provide timely health assessments at SCI. Of the 15 records reviewed, only two did not reflect a health assessment within the required timeframe. One inmate received the health assessment on the 11th day and another patient received the health assessment on the 10th day.

Although the timeliness of the health assessments has improved, there continues to be a problem with the quality of the health assessments. Eight of the 15 records reflected inadequate health assessments, in that the physical examination and patient histories were not adequate. The problems with the health assessments may be attributable to the fact that a recently hired NP is performing them, and the Monitoring Team found that she has not been supervised adequately.

[61] A problem list should be initiated after the inmate's health assessment, and placed in an obvious place in the file.

Regarding mental health assessments, the Monitoring Team found that mental health staff is not reviewing the records of readmitted inmates as required by this provision, despite the fact that the Monitoring Team has discussed this failure in the last two reports. If not for this lack of review by mental health staff, the State would be in substantial compliance with this provision with respect to mental health.

F. Recommendations

At Baylor, the Monitoring Team recommends the following:

- All patients must be seen by an advanced level provider within seven days for a health assessment or a combined health assessment/chronic disease visit, in order to comply with the State's policy, or within 14 days for non-chronic care patients.
- For patients who arrive on medications for chronic conditions or with serious medical problems, there should be a same day notification to the advanced level provider to initiate an order for medication, and stock medications provided to bridge over until the medication is obtained pursuant to the order.
- For patients who have been in and out of the facility, and have had a physical health assessment within the previous twelve months, there must be a mini-intake performed by an advanced level provider again within the seven day time frame. The policy should be changed to require this.
- No health assessment refusals are acceptable unless the refusal is face-to-face with an advanced level provider who documents counseling the patient about the risks involved.
- The program should provide a system to monitor any patients who have refused the physical assessment.
- Intense monitoring of the intake health assessment process, including medication timeliness, completeness of the health assessment, initiation of appropriate follow-up, problem list documentation and referral for any other required follow-up should be performed intensively until this process stabilizes.

At JTVCC, the Monitoring Team recommends that the State take the following actions:

- Insure that health assessments are performed within the seven day time frame in order to comply with the State's policy for chronic care patients, or within 14 days for non-chronic care patients.
- Insure that the clinicians performing the assessments use the correct forms, obtain sufficient history related to the problems presented and that at the end of the health assessment an initial problem list, along with a diagnostic and therapeutic plan, are adequately developed;
- Monitor the clinicians' performance with regard to their assessment of degree of control and the appropriateness of their plans;
- Insure that all RNs performing transfers understand how to use the computer system to facilitate timely continuity of services.

At HRYCI, the Monitoring Team recommends that the State do the following:

- Monitor the intake health assessments, both for those inmates with no identified chronic problems and for the subset of individuals identified with chronic problems.
- Monitoring health assessments must include both the timeliness and appropriateness of the process.
- For all individuals with identified problems, an initial problem list with an appropriate plan must have been promulgated at the time of the health assessment and the quality of this service should be part of the CQI program reviews.

At SCI, the Monitoring Team recommends the following:

- The physician should, on an ongoing basis, review the performance of the NP with regard to completing the health assessment, developing the initial problem list, and initiating a diagnostic and therapeutic plan.
- Health assessments should be monitored as part of the CQI program.

13. Referrals for Specialty Care

A. Relevant MOA Provision

Paragraph 13 of the MOA provides:

> The State shall ensure that: a) inmates whose serious medical or mental health needs exceed the services available at their facility shall be referred in a timely manner to appropriate medical or mental health care professionals; b) the findings and recommendations of such professionals are tracked and documented in inmates' medical files; and c) treatment recommendations are followed as clinically indicated.

The MOA requires that the State ensure that inmates whose medical or mental health needs exceed the services available at the Facility shall be referred in a timely manner to appropriate medical and mental health care professionals. For routine referrals, generally accepted professional standards would permit a timely referral to be defined as being seen by a specialist within 40 days, unless that inmate is seen by the primary care physician at the Facility every 30 days until the specialist appointment occurs. In any event, the appointment with the specialist should not occur more than 100 days after the initial request. For urgent consultations, the process should occur within 14 days. In addition, the MOA requires that once an inmate has seen the appropriate medical or mental health professional, the findings and recommendations are tracked and documented in inmates' files, and the patients are seen in follow-up by their primary care physician at the Facility.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA, but is nearly in substantial compliance.

2. Findings

On average, during the three months prior to the Monitoring Team's visit, 10 to 15 inmates per month were sent outside of the facility to receive consultations or other major medical procedures. The Monitoring Team reviewed the records of six such inmates. The Monitoring Team found that two of the six records were missing an initial progress note, which would note the reason for the inmate being sent offsite. In one of the six records, there was a substantial delay between receipt of the procedure and the institution being able to take action on the result.

In the Third Report, the Monitoring Team found that these services were provided on a timely basis, and the follow-up to the care was appropriate. However, the Monitoring Team noted that this success was a direct result of extraordinary efforts by the on-site Medical Director to ensure that the tracking and follow-up occurred. As noted above, the Medical Director is no longer at Baylor (*see* discussion of paragraph 7 of the MOA), and the result has been a decline in the adequacy of performance pursuant to this provision of the MOA.

With respect to mental health referrals, the Monitoring Team is unable to assess this provision as no mental health inmates have been referred by mental health staff to specialty clinics.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

As noted in the Third Report, if the clinician referring the patient for an outside consult is an NP, policy mandates that the Medical Director review the request and see the patient prior to approving the referral. A consult that is authorized to go forward is then sent to the scheduler, who faxes the request to the utilization management group for approval. At the time of the Monitoring Team's visit, approval for urgent requests ordinarily took one to two days, and approval for routine requests ordinarily took three to four days. After approval, the scheduler then calls the service for appointments. For most specialty services, outside appointments are available within 30 days. At the time of the Monitoring Team's visit, an exception was endocrinology, which took approximately 60 days.

In addition, as also noted in the Third Report, JTVCC has a process in place for the patient to return to the medical area after the specialty referral, where a nurse would fill out a pink form called the "Off-site Return Progress Note." This form is designed to ensure adequate record-keeping and follow-up regarding off-site referrals. The form includes a number of sections requesting information such as the patient's name and number, the specialty service from which the person just returned, and recommendations from the specialty service provider.[62] The form also includes a section requesting information such as vital signs, and a plan to contact the physician to ensure that orders were received, and the patient was scheduled for a provider visit on return. Finally, the last section of the form includes a space to note the patient's disposition. In other words, whether the patient should be held for the provider to see immediately, or could return to the general population. As observed previously, this helpful form is still not being used properly or consistently.

The Monitoring Team reviewed 10 records of patients sent offsite for specialty care or offsite procedures (*e.g.* scans or diagnostic scoping procedures). More than half of these records reflected a lack of appropriate follow-up. The patients usually were seen by a nurse when they returned from the offsite visit. However, the nurses were not scheduling the follow-up visit with the primary care provider. In addition, for patients housed in the MHU or SHU, it was less likely that the Monitoring Team would even find a note by the nurse indicating that the patient had been seen at the time of return. That problem may be unique to the return of patients who are housed in the MHU or SHU. In general, reports from offsite visits (*e.g.* consultation, x-ray, MRI) were available and usually there were progress notes at the time of an order.

With respect to mental health referrals, the Monitoring Team is unable to assess this provision as no mental health inmates have been referred by mental health staff to specialty clinics.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed seven records of patients sent offsite for consultations or tests. Two of the seven records did not contain an initial progress note at the time of the order to send the inmate offsite. Five of the seven records did not reflect a follow-up visit with a clinician after the results were back in the chart.

[62] In the event that there was no consultation report, this form is supposed to be forwarded to the scheduler, who is to call the specialty service provider in order to obtain such a report.

The State should ensure that the person who manages the offsite scheduling keeps track of when reports regarding offsite treatment are expected back to the facility. In the case of consultations, the report is usually returned to the facility with the patient, and, for other procedures, a predictable amount of time for each procedure. If the report is not returned within the expected time frame, then the person responsible for scheduling should contact the offsite provider.

With respect to mental health referrals, the Monitoring Team is unable to assess this provision as no mental health inmates have been referred by mental health staff to specialty clinics.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed eight records of patients referred for specialty care, and the offsite services tracking log. Consistent with the findings in the Third Report, the timeliness of completion of specialty consultations and offsite tests is good. On average, patients are seen within four to six weeks of the physician request. The Monitoring Team learned that the regional medical director has left, and was concerned that what has been a timely Utilization Management ("UM") process (for which the departing regional medical director had the responsibility) would not be maintained. The Monitoring Team was informed that the UM responsibility was going to be shared by the corporate medical director and another physician and they had every intention of continuing the same timely process.

The Monitoring Team found that all eight records reflected that the inmate had been seen by a nurse upon return to the Facility, and an offsite referral continuity form was used to document care. However, the form was not being utilized appropriately, and, as a result, patients were not being scheduled routinely for a follow-up visit with the primary care provider. The Monitoring Team found that several health records lacked a progress note at the time of initiation of the order for the offsite referral.

With respect to mental health referrals, the Monitoring Team is unable to assess this provision as no mental health inmates have been referred by mental health staff to specialty clinics.

F. Recommendations

At Baylor, the Monitoring Team makes the following recommendations:

- Tracking of reports of consultations or procedures performed offsite should be assigned

to one of the staff members.

- The expectation is that, in the case of offsite consultations, the patients should return with a handwritten consult report. However, in the case of offsite procedures, the person responsible for tracking offsite services needs to be aware of the expected time frame in which that report should return and then call the service provider if the report is not back in the expected time frame.
- When the report arrives, the patient must be scheduled for a follow-up visit with the primary care provider.
- All consults or ancillary services must be accompanied by a progress note at the time the order is written and the request is made.

At JTVCC, the Monitoring Team makes the following recommendations:

- Insure that patients returning from offsite appointments are seen by a nurse whether they are housed in the MHU, SHU or the main compound;
- Insure that the nurses use the Return From Offsite Visit Encounter Form appropriately, including scheduling a follow-up visit with the primary care clinician;
- When the patient returns from an offsite service without a report, it is the responsibility of the nurse to insure that the report is obtained and that the follow-up visit is scheduled.

At HRYCI, the Monitoring Team makes the following recommendations:

- The ordering physicians must be reminded to write a progress note indicating the reason for the test or consultation ordered, as well as fill out the consult request form at that time. This should be monitored by the CQI program.
- The scheduler should be responsible for tracking return of all reports, those that are expected to arrive with the patient and those for which a phone call will be necessary if they have not arrived within the expected time frame.
- Once the reports are back, the physician should expect to review them and schedule a visit with the patient to discuss the findings and the plan.
- All of this should monitored by the CQI program.

At SCI, the Monitoring Team makes the following recommendations:

- Reinforce with the clinicians the requirement to document a progress note at the time of a request so that the reason for the requested service and a discussion with the patient are part of the documentation.
- Retrain the nurses who are receiving patients upon return from an offsite service so that part of their responsibility is scheduling the follow-up visit with the primary care provider who can discuss the findings and plan with the patient.
- When the offsite service is such that a report does not return with the patient, then the responsibility for scheduling the follow-up visit with the primary care provider should rest with the person who receives the reports back from the offsite service.

14. Treatment or Accommodation Plans

A. Relevant MOA Provision

Paragraph 14 of the MOA provides:

> Inmates with special needs shall have special needs plans. For inmates with special needs who have been at the facility for thirty (30) days, this shall include appropriate discharge planning. The DOJ acknowledges that for sentenced inmates with special needs, such discharge planning shall be developed in relation to the anticipated date of release.[63]

A treatment plan for a special needs inmate should include, at a minimum:

- The frequency of follow-up for medical evaluation and adjustment of the treatment modality;
- The type and frequency of diagnostic testing and therapeutic regimens; and
- When appropriate, instructions about diet, exercise, adaptation to the correctional environment, and medication.

J-G-01; P-G-01. Further, each Facility should maintain a list of special needs inmates for tracking purposes. *Id*. With respect to discharge planning, in cases of a *planned* discharge, (i) the health staff of a Facility should arrange for a sufficient supply of current medications to last until the inmate can be seen by a community health care provider; and (ii) for inmates with critical medical or mental health needs, arrangements or referrals should be made for follow-up services with community providers. J-E-13; P-E-13.

The list of special needs inmates should include individuals with both serious medical problems, and, in many instances, behavioral problems. The Facilities should forward the list to the OHS on a monthly basis. For any patient on the list, the patient's health record should reflect that a multidisciplinary treatment team meeting has taken place, and there should be documentation containing a summary of the meeting, and all plans in place for the patient. In order to ensure improved outcomes for the patients, the plans should indicate when follow-up multidisciplinary meetings should occur.

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[63] According to Section II.F. of the MOA, "inmates with special needs" are,

> [I]nmates who are identified as suicidal, mentally ill, developmentally disabled, seriously or chronically ill, who are physically disabled, who have trouble performing activities of daily living, or who are a danger to themselves.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the records of six patients on the special needs list, and found follow-up notes on each of these patients in the chart. The staff could improve the process by indicating in the notes the specific reasons that the patient is on the list and the goals of this multidisciplinary committee, as well as the strategies to be implemented. Finally, assignment of responsibility with regard to monitoring the patient's progress should be documented as well as a description of any progress being made.

Discharge Planning for Mental Health Patients

The Monitoring Team has had discussions with the State about the levels of appropriate planning that is necessary and has made appropriate recommendations concerning this issue. The Monitoring Team believes that the State should direct inmates towards certain resources which will assist them upon their release. These resources include housing resources and certain welfare entitlements such as food stamps. The Monitoring Team is not requiring the State to actually obtain these resources for inmates, but instead believes the State should provide inmates with information and resources so that inmates know how to obtain them. The Monitoring Team notes that the State is currently initiating appointments for inmates with mental health centers prior to their discharge from the facility. Finally, at the time of the Monitoring Team's visit, the State had recently started a CQI study regarding discharge medications.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found that JTVCC is in partial compliance with respect to mental health services and is not in compliance with respect to medical services.

2. Findings

In a lengthy discussion with the Medical Director, the Monitoring Team learned that this treatment and accommodation plan program really had not been implemented, and there was a lack of understanding regarding what needs to be in place. Although there were accommodation plans for mentally ill patients, the program had not been implemented for medical patients.

The Monitoring Team offered technical assistance to the staff members at the facility regarding both the types of patients who should be listed on the special needs list, and the type of documentation and follow-up for which the Monitoring Team is looking in order to find the State in substantial compliance with this provision of the MOA. In a facility which houses so many complex patients, developing such a list could prove to be counterproductive unless one specifically indicates on the list only those patients for whom clear collaboration between medical, mental health, and custody are indicated to achieve specific outcomes. It is the Monitoring Team's perception that the Medical Director understands this and will be developing the list and implementing the form to be used to document notes in the medical record.

Discharge Planning for Mental Health Patients

Staff reported that discharge planning in the SHU had been hampered by the fact that staff frequently is not informed in a timely fashion of inmates' discharge dates. It is estimated that approximately three inmates per month are discharged from the SHU.

Staff indicated that discharge planning includes a 30 day supply of medications, linkage with community providers, providing information relevant to housing and entitlement benefits. As stated above, there is difficulty with receiving information relevant to the discharge dates of inmates in a timely manner. Staff perceived that discharge medications, when ordered, are generally received by the inmate at the time of discharge. Assisting the inmate with housing was reported to be the responsibility of correctional counselors in contrast to mental health staff.

Inmates are permitted to be discharged with their prison ID remaining with them. It is important to allow inmates to retain their prison IDs, because these Ids enable inmates to obtain driver's licenses upon release from prison, in the event they are lacking other forms of required identification. Additionally, it serves as an official State ID, which facilitates the released inmate's ability to obtain appropriate entitlements.

A CQI relevant to this provision has not been performed.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The institution is maintaining a list of special needs cases. At the time of the Monitoring Team's visit, there were six patients on the list. The Monitoring Team reviewed five of the six records. Each of these patients appeared to be good candidates for special attention. There was an effort to utilize a multidisciplinary approach. Although custody was not invited to the special needs meetings, cases from the special needs list apparently were discussed at subsequent MAC meetings at which custody staff is present.

The main problem that the Monitoring Team identified was that in reviewing the records during its visit the week of September 22, 2008, the Monitoring Team observed that there have been no special needs meetings since August 14, even though it was expected that at a minimum these patients would be reviewed on a monthly basis. In a few of the records, there was as indication that there would be a special needs meeting on August 21, but no subsequent meetings have taken place.

Discharge Planning for Mental Health Patients

CMS conducted a CQI study during July 2008 to examine discharge planning with reference to medications. Results revealed that pre-sentenced and sentenced inmates rarely received appropriate discharge medications, but that inmates who were discharged from the transition unit consistently received appropriate medications.

CMS has revised their audit in a manner that is intended to help structure future discharge planning elements. Although the Monitoring Team did not see the corrective action plan, it reportedly includes the following elements:

- a clerk will pull the weekly list of inmates being discharged (in contrast with the previous practice of checking the list on a monthly basis);
- a specific staff member will be assigned for discharge planning purposes;
- the inmate will be asked to sign a form verifying they have picked up their medications; and
- the process will continue to be audited by a CQI study.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

At the time of the Monitoring Team's visit, SCI maintained a list of special needs inmates, which contained 12 names. The Monitoring Team reviewed the records of six of those patients. All of the patients appeared to be appropriately listed, as they had a combination of medical and mental health or behavioral problems. There was a well-designed form being utilized for the meeting minutes where these difficult cases were discussed. However, the forms were not utilized appropriately.

Discharge Planning for Mental Health Patients

Discharge planning at SCI includes a 30-day supply of medications and a completed discharge form to community mental health services which is faxed to the community

mental health provider. The State maintains a discharge medication log which identifies if an inmate refuses or receives the discharge medications. However, this log does not indicate inmates who are not offered discharge medications but should have been.

F. Recommendations

At all of the Facilities, the State should conduct a CQI study addressing discharge planning and should take appropriate action in connection with the results of that study.

At Baylor, the Monitoring Team recommends that the State continue conducting the meetings and document all of the items cited above. Additionally, with respect to mental health services, the Monitoring Team reiterates the following recommendations from the Third Report:

- Discharge planning should be conducted at the time of the initial visit. This gathering of information should be done by the counselor at time of assessment and treatment planning. Inmates should also receive a copy of referral sources at time of assessment.
- The State should develop and implement a system to ensure that inmates receive information about certain financial entitlements, such as Medicaid and social security benefits, in a timely manner upon their release.

At JTVCC, the Monitoring Team recommends that the Director of the OHS collaborate closely with the Medical Director at JTVCC so that there is a shared understanding of which patients should be on this list and that the multidisciplinary meetings and the documentation of those meetings will facilitate achieving substantial compliance.

At HRYCI, the Monitoring Team recommends the following:

- Continue the program of identifying special needs patients and reviewing them in a multidisciplinary format at least monthly and more often as needed.
- These meetings should be summarized in the note, the required content of which has been described in the Monitoring Team's Third Report.

At SCI, the Monitoring Team recommends the following:

- The State should clearly state the specific reason why a given patient is included in the special needs program.
- The State should specify what outcomes are to be achieved with regard to the specific problems.
- The State should detail the specific strategies that are to be utilized.
- The State should conduct follow-up meetings to address the effectiveness of achieving the outcomes.

15. Drug and Alcohol Withdrawal

A. Relevant MOA Provision

Paragraph 15 of the MOA provides:

> The State shall develop and implement appropriate written policies, protocols, and practices, consistent with standards of appropriate medical care, to identify, monitor, and treat inmates at risk for, or who are experiencing, drug or alcohol withdrawal. The State shall implement appropriate withdrawal and detoxification programs. Methadone maintenance programs shall be offered for pregnant inmates who were addicted to opiates and/or participating in a legitimate methadone maintenance program when they entered the Facilities.

This provision of the MOA requires that the State develop and implement appropriate written policies, protocols, and practices, consistent with standards of appropriate medical care, to identify, monitor, and treat inmates at risk for, or who are experiencing, drug and alcohol withdrawal. The State has developed an adequate policy with respect to drug and alcohol withdrawal. *See* State Policy G-06.

Further, established protocols regarding the treatment and observation of individuals manifesting symptoms of intoxication or withdrawal should be followed in order to complete successful implementation of the policies. J-G-06; P-G-06. Inmates experiencing severe, life-threatening intoxication (overdose) or withdrawal should be transferred immediately to a licensed acute care facility. *Id*. Individuals at risk for progression to more severe levels of intoxication withdrawal should be kept under constant observation by qualified health care professionals or health-trained correctional staff, and whenever severe withdrawal symptoms are observed, a physician should be consulted promptly. *Id*. If a pregnant inmate is admitted with a history of *opiate* use, a physician should be contacted so that the opiate dependence can be assessed and treated appropriately. *Id*. The facility should have a policy that addresses the management of inmates, including pregnant inmates, on methadone or other similar substances. Pregnant inmates entering the facility who were addicted to opiates and/or participating in a legitimate methadone maintenance program should be offered methadone maintenance programs.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team reviewed the records of five patients who entered the

facility in either drug or alcohol withdrawal. In each case, the appropriate protocol had been implemented. In two of five cases, the nurses who monitored these patients did not utilize the correct form, but there was documentation of monitoring in the medical record. All of the patients were able to return to their housing units without any problems.[64]

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The leadership onsite learned that staff members did not understand how to implement the drug and alcohol protocol correctly. As a result the leadership's discovery that staff members did not understand how to implement the drug and alcohol withdrawal protocol correctly, staff at JTVCC is using a new set of protocol forms, which are more closely associated with the standard forms that are used in hospitals. Staff members at JTVCC recently have been trained in the use of these forms.

Of the records that the Monitoring Team reviewed in relation to this provision of the MOA, four records indicated that the patients had been seen before staff had received the training on the new forms. The Monitoring Team noted that, those four records demonstrated that staff members were not monitoring patients appropriately. Specifically, staff members would perform a monitor on the first day but then not repeat it, regardless of the findings. The Monitoring Team also found that withdrawal medication had been given without an order, and found a lack of correlation between the scoring on the old forms and actions taken. The Monitoring Team is hopeful that the training on and implementation of the new protocol forms will improve performance in this area.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed five records of patients who, after entering the system, were assessed as needing substance withdrawal treatment. In each case, the patient was placed in the infirmary and ultimately received appropriate medical care. However, the nurse

[64] There were no pregnant inmates with withdrawal symptoms during this monitoring period.

assessment form was not being used. The nurse assessment form was designed to insure that nurses are assessing patients correctly, and contacting an advanced level provider when indicated based on the symptom presentation. Instead, records indicated that the nurses would assess an acuity level but not list any of the symptoms, as the form should include. The forms would just say "acuity level 2." Both the nursing staff and the regional medical director indicated that this was not appropriate, and that the nurses were expected to utilize the forms so that they would remember which symptoms should trigger more aggressive monitoring and/or contact with an advanced level provider clinician.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

2. Findings

The new drug and alcohol withdrawal protocol has been implemented. The Monitoring Team found that patients are being monitored, and physicians are being contacted when necessary. The only concern that the Monitoring Team had with the alcohol withdrawal protocol is that it does not include fluid therapy as part of the strategy. One patient was admitted to the infirmary for dehydration which might have been prevented had fluids been available and pushed. Many jails find it very helpful to provide Gatorade as the fluid of choice, since it contains appropriate electrolytes and it is palatable. The Monitoring Team also found that patients who had been released, and then re-entered the facility with alcohol withdrawal did not have withdrawal listed on their problem list.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State's protocol be modified so that diabetic patients in withdrawal who develop symptoms of vomiting, diarrhea or increased urination should trigger an immediate contact with the advanced level provider regarding their status. Currently, only patients deemed level three result in a trigger to contact the advanced level provider.

At JTVCC, the Monitoring Team recommends that the State monitor the use of the withdrawal protocol forms and provide feedback to the staff on a weekly basis until supervisory staff are satisfied that the nursing staff has successfully implemented the new program.

At SCI, the Monitoring Team recommends that the State:

- Modify its withdrawal protocol to encourage an increase in fluid intake as part of the regimen with a possible use of Gatorade or similar electrolyte sufficient fluids;
- Add patients whose alcohol withdrawal is in fact observed within the Department of

Corrections to their problem list.

16. Pregnant Inmates[65]

A. Relevant MOA Provision

Paragraph 16 of the MOA provides:

> [t]he State shall develop and implement appropriate written policies and protocols for the treatment of pregnant inmates, including appropriate screening, treatment, and management of high risk pregnancies."

According to NCCHC standards, pregnant inmates shall receive timely and appropriate prenatal care, specialized obstetrical services when indicated, and postpartum care. J-G-07. Appropriate prenatal care should include medical examinations, laboratory and diagnostic tests (including offering HIV testing and prophylaxis when indicated), and advice on appropriate levels of activity, safety precautions, and nutritional guidance and counseling. *Id*.

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA, but is nearly in substantial compliance. A family NP runs this program at Baylor. The NP conscientiously monitors patients, and documents in their health records. The Monitoring Team reviewed five records, and found several issues. In one case, the inmate did not have an obstetrical visit until one month after the inmate entered the facility. All other cases generally were monitored satisfactorily.

The Monitoring Team also found one case in which the patient presented with anemia, which was identified and followed by the NP, but there was no discussion with the physician, which should have occurred. The Monitoring Team also found a few patients who were followed well, delivered their babies, and then were admitted to the infirmary post-partum but whose records lacked an advanced level provider note at the time of release from the infirmary.

The Monitoring Team recommends that any pregnant inmate who develops a problem which does not appear to be responding to the family NP's regime must be discussed with the physician or an obstetrician.

17. Communicable and Infectious Disease Management

A. Relevant MOA Provision

Paragraph 17 of the MOA provides:

[65] As Baylor is the only one of the Facilities which houses female inmates, it is the only one to which this provision applies.

> The State shall adequately maintain statistical information regarding contagious disease screening programs and other relevant statistical data necessary to adequately identify, treat, and control infectious diseases.

The NCCHC recommends that facilities with populations over 500 inmates should have a committee to oversee infection control practices. P-B-01. The infection control committee should consist of representation from the facility's administration, the responsible physician or designee, nursing and dental services, and other appropriate professional personnel involved in sanitation or disease control. *Id.* Further, facilities should follow a TB control plan that is consistent with current published guidelines from the Centers for Disease Control.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team evaluated this provision by interviewing the infection control nurse ("ICN") and examining statistical data regarding communicable diseases.

An RN is designated as the ICN. However, since the Monitoring Team's last visit, the ICN had been out on leave from the end of May to mid-August. In the meantime, the HSA (who has an infection control background) made efforts to maintain the program, including maintaining reportable disease tracking logs. However, the HSA indicated that more work needs to be done to bring the program into full compliance, including tracking laboratory reports of patients tested for communicable diseases and conducting blood-borne pathogen training for staff. The ICN has now returned, and the HSA indicated that she would undergo additional training and supervision to address the problems identified in the Third Report regarding this provision of the MOA.

C. JTVCC

1. <u>Assessment</u>

The Monitoring Team found that JTVCC is not in compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team assessed compliance with this provision by reviewing policies and procedures, and actual practices related to infection control and reportable diseases. This includes determining whether there is an effective surveillance program to detect inmates with communicable diseases (*e.g.*, HIV, Chlamydia and gonorrhea, syphilis, MRSA (defined

herein), and TB infection) and whether the facility uses this information to identify, treat and control communicable diseases.

The ICN in place at the time of the last monitoring period had been terminated due to failure to fulfill her duties. This included no reporting of communicable diseases to the State since January 2008. The facility was not conducting infection control meetings. Therefore, there was no active system in place to monitor the prevalence and incidence of communicable diseases.

The Monitoring Team interviewed the new ICN, who was hired October 5, 2008. The infection control program is still in the early stages of development. The local operating procedures related to infection control (including OSHA-required exposure control plans) have not yet been developed and finalized. The facility was not conducting infection control meetings.

There is now a functional reporting system for required state reporting of infectious/communicable diseases. However, review of numerous health records shows that inmates are not being tested annually for TB. Some inmates have not been TB skin tested since 2005. This poses a risk that inmates with TB infection and TB will not be identified and treated in a timely manner. The ICN reported that tracking systems and documentation for staff and inmate immunizations and TB skin testing are a work in progress and will be computerized. Training for inmate workers regarding prevention of blood-borne pathogens has started and there is some documentation of this training.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated this provision by reviewing policies and procedures related to infection control and communicable disease screening programs. The Monitoring Team reviewed 10 inmate records to determine compliance with annual TB skin testing. The Monitoring Team reviewed five employee records to assess compliance with TB skin testing and Hepatitis B immunization. The team also reviewed compliance with infection control practices in the facility to ensure that a safe environment is provided for inmates and staff. This area is close to being in substantial compliance.

Review of documents showed that the State had drafted and implemented policies and procedures, local operating procedures, and has an infection control manual in place. The contents of the infection control manual were consistent with current Centers for Disease Control guidelines and OSHA requirements.

The Monitoring Team also found that all aspects of an infection control program are in place: TB prevention, reporting of infectious or communicable diseases, tracking systems, infection control committee, written policies and procedures, and training programs.

However, the facility has not consistently conducted quarterly infection control meetings with minutes reflecting OSHA requirements. The last quarterly meeting was held in July 2008. The minutes reviewed for the first and second quarter did not show required discussion topics. The Monitoring Team notes that most recommendations from the previous audit have been implemented.

Of the 10 inmate records reviewed for compliance with TB testing, all of the records reflected that the inmate had an annual TST performed; however, in three cases, the results had not yet been recorded in the health record (but were recorded in DACS).

The Monitoring Team also reviewed five employee records. Of these, three recently hired employees had a two-step TST done at hire; two staff had their annual TST performed and documented both in the health record and tracking system. All five employees had signed refusals for the Hepatitis B vaccination.

With respect to implementation of exposure control plans, personal protective equipment ("PPE") had been relocated to one area of the clinic in a self contained kit and there is a sign posted at the door of the storage closet indicating its location. However, when the Monitoring Team searched for the PPE, it was not readily visible and not located without additional assistance. The eyewash station in the east side clinical exam room sprayed over the counter and needs to be repaired.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

There have been no significant changes since the Monitoring Team's last visit and this program is in the early stages of development. The vendor has extensive infection control policies and procedures that include exposure control plans, reporting of communicable disease, etc. A new nurse has been assigned to infection control duties. There is a job description for her position, but she has not had any formal training.

With respect to statistical data, the facility maintains records of patients with communicable diseases who have been reported to the local or state health department. The ICN maintains this reportable information on a flash drive that she takes home with her each evening. This is confidential medical information that should be securely stored at the facility.

At the time of the Monitoring Team's visit, the facility had not yet implemented infection control meetings in which trends in communicable diseases (*e.g.*, TB skin testing programs for staff and inmates, incidence of MRSA (defined herein) skin infections, etc.) can be monitored and addressed. In addition, there was no schedule of sanitation and infection control activities to be performed in each clinical area.

F. Recommendations

At Baylor, the Monitoring Team recommends that:

- Additional training and supervision be provided to the ICN.
- Health care leadership establish a more reliable system for screening, treating, tracking and reporting of communicable diseases.
- The State and CMS implement a policy and procedure to routinely screen and treat detainees and sentenced inmates for STDs.
- The health care leadership implement infection control meetings to monitor trends in communicable diseases, and monitor compliance with infection control guidelines.

At JTVCC, the Monitoring Team makes the following recommendations:

- The facility should formalize the Infection Control Committee and hold meetings a minimum on a quarterly basis, at a minimum, with minutes that reflect content of the meetings.
- The State should finalize development of local operating procedures related to infection control and communicable diseases.
- The State should ensure compliance with OSHA requirements including exposure control plans for blood borne pathogens and TB.
- Continue development and implementation of tracking logs for inmates and employees related to TST and hepatitis B vaccination.
- As soon as possible, begin annual TST of staff and inmates.

At HRYCI, the Monitoring Team recommends that the facility continue to receive the report from the State regarding whether or not patients are up to date for their immunizations and use that to insure necessary vaccines are ordered at the time of the intake physical exam.

At SCI, the Monitoring Team recommends that health care leadership arrange for the ICN to receive appropriate training for her position. Confidential public health information should remain securely stored at the facility. The facility should initiate infection control meetings that monitor and address trends in communicable diseases, as well as staff adherence to infection control practices such as hand-washing, use of personal protective equipment, disposal of sharps, etc. The ICN also should monitor and ensure that sanitation and infection control practices in all areas of the medical clinic are developed and implemented.

18. Clinic Space and Equipment

A. Relevant MOA Provision

Paragraph 18 of the MOA provides:

> The State shall ensure that all face-to-face nursing and physician examinations occur in settings that provide appropriate privacy and permit a proper clinical evaluation including an adequately-sized examination room that contains an examination table, an operable sink for hand-washing, adequate lighting, and adequate equipment, including an adequate microscope for diagnostic evaluations. The State shall submit a comprehensive action plan as described in Paragraph 65 of [the MOA] identifying the specific measures the State intends to take in order to bring the Facilities into compliance with this paragraph.

An adequately-sized examination room is one that is large enough to accommodate the necessary equipment, supplies, and fixtures, and to permit privacy during clinical encounters. J-D-03; P-D-03. According to the NCCHC, Facilities should have, at a minimum, the following equipment, supplies, and materials for the examination and treatment of patients:

- hand-washing facilities or appropriate alternate means of hand sanitization;
- examination tables;
- a light capable of providing direct illumination;
- scales;
- thermometers;
- blood pressure monitoring equipment;
- stethoscope;
- ophthalmoscope;
- otoscope;
- transportation equipment (*e.g.* wheelchair, stretcher);
- trash containers for biohazardous materials and sharps; and

- equipment and supplies for pelvic examinations if female inmates are housed in the facility.

Id.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated compliance with this provision by touring clinic space, interviewing staff and inmates, and observing clinical encounters. The Monitoring Team reviewed each area with respect to sanitation, organization, lighting, access to hand-washing, and medical equipment and supplies.

The medical clinic area is essentially unchanged since the Monitoring Team's last visit. There are plans that are actively underway, however, to expand the medical clinic to an area directly across the hall. Although space plans are not yet finalized, there are tentative plans to move administrative offices, medical records, and medication administration into the new area.

Sanitation and organization in the medical clinic continues to improve. The floors are cleaner; medical equipment, supplies, and boxes have been moved into the expanded medical clinic across the hall, which has reduced clutter. However, there still is no posted schedule of sanitation activities that includes disinfection of surfaces. The laboratory room sink did not appear to have been cleaned for some time.

As reported in previous reports, the medication room has been improved with respect to sanitation and organization, but the area is too small to adequately store equipment, medication, and supplies, and the cabinets are in disrepair (*e.g.*, missing cabinet doors and broken drawers). The health records room remains cramped.

The Monitoring Team found that examination rooms are not uniformly equipped and supplied. The room where nurses perform sick call does not have an otoscope/ophthalmoscope, penlights or basic supplies such as tongue blades. In the two other examination rooms used by clinicians, neither of the wall mounted oto/ophthalmoscopes worked properly. A portable otoscope on the desk in one room was not working, presumably because the battery needed charging. During inmate group interviews, inmates complained that blood pressure cuffs did not work properly or that staff used the wrong size cuffs to obtain blood pressure measurements.[66]

[66] It is important to use the proper size cuff to obtain accurate blood pressure measurements. A cuff that is too small for the patient will result in artificially high blood pressure readings. Patients complained that

There are three rooms used to house patients for medical or mental health reasons. One room is a three-bed infirmary that does not provide sight or sound contact with staff. It is at the farthest end of the clinic, and it does not have a functional patient call or intercom system. The Monitoring Team interviewed one inmate currently housed in the infirmary who recently had undergone abdominal surgery. She and other inmates reported that they have to yell, scream or bang on the door to get a staff member's attention. There is no officer in the clinic to alert staff and there is no schedule of nurse rounds.

Although there are three beds in the room, there is only one nightstand and a small table. Patients reported that when they were admitted to the infirmary they have had to provide their own linens and hygiene items because these are not provided to them in the medical section. This infirmary is a depressing and non-therapeutic environment.

Another room has two medical beds, an EKG machine, and a toilet. This room does not have an intercom but is kept unlocked when patients are housed there.

There is a single safety cell, which is monitored by camera and used primarily for mental health patients. However, the Monitoring Team observed what they believe is inappropriate use of this room. Specifically, a patient with a history of mental health problems, substance abuse and new onset tremors was placed in this room, presumably to have cameras monitor the frequency and timing of her tremors that the physician suspected were intentional by the patient. However, neither correctional nor health staff monitored the camera. This patient did not receive an appropriate medical evaluation, and had no working diagnosis or treatment plan. She essentially was ignored by staff until the Monitoring Team intervened, and the following day was sent to the emergency room for evaluation at the direction of the CMS Regional Medical Director. The patient was later diagnosed with a potentially life-threatening condition.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

Health care leadership is taking some steps to address problems with clinic space, and medical equipment and supplies. In the main medical clinic area, an office and examination room is being constructed for the medical director. In addition, a nursing sick call room has been established. Finally, an active leak in the ceiling near the staff break room appears to have been repaired.

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nurses use a wrist blood pressure cuff that is inaccurate. This particular complaint was not investigated by the monitoring team but is shared so that staff can investigate further.

Some problems remain, however. Health care leadership reported that a recent internal assessment found that medical supplies were disorganized and scattered throughout the medical section. The Monitoring Team found that there were no established par levels,[67] and no one is accountable for ordering equipment and supplies. At the time of the Monitoring Team's visit, there was no standardized list of equipment and supplies for each examination room and the nursing sick call room is not equipped with an examination table and oto/ophthalmoscope.

There were no posted sanitation schedules. Although sanitation in the main hallway is good, sanitation in examination rooms and offices continues to be poor. Examination room counter tops had layers of dust on them and sinks were not clean. The Monitoring Team notes that sanitation in many other areas of the institution greatly exceeds sanitation in the medical clinics.

In the SHU, plans are being made to move the medical administrative clinic to a larger area behind the security station. This should be a significant improvement.

In the MHU, the main clinic hallway has been reorganized to remove a table that partially obstructed the emergency exit. In general, the area was better organized.

The SHU and MHU examination rooms were generally well organized, equipped and supplied. There were no posted sanitation schedules.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

To assess clinic space and equipment, the Monitoring Team toured the medical clinic areas in both the west and east buildings and the clinic in the booking area. The Monitoring Team reviewed each area with respect to sanitation, medical equipment and supplies, lighting, access to hand-washing, and the ability to provide privacy.

In the booking area, nurses conduct medical screening in an adequately sized room that has an adjacent room to store medical records. The room was partially equipped with an oto/ophthalmoscope. It does not have a sink for access to hand-washing but did contain hand-sanitizer. Thus, the area is adequately equipped for medical screening, but if the State plans to use it as an examination room, it would need to be fully equipped.

[67] A "par level" for medical supplies means the minimum types and numbers of supplies that should be kept on hand at all times. When supplies drop below par levels, they should be reordered.

The room was disorganized and cluttered. There were piles of old medical records awaiting archiving on the floor rather than on shelving. There were four full sharps containers sitting on the counter. The medical supply cabinet was disorganized. There was no schedule of sanitation activities posted and the floors were dirty. The room also contained unlocked controlled substances and stock medications that were not inventoried and for which there was no accountability system.

The booking area often can be congested and noisy. A continuing concern is that, for the medical screening process, the inmate still is required to stand outside the room at a half door while the nurse sits at a desk inside the room completing a seven page medical and mental health questionnaire. Many newly arriving detainees are under the influence of drugs and may have experienced trauma or have acute or poorly controlled chronic diseases. Therefore, this arrangement does not provide privacy, and is not conducive to obtaining a thorough medical and mental health history and, if necessary, performing a nursing assessment. The Monitoring Team was advised that inmates are not permitted to come into the room for security reasons. However, the Monitoring Team is unaware of any similar arrangement where a patient is not permitted to enter an examination room for an interview or assessment.

The west side clinic and infirmary area is cleaner and better organized than on previous visits. A clinical examination room has been established in the infirmary area. The new medication room is well organized, but the floor and sink were dirty. Old medical equipment (*e.g.* oxygen concentrators and blood pressure monitoring equipment) are being stored in this area and should be removed.

In the east side medical clinic, there is only one examination room and staff members advised the Monitoring Team that both the clinician and nurse conduct sick call in the clinic room at the same time, which does not permit adequate privacy. Consideration should be given to converting the old medication room into another examination room.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA

2. Findings

Since the Monitoring Team's last visit, improvements have been made with respect to clinic space. There are three areas of the institution where medical examinations are performed: in MSB, pretrial and in boot camp.[68]

[68] The boot camp area is not covered by the MOA.

In the MSB, construction has resulted in the addition of an examination room and changes were made to an existing examination room. These changes have resulted in increased privacy. The new examination room is small, but has an examination table and some supplies. It does not have a sink but did contain a hand-sanitizer.

As noted above (*see* discussion of paragraph 11 of the MOA), two other rooms were created to permit nurses to perform sick call. However, these rooms are so small they resemble booths more than examination rooms. Although these rooms provide auditory privacy, there is no room for an examination table or medical equipment and supplies to perform clinical assessments. These rooms would not provide any visual privacy should an examination be required.

Because of lack of adequate space, nurses continue to provide treatments simultaneously to inmates at an open table in the center of the clinic. The medication room is small, unsanitary and has makeshift cabinets for storage of medications and related-supplies. Although sanitation in the main clinic hallway was improved, sanitation in the examination rooms and back offices was poor. In addition, in the area where the DON office was located, wires taped to the floor for safety purposes were coming loose, presenting a hazard to staff.

In the pre-trial building clinic, there is a well-equipped clinic room that provides privacy for examinations. The medication room was of adequate size. The sanitation of the floors was fair, but could still use improvement.

In the boot camp area, a clinical examination room had been established since the Monitoring Team's last visit. It contained an examination table, weight scale and blood pressure monitoring equipment, but no oto/ophthalmascope. A supply cart contained miscellaneous supplies; however, there was no list to indicate what types and amounts of supplies the cart should be stocked with. This room is used to conduct sick call for boot camp inmates for approximately an hour each day. However, given space limitations in the MSB, it should be considered for expanded use.

The Monitoring Team understands that, once the new building is built for expansion of mental health and dental services, additional renovation in the MSB area will take place.

F. <u>Recommendations</u>

At Baylor, the Monitoring Team recommends the State do the following:

- Develop, implement and monitor a sanitation schedule that includes disinfection activities. The performance and monitoring of sanitation should be incorporated into job descriptions or post duties to ensure that they take place.
- Health care leadership should standardize medical equipment and supplies in each examination room.
- Replace or repair non-functional equipment including blood pressure cuffs and otoscopes.

- Establish medical supply par levels and assign staff responsibility for monitoring and ordering equipment and supplies.
- Infirmary patients should be within sight or sound of health care staff at all times. This can be accomplished by repairing or installing a new intercom or call light system that is accessible to all three beds in the infirmary.
- Ensure that there is appropriate medical furniture (functional medical beds, nightstands, chairs) and that clean linens and hygiene items are provided to infirmary patients.

At JTVCC, the Monitoring Team recommends the State do the following:

- With respect to all health care service areas, the Monitoring Team recommends that the facility and health care leadership develop and implement a master schedule of sanitation and disinfection activities. The schedule should list the type of activity (*e.g.,* stripping and waxing of floors, disinfecting examination tables, etc.), the frequency (*e.g.,* monthly, weekly, daily, each shift, etc.), and who is responsible for performing and monitoring each task. This system should include administrative areas and clinics in each of the housing units. An inspection system should be put in place to ensure that the desired results are achieved.
- While the health care and facility leadership are to be commended for improvements in the clinical space, they should continue to jointly assess each area where medical services are delivered and consider further adjustments to optimize the use of existing space.
- Consider expanding the pharmacy/medication room into adjacent areas. The room should be terminally cleaned and completely reorganized.
- Inventory equipment and supplies and establish par levels.
- In the MHU, establish a medication room to securely store medications and other medical supplies. If this is not possible with existing use of space, consider relocation of non-health care personnel to other areas of the building. Consider converting one staff bathroom to a storage room for cabinets, wheelchairs, etc.
- Health care leadership should continue to establish medical equipment and supply par levels and establish an accountability system.

At HRYCI, the Monitoring Team recommends the following:

- In the booking area, nurses should interview inmates in the room to provide adequate privacy. To address security concerns, consideration should be given to installing a Plexiglas window or cameras in this area.
- On the west side, clinical encounters should be performed with adequate visual and auditory privacy. The establishment of additional examination rooms in the infirmary and radiology room should provide additional options.
- Consider converting the east side medication room into an examination room for nurses to conduct sick call.
- The issue of poor sanitation in health care areas is an ongoing theme at HRYCI and the other Facilities. While health care staff should participate in disinfection activities, it is unreasonable to expect health care staff to perform terminal cleaning duties such as stripping, waxing and buffing of floors, etc. The Monitoring Team recommends that the

State develop policies and procedures that ensure comprehensive and timely sanitation and disinfection in all health care areas. If inmate porters are prohibited from entering certain areas, the State must ensure an alternate mechanism for ensuring adequate sanitation such as hiring a private company to clean under correctional officer supervision.

At SCI, the Monitoring Team recommends that the final space plans for the MSB area include the following:

- Sufficient numbers of clinical examination rooms for clinicians and nurses to conduct clinical examinations within appropriately equipped rooms with adequate privacy;
- Each clinical examination room should be standardized with respect to medical equipment and supplies;
- An expanded medication room with lockable cabinetry for storage of medications, access to a sink, and two windows from which nurses can simultaneously administer medications to the general population;
- A medical records room of sufficient size to permit secure storage of medical records and sufficient cubicles/space to perform medical record duties.

Also at SCI, health care leadership, in collaboration with the Warden, should ensure that sanitation and disinfection activities are routinely carried out.

ACCESS TO CARE

19. Access to Medical and Mental Health Services

A. Relevant MOA Provision

Paragraph 19 of the MOA provides:

> The State shall ensure that all inmates have adequate opportunity to request and receive medical and mental health care. Appropriate medical staff shall screen all written requests for medical and/or mental health care within twenty-four (24) hours of submission, and see patients within the next 72 hours, or sooner if medically appropriate. The State shall maintain sufficient security staff to ensure that inmates requiring treatment are escorted in a timely manner to treatment areas. The State shall develop and implement a sick call policy and procedure which includes an explanation of the order in which to schedule patients, a procedure for scheduling patients, where patients should be treated, the requirements for clinical evaluations, and the maintenance of a sick call log. Treatment of inmates in response to a sick call slip should occur in a clinical setting.

NCCHC standards generally recommend that inmates have access to care to meet their serious medical, dental, and mental health needs, and that unreasonable barriers to inmates' access to health services are to be avoided.[69] J-E-01; P-E-01. The MOA provides the requirements for the Facilities' sick call process, which is a large part of affording inmates access to care. The MOA requires that appropriate medical staff screen[70] all written requests for medical and/or mental health care within 24 hours of submission, and see patients within the next 72 hours, or sooner if medically appropriate. Further, the MOA sets forth the required elements of the State's policies and procedures relating to the sick call process. Those elements are: (i) an explanation of the order in which to schedule patients; (ii) a procedure for scheduling patients; (iii) where patients should be treated; (iv) the requirements for clinical evaluations; and (v) the maintenance of a sick call log. With respect to patient scheduling, not every sick call slip requires an appointment; however, when a sick call slip describes a clinical symptom, a face-to-face encounter between the inmate and a health professional is required. J-E-07; P-E-07. The

[69] "Access to care" means that in a timely manner, a patient can be seen by a clinician, be given a professional clinical judgment, and receive care that is ordered. J-E-01; P-E-01. The NCCHC provides the following examples of unreasonable barriers to inmate health care: (i) punishing inmates for seeking care for their serious health needs; (ii) assessing excessive co-pays; and (iii) deterring inmates from seeking care for their serious health needs, such as by holding sick call at 2:00 a.m., when the practice is not reasonably related to the needs of the institution. *Id*.

[70] The process of screening the written requests for medical or mental health care is referred to as "triage." The NCCHC defines "triage" as "the sorting and classifying of inmates' health requests to determine priority of need and the proper place for health care to be rendered." J-E-07; P-E-07.

sick call encounters should take place in a clinical setting (*i.e.*, an examination or treatment room appropriately supplied and equipped to address the patient's health care needs). *Id*.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

In order to evaluate this provision of the MOA, the Monitoring Team reviewed the sick call logs for the 90 days prior to the Monitoring Team's visit to Baylor, and then selected 10 health care encounters in eight health records in order to determine the timeliness of screening of inmates' sick call requests, and the resulting scheduled medical encounter. In addition, the Monitoring Team reviewed the health records for the appropriateness of the nursing evaluation, and timeliness of physician referral, if any.

The Monitoring Team found that the initial screenings of sick call requests is occurring on a timely basis. Only five of 10 entries reflected that there were patients seen by a nurse or a clinician within 72 hours for the face-to-face encounter as required by the MOA. In the other five entries, the nurse referred the patient directly to a clinician. In those cases, patients were not seen for 11, 10 and 4 days respectively, and 2 patients were not seen at all.

As noted in the Third Report, the quality of the nursing assessments performed at nursing sick call[71] also needs improvement with respect to the accuracy and completeness of both the patient history and physical assessment. Nursing sick call is conducted by the charge nurse, who is an RN. In her absence, however, nursing sick call may be conducted by an LPN. The Monitoring Team reviewed the record of a patient who submitted a sick call request complaining of breaking out in hives. At 9:30 p.m. on the date the sick call request was submitted, an LPN saw the patient and noted that she had nausea, vomiting and difficulty breathing following a dose of an antibiotic to which she had previously experienced an unrecognized allergic reaction. The LPN performed an initial assessment, and called a physician who ordered an injectable steroid. The LPN did not document any further assessments of the patient, and, as of the next day, there was no further information in the record. This was a potentially life-threatening situation that called for an urgent evaluation by a higher level provider (RN or higher).

As discussed in previous reports, it is not within the scope of practice for LPNs to perform independent assessments. Therefore, sick call should be performed by RNs, who have

[71] "Nursing sick call" is the first clinical encounter with an inmate after he or she has submitted a sick call request. It is this clinical encounter that must take place within 72 hours of submission of the sick call request, and will lead to a referral to a physician if necessary.

had adequate training in health assessment and nursing protocols. Also, as discussed in the previous report, the Monitoring Team reviewed the nursing protocol forms, and found them to be poorly designed in some instances in that they do not prompt the nurse to elicit important presenting symptoms or information about a patient's medical history.

Access to Mental Health Care

The Monitoring Team reviewed the records of twelve inmates. The records were chosen after a review of the mental health referral log for August and September 2008. The inmate sick call slips within those records were reviewed with a focus on the timeliness of the clinical response as well as the clinical appropriateness of the responses. Of the twelve reviewed charts, the Monitoring Team found that the responses in ten of these charts were adequate under this provision. In one of the inadequate responses, the inmate was not seen until five days after his sick call request was screened. In the other inadequate response, documentation relevant to the inmate's referrals was not present within her chart.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is not in compliance with this provision of the MOA.

2. Findings

To evaluate this provision of the MOA, the Monitoring Team reviewed the current sick call procedure with the DON. The procedure recently has been reviewed and revised. According to the DON, the correctional officers are responsible for ensuring the availability of sick call request forms. An LPN is to collect sick call requests during the 4:00 p.m. hour medication pass. The LPN returns to the unit, stamps the sick call requests as being received, and the forms are delivered to medical records. The evening medical records staff members place the sick call request in the inmate's health record for review by an RN the following morning. The RN is to both triage and schedule inmates for sick call in DACS the following business day. The Monitoring Team was told that training regarding the revised sick call procedures had recently been conducted for nursing staff.

The Monitoring Team obtained a DACS printout of patients who were scheduled for nursing sick call from August to November 2008. From this list, the Monitoring Team selected 24 records, which included a sample from each of the primary housing areas (main medical area, SHU and MHU). The Monitoring Team reviewed each record to determine the timeliness of care by a nurse or health care provider once the request was collected. To assess the accuracy of information reported in DACS, the Monitoring Team also compared the date the patient was scheduled to be seen to the actual dates the patient was seen as shown in the health record.

In general, the Monitoring Team found continued systemic problems with access to care that were reflected throughout the process, from collection of sick call forms, triage process, scheduling patients, timeliness and adequacy of evaluations.

Although sick call requests are to be picked up daily, the Monitoring Team found that, in the pre-trial area, 111 sick call requests were collected on November 17, 2008. Some of those sick call requests had been submitted a week prior to the Monitoring Team's visit (*e.g.* November 9, 2008). Staff members reported that sick call requests are not being picked up daily.

Also, in the main unit, the Monitoring Team conducted a random review of 10 sick call requests. Two of the sick call requests were triaged the day after the forms were stamped as received, two were triaged four days after receipt, and four were triaged five days after receipt. Thus, only 20% were triaged in a timely manner.

The Monitoring Team also found that forms were not consistently stamped as to when they were received, and frequently nurses did not document a disposition or sign and date the form. In the review of the first 10 sick call requests selected to be reviewed for timeliness, only one of the sick call requests reflected that the patient was seen by the nurse. Of the remaining nine cases, there was either no disposition documented or the nurse referred the patient directly to a clinician. Three patients were not seen at all. In the remaining six cases, where the nurse made a direct referral to a clinician, the average length of time from receipt of the request until the referral took place was 17 days (range 6-29). The Monitoring Team is unable to make a general statement regarding the quality of nursing assessments, since only one of the records reflected an actual assessment by the nurse.

As noted above, with respect to staff members' use of DACS and the timeliness of the clinical encounters, the Monitoring Team found that, for the six patients for which the Monitoring Team was able to evaluate the timeliness of access, the average length of time it took to see *any* health care professional following receipt of the request was 17 days. This raises questions about staff members' understanding and performance with respect to scheduling patients in DACS to have appointments take place in a timely manner.

In a second sample of 14 records, only four contained documentation that a sick call request had been triaged within 24 hours of receipt. In five of the records, the sick call request was not dated and timed as to when it was received.

In addition, only five of 13 applicable records showed that the patient was seen in a timely manner following triage of the sick call request. In two of 13 records, the nurse directly referred the patient to a provider but in neither case was the patient seen timely.

Access to Mental Health Care

Sick call requests are first triaged by the nursing staff, which then refers mental health sick call requests to the mental health staff. The mental health clerk then triages these requests a second time and assigns them to specific clinicians.

The Monitoring Team reviewed the results of a CQI study done at JTVCC. This study showed that the majority of mental health sick call requests were triaged by the mental health clerk within 24 hours of being triaged by the nursing staff. However, the Monitoring Team notes that many other relevant aspects of the mental health sick call process were not audited. These relevant aspects include when sick call requests were initiated by the inmate in the context of being received by mental health staff, when the nursing staff initially triages them, and the response time by mental health staff in responding to the requests.

The Monitoring Team had discussions with mental health staff members who reported that problems existed related to the mental health sick call process. These problems included delays in receiving the triaged sick call requests, and in many cases not receiving requests from inmates who reportedly had initiated multiple requests. Mental health staff members indicated that they generally respond to sick call requests within 24 to 48 hours of receiving them from nursing staff.

The Monitoring Team independently reviewed the records of four inmates who had made sick call requests or had received mental health referrals since April 2008, the time of the Monitoring Team's last visit to the facility. These four records included a total of 10 sick call requests or mental health referrals. The Monitoring Team found that 7 of the 10 requests were responded to in a timely manner. The three requests which were inadequate had no documentation of a response by mental health staff.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

To review inmate access to care, the Monitoring Team selects health records from a DACS printout of nursing sick call visits that were scheduled in the 120 day period prior to the Monitoring Team's visit. This review typically includes a sample of records with appointments that were noted as attended, rescheduled or still open. Upon the Monitoring Team's arrival, staff had printed a DACS list that contained only attended nursing sick call appointments and did not include appointments that were still open, rescheduled or canceled. The Monitoring Team used this list to select 14 patient records from both the east and west sides with intent to select additional records if necessary.

From this sample of records, the Monitoring Team found persistent problems with access to care. Of the 14 records that were selected from a DACS list of attended appointments, five (36%) patients had been seen in a timely manner by a nurse or NP, seven (50%) had not been seen in a timely manner, and two (14%) had not been seen at all. Thus, 64% of all patients either were not seen in a timely manner, or not seen at all. While this might initially be viewed as a slight improvement from the last review when 75% of patients were not seen in a timely

manner, the sample was representative only of attended appointments and not all scheduled appointments (*e.g.*, open, rescheduled, etc.). The appointment status in DACS was incorrect for the two patients that were not seen.

With respect to sick call request collection and initial nursing triage decision, the Monitoring Team's review showed that five (33%) of 15 forms were not date-stamped upon receipt and signed by staff. Of the 12 patients that were seen by any staff member, six (50%) had been seen by a nurse (typically an LPN), five (42%) had been seen by a nurse practitioner, and one (7%) had been seen by a mental health staff member. The average length of time from date of sick call request triage until the patient was seen was 12 days (range of one to 26 days).

Although the Monitoring Team was advised that RNs now conduct sick call, the Monitoring Team's record review showed that this does not consistently occur. The Monitoring Team notes that LPNs continue to perform independent assessments. As stated in previous reports, LPNs should not conduct independent nursing assessments. CMS has yet to implement the practice of an RN or higher level of provider performing sick call.

With respect to security practices that affect access to care, at the last visit the Monitoring Team noted that two reliable correctional officers had been assigned to the medical unit and that these officers did an excellent job of managing patient flow. However, on a good day, clinic staff was only able to see approximately 70% of inmates who are on the list to be seen. On a bad day this may drop to 50% or less. According to staff, contributing to this are frequent "code reds" throughout the day shutting down all inmate movement at the facility. During this visit, the Monitoring Team was not able to evaluate the impact of security practices on access to care but will do so at the next visit.

The Monitoring Team utilized a report from the DACS system that provided the timeframe between entering the sick call request into DACS and the documented visit by a nurse after receipt. The Monitoring Team had separate reports for both the east and west sides. For the east side, the timeframe between receipt of request and nurse visit was six days. For the west side, the timeframe between receipt of request and nurse visit was also six days.

The Monitoring Team also used the DACS report to determine the timeframe between nurse referral and advanced level provider visit. On the east side, this timeframe was 13 days, and for the west side, seven days. This data suggests that the timeliness of the process should be reviewed by the CQI program as soon as possible in order to determine the cause.[72]

Access to Mental Health Care

The Monitoring Team had discussions with mental health staff members about the sick call request process. With respect to mental health referrals, these referrals are printed from

[72] The Monitoring Team was told by the advanced level provider on the east side that her volume of activity precludes timely access at this time. She indicated that if an RN could perform a screening sick call each day, this is not likely to take any more than two to four hours, and, by reducing her load by that number, she felt she would be able to see the patients referred to her within the required timeframes.

DACS on a daily basis by mental health staff. Sick call requests are picked up every morning by nursing staff, time-stamped, recorded in their sick call log, and triaged by nursing staff. Mental health sick calls are separated and collected every morning by the mental health staff. These referrals and sick calls are then alphabetized, entered in the mental health sick call and referral log, assigned to the appropriate mental health clinician by housing area, and placed in the clinicians' mailboxes. Referrals are triaged, with emergent referrals to be seen immediately, urgent to be seen within 24 hours, and routine to be seen within 72 hours. Sick calls are to be seen within 24 hours while administrative sick calls, such as requests for materials from mental health, are to be seen within four days. Mental health staff initial and date the entries in the mental health sick call and referral log when the inmates have been seen. All mental health contacts, including psychiatry visits, are entered into DACS by the mental health clerk.

Mental health staff members reported that there were intermittent, but significant delays between the submission of mental health referrals and receipt by mental health staff. These delays typically occurred on the weekends and often resulted in referrals reaching the mental health staff in an untimely manner.

The Monitoring Team independently reviewed the charts of 16 inmates in order to assess the mental health response to sick call requests. Of these charts, the Monitoring Team found that 13 of the responses were adequate. Of the three inadequate responses, two were inadequate because the responses did not meet the 72 hour time frame required by this provision. The remaining inadequate response was timely, but the assessment was inadequate because both the diagnostic assessment and the disposition sections of the response were blank.

E. SCI

1. Assessment

The Monitoring Team found that SCI is not in compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that there has been no significant improvement in access to care since the Monitoring Team's last visit, and with respect to sick call and chronic disease management, access has declined.

Using the DACS list of inmates scheduled for nursing sick call, the Monitoring Team selected 16 health records of inmates housed in MSB, pre-trial and boot camp. From these records, the Monitoring Team reviewed 22 sick call requests that were submitted from late July until October 2008. Although all of the sick call requests were collected in a timely manner, in only eight (36%) of 22 encounters did a nurse see the patient in a timely manner. In one case, a patient submitted seven separate sick call requests for complaints of neck and back pain from late August to mid-October, and was never assessed by a nurse or physician. Despite the lack of a clinical evaluation, the patient was started on Vicodin via a verbal order.

In another case, a nurse saw a patient who was complaining of a recurrent ear infection. The nurse did not examine the patient's ear, but consulted the NP who also did not examine the patient, but did order oral antibiotics. Unfortunately, a previously obtained culture showed that the patient's infection was caused by Methicillin-Resistant *Staphylococcus Aureus* (MRSA) and the antibiotic the NP selected to treat the infection was likely to be ineffective.

The Monitoring Team has serious concerns regarding the referral process. Out of nine cases in which a nurse documented a referral to the physician, none of the patients were seen by a primary care provider.

In records in which a nurse evaluated the patient, the quality of the assessments was poor. Health care leadership reported that LPNs continue to perform the majority of sick call due to lack of adequate RN staffing. As noted in previous reports, the education and training of LPNs does not prepare them for this role, and their scope of practice does not permit them to perform independent assessments. In addition, the Monitoring Team's review shows that RNs need additional training in physical assessment and nursing protocols.

The Monitoring Team also noted that DACS does not accurately reflect the status of the patient with respect to the appointment having successfully occurred. For example, the Monitoring Team requested a list of patients scheduled in DACS for nursing sick call in September 2008 and then reviewed records selected from this list. In several cases, the patient was listed as having been seen in nursing sick call, when this was not the case.

Access to Mental Health Care

The Monitoring Team reviewed the charts of nine inmates who were on the mental health chronic care list and were also on medications that should require laboratory monitoring. The Monitoring Team found that only one of the nine charts reflected an adequate response to sick call requests. In many of the cases with inadequate responses, there was a delay of a week before the inmate's sick call request was responded to. In multiple instances, there is no documentation that the sick call request was responded to at all.

The Monitoring Team spoke with mental health staff members at SCI, who perceived themselves as doing much better than the Monitoring Team's audit portrayed them as doing. Staff believed they were doing very well in this area, and reported themselves as being at most three to four days behind in seeing requested sick calls. The Monitoring Team believes this difference is due to the fact that the facility has not performed a CQI study to examine this issue, and, as a result, staff members are basing their opinions on their own perceptions which are often uninformed. Additionally, the Monitoring Team looked not only at the timeliness of responses but also the quality of the documented response.

The Monitoring Team found that the sick call log at SCI did not track the time sick call requests were received in comparison to when they were responded to. However, both items are now being tracked.

F. Recommendations

At Baylor, the Monitoring Team makes the following recommendations:

- The State should revise the sick call policies and procedures to require that a RN or higher level provider performs nursing sick call.
- The State should assess and, if necessary, supplement RN staffing patterns to ensure that a RN is available to conduct sick call.
- The State should establish a triage system that ensures that patients receive an appropriate evaluation within 72 hours, and sooner if clinically indicated.
- The State should ensure that nurse referrals to a primary care provider take place in a timely manner. At the referral appointment, clinicians should address all significant problems, not just the reason for referral.
- The State should provide health assessment and nursing protocol training to RNs performing sick call.

At JTVCC, the Monitoring Team makes the following recommendations:

- The State should ensure that DACS is utilized appropriately to schedule patients in accordance with the demand.
- The State should ensure that a RN or higher level provider performs sick call.
- The State should ensure that staff members reliably collect, date stamp, triage, schedule and evaluate patients within 72 hours or sooner, as clinically indicated.
- The State/CMS should ensure that patient referrals to a primary care provider occur in a timely manner.
- The State/CMS should conduct CQI studies related to the identified problems; and implement and monitor corrective action plans.

At HRYCI, the Monitoring Team recommends the State do the following:

- Utilize the DACS reporting system to monitor timeliness of access to initial nurse screening as well as referral to advanced level provider for each side separately.
- Consider utilizing a RN to perform screening sick call for the east side of the facility.
- Consider utilizing the nurse screening process on the evening shift in order to decongest the west side.
- Monitor the timeliness of this process on a monthly basis until the process meets the intended threshold on a consistent basis.
- Amend policies and procedures to require that a RN or higher level provider performs sick call.
- Assess and, if necessary, supplement RN staffing patterns to provide the resources necessary to accomplish the above.
- Establish a triage system that ensures that patients receive an appropriate evaluation within 72 hours and sooner, if clinically indicated.
- Ensure the integrity of the information entered into DACS with respect to patient status.
- Explore practices to expand access to patients while maintaining a safe and secure

environment.

At SCI, with respect to ensuring appropriate access to care the Monitoring Team recommends the following:

- The State should insure that only RNs perform nursing sick call assessments.
- The State should develop and implement a more comprehensive training program for health assessment and nursing protocols.
- CQI studies should be performed related to the proper use of DACS scheduling and the timeliness and appropriateness of nursing sick call and physician referral.
- Health care assessments should be performed in appropriate clinical settings with privacy.

20. Isolation Rounds

A. Relevant MOA Provision

Paragraph 20 of the MOA provides:

> The State shall ensure that medical staff[73] make daily sick call rounds in the isolation areas, and that nursing staff[74] make rounds at least three times a week, to give inmates in isolation[75] adequate opportunities to contact and discuss health and mental health concerns with medical staff and mental health professionals[76] in a setting that affords as much privacy as security will allow.

The purpose of this MOA provision is to ensure that inmates placed in isolation maintain their medical and mental health while physically and socially isolated from the rest of

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[73] According to the MOA, the term "medical staff" includes "medical professionals, nursing staff, and certified medical assistants." *See* MOA II.I. The term "medical professionals" includes "a licensed physician, licensed physician's assistant, or a licensed nurse practitioner provision services at a facility and currently licensed to the extent required by the State of Delaware to deliver those health services he or she has undertaken to provide" *See* MOA II.J.

[74] According to the MOA, "Nursing Staff" means "registered nurses, licensed practical nurses, and licensed vocational nurses providing services at a facility and currently licensed to the extent required by the State of Delaware to deliver those health services he or she has undertaken to provide." *See* MOA II.M.

[75] According to the MOA, "isolation" means "the placement of an individual alone in a locked room or cell, except that it does not refer to adults single celled in general population." *See* MOA II.G.

[76] "Mental Health Professionals" means "an individual with a minimum of a master's-level education and training in psychiatry, psychology, counseling, psychiatric social work, activity therapy, recreational therapy or psychiatric nursing, currently licensed to the extent required by the State of Delaware to deliver those mental health services he or she has undertaken to provide." *See* MOA II.K.

the inmate population.[77] J-E-09; P-E-09. The NCCHC recommends that, upon notification that an inmate is placed in segregation,[78] a qualified health care professional reviews the inmate's health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation, and that such an evaluation should be placed in the inmate's medical record. *Id*.

The Second Report identified some confusion over the proper interpretation of this provision of the MOA. The NCCHC standard that appears to be applicable to this provision of the MOA also appears to apply in a limited sense to provision 39 of the MOA. According to the NCCHC, monitoring of inmates in segregation should be dictated by the inmate's degree of isolation. *Id*. Inmates under extreme isolation[79] with little or no contact with other individuals should be monitored daily by medical staff and at least once a week by mental health staff. *Id*. Inmates who are segregated and have limited contact with staff or other inmates are monitored three days a week by medical or mental health staff. *Id*. Inmates who are allowed periods of recreation or other routine social contact among themselves while being segregated from the general population should be checked weekly by medical or mental health staff. *Id*.

In response to this confusion, the parties agreed that this provision of the MOA imposes requirements relating only to monitoring of inmates in isolation (as defined by the MOA; *see* above) by medical staff for medical and mental health issues, and provision 39 imposes requirements relating to monitoring of inmates in isolation by mental health staff.[80] Ultimately, in spite of all of the confusion, this MOA provision requires that medical staff make daily sick call rounds, and nursing staff make sick call rounds three times per week.

The sick call rounds performed pursuant to this provision of the MOA should ensure that each isolated inmate has the opportunity to request care for medical or mental health problems and allow staff to ascertain the inmate's general medical and mental health status. *Id.* The NCCHC standard recommends also that documentation of isolation rounds be made on individual logs or cell cards,[81] or in an inmate's health record and include: (1) the date and time

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[77] As this NCCHC standard applies to the MOA, it is more pertinent to MOA provision 39. Provision 20 of the MOA, is directed more towards ensuring that inmates in isolation have adequate access to care in general.

[78] A "segregated" inmate is one who is isolated from the general population and who receives services and activities apart from other inmates. J-E-09; P-E-09. Such segregation could include administrative segregation, protective custody, disciplinary segregation, or a SHU tier. *Id*.

[79] "Extreme isolation" means "situations in which inmates are seen by staff or other inmates fewer than three times a day." J-E-09; P-E-09.

[80] The State subsequently revised its policy regarding isolation rounds in order to cure any potential confusion, and provided the revised policy to the Monitoring Team.

[81] The applicable NCCHC standard also states that when the cards or logs are filled, they are filed in the inmates' heath record.

of the contact; and (2) the signature or initials of the health staff member making the rounds. *Id*. Finally, any significant health findings should be documented in the inmate's health record. *Id*.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

As discussed in the Third Report, the policy at Baylor is to not use isolation or disciplinary segregation for extended periods of time. Instead, placement in these settings is kept to a brief timeframe of a few days. Then there is some accommodation such as a change in housing or a return to the inmate's previous setting with a loss of some privilege for awhile. Because of this approach, an inmate's stay in isolation is generally less than three days rendering this provision largely inapplicable at Baylor.

The Monitoring Team reviewed 12 Segregation Record Review and Visit Logs[82] of inmates placed in isolation to assess the frequency of monitoring by health care staff while the inmate was in segregation. In only five of 12 logs did staff document the date that health care staff was notified that the inmate was placed in segregation.[83] None of the 12 forms documented when the inmate was released from segregation. None of the forms contained information regarding whether the inmate had existing medical or mental health conditions that preclude the inmate from being placed in segregation, whether the inmate is receiving medication, or whether mental health staff was notified of the inmate's placement in segregation. The Monitoring Team also notes that the form covers a calendar year period (January to December), and is used to document rounds for presumably two separate placements in segregation. Thus, determining when inmates are placed in and released from segregation is difficult with the current form, unless staff document on the back of the form.

The 12 logs showed that rounds typically occurred for one to five days. Staff documented the inmate's condition, (*e.g.*, alert and oriented, agitated, refused medications) on the back of the form.

In summary, although logs show that rounds are being made, it is not possible to know that the provisions of the MOA are met without documentation of the dates of the inmate's placement and release from segregation.

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[82] This is a Correctional Medical Services form.

[83] It is unclear to the Monitoring team that the date the health care staff is notified is the actual date the inmate is placed in segregation.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed several months of nursing rounds documentation in the SHU and found that rounds were consistently made three times weekly for this population. Mental health staff makes rounds on alternate days and documents their rounds in DACS.

With respect to mental health, the Monitoring Team observed mental health rounds for inmates in isolation and found these rounds to be adequate. By adequate, the Monitoring Team means that the rounds were occurring at least three times per week, and were also conducted in a manner that was both reasonable and effective.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that there is a logbook containing segregation round sheets for inmates placed in segregation. The Monitoring Team reviewed at least 10 records of inmates whose names are in the log book. In most cases, the staff member completing the form did not fill out the top of the form indicating when the inmate was placed in segregation and whether or not the inmate had any medical or mental health conditions. The forms also did not document when the patient was released from segregation. Therefore it was not possible to know whether rounds were made in compliance with requirements of the MOA.

With respect to mental health-related issues, the Monitoring Team notes that isolation rounds are conducted three times per week in the isolation units. The Monitoring Team observed the mental health rounds process which are conducted with the nursing staff, which helps to coordinate care. The Monitoring Team believes the rounds process is hampered by the use of multiple mental health clinicians for rounds instead of having one assigned clinician conduct them. By using one clinician to conduct rounds, it gives that clinician an opportunity to better know the inmates and their problems and also eliminates the possibility of inmates asking multiple clinicians the same questions because they do not like the answer given by one.

The Monitoring Team also believes that the State should provide further training for staff who are assigned to the isolation rounds process. This training should specifically

include training regarding privacy issues during the rounding process and how to better deal with this issue.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found that SCI is in substantial compliance with respect to mental health services and in partial compliance with respect to medical services.

2. Findings

The facility has 18 disciplinary isolation beds in Unit 4 (pre-trial), two beds in boot camp, and 14 administrative segregation beds on MSB. Night shift nurses make daily rounds and initial each isolation round sheet. The Monitoring Team reviewed isolation logs (containing at least 10 log sheets) in pre-trial that showed that nurses documented the date of admission to segregation and with some exceptions made daily rounds. This area is close to being in substantial compliance with respect to medical services.

With respect to mental health, staff reported that mental health rounds were being performed three times per week as required by this provision. Discussions with inmates and a review of appropriate log books confirmed this.

F. Recommendations

At Baylor, the Monitoring Team makes the following recommendations:

- When inmates are placed in segregation, health care staff should review the health record and if necessary, evaluate the inmate if necessary to determine if there are any medical or mental health reasons that would preclude the inmate from being placed in segregation.
- Health care staff should fill out the form completely, documenting the date the inmate was placed in and released from segregation. Staff should notify mental health staff of the patient's placement in segregation.

At HRYCI, the Monitoring Team recommends:

- Add a place on the form to document the date/time the inmate was placed in segregation and the date/time he was released.
- Health care leadership should ensure that rounds take place in accordance with the requirements of the MOA.

At SCI, the Monitoring Team recommends that the segregation form be amended to reflect the date of admission to segregation as well as the date of release, and that nurses consistently complete this documentation.

21. Grievances

A. Relevant MOA Provision

Paragraph 21 of the MOA provides:

> The State shall develop and implement a system to ensure that medical grievances are processed and addressed in a timely manner. The State shall ensure that medical grievances and written responses thereto are included in inmates' files, and that grievances and their outcomes are logged, reviewed, and analyzed on a regular basis to identify systemic issues in need of redress. The State shall develop and implement a procedure for discovering and addressing all systemic problems raised through the grievance system.

This MOA provision requires the State to develop and implement a system to ensure that medical grievances are processed and addressed in a timely manner. This requirement is similar to the NCCHC standards, which recommend that there be a grievance mechanism to address inmates' complaints about health services. *See* J-A-11; P-A-11. The State has developed a grievance policy. *See* State Policy A-11. The Monitoring Team finds that this policy is adequate. Appropriate timeliness of processing and addressing grievances is not defined by the NCCHC standards or the State's policy.

The NCCHC also recommends that in addition to the formal grievance mechanism, institutions attempt to informally resolve inmates' complaints about health services. J-A-11; P-A-11. The informal dispute resolution can consist of a face-to-face interview by a HSA, responsible physician, or nursing supervisor, and is often an effective way to resolve problems and demonstrate health staff's concern. *Id*.

This provision of the MOA also requires that the State shall ensure that medical grievances and written responses thereto are included in inmates' files. For this requirement of the MOA, the requirements of provision 3 of the MOA also will apply with respect to timeliness and appropriateness of filing grievance information in inmates' medical records.

Finally, this provision of the MOA also requires that the State ensure that grievances and their outcomes are logged, reviewed, and analyzed on a regular basis to identify systemic issues in need of redress, and to develop and implement a procedure for discovering and addressing all systemic problems raised through the grievance system. This requirement is most appropriately addressed in relation to provisions 54 and 55 of the MOA, which relate to the State's CQI efforts. *See* J-A-06; P-A-06 (NCCHC standards for CQI programs).

The grievance process implemented by the State is essentially the same at each of the Facilities. The grievance process consists of three parts. At Level 1, an RN (or other medical staff member) interviews the patient, reviews the health record, develops a plan for resolution, and discusses this plan with the patient. Level 1 review of a grievance is to take place within seven days of receipt of the grievance and entry into DACS.

If the grievance is not resolved at Level 1, then it becomes Level 2. At Level 2, there is a committee that meets twice monthly, which consists of an RN, and two other medical staff members.[84] The Level 2 grievance process is to take place within 30 days of the date that the Level 1 grievance investigation is completed.

Finally, if the grievance is not resolved at Level 2, then it becomes Level 3. At Level 3, the grievance is addressed by the OHS. The Level 3 grievance process is permitted to take up to six months from the filing of the grievance.

At each Facility, the Monitoring Team reviewed the timeliness of the grievance process by obtaining reports generated by DACS, which reflected the status of all grievances at each Facility. In addition, the Monitoring Team observed Level 1 and Level 2 grievance proceedings. The Monitoring Team found the medical grievance committee meeting to be a highly instructive process, which was designed to be responsive to the concerns of the grievant.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found that Baylor is in partial compliance with respect to mental health services and in substantial compliance with respect to medical services.

2. Findings

The Monitoring Team reviewed 42 grievances, which had been filed between May 5 and August 17, 2008. Of those, the Monitoring Team found six grievances that were at level one and were overdue.[85] However, at the time of the Monitoring Team's visit, the level one review had been completed. There were no overdue level two grievances, and there was one overdue level three grievance. An overdue level three grievance is not a reflection of the performance of the institution, however. Therefore, the Monitoring Team's assessment is compliance with respect to medical grievances.

At Baylor, the HSA addresses all level 1 grievances. If the grievance is a mental health issue with regard to access to care, the HSA ensures that a visit with an appropriate mental health staff clinician takes place. Where there are mental health treatment issues, the grievance is discussed with or referred to the director of mental health. There have been relatively few of the latter type of grievances. The involvement of mental health staff in the grievance process is an improvement over the Third Report.

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[84] A security officer is also present, but only for security purposes and to enter information into DACS.

[85] At times, a delay can be caused by a delay in entering the grievance results into DACS, which is not a function that is performed by medical staff.

In previous reports, the Monitoring Team was critical of the lack of involvement by mental health staff in the grievance process when grievances are relevant to mental health issues. The State has taken steps to remedy this and as a result, mental health staff has been involved in the process since July 2008. The Monitoring Team has assessed this as partially compliant from a mental health perspective due to the involvement of mental health staff. However, the Monitoring Team has not found the State in substantial compliance with this provision due to the fact that there has not yet been an analysis of the grievances on an aggregate basis to examine systemic mental health issues in need to redress.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found that JTVCC is not in compliance with respect to mental health services and in partial compliance with respect to medical services.

2. Findings

At the time of the Monitoring Team's visit, there were 51 level 1 grievances outstanding greater than seven days. There were 74 level 2 grievances outstanding greater than 37 days. The Monitoring Team talked with the HSA and members of the OHS about the need to insure that level 1 reviews are completed within seven days, and level 2 committee reviews within 37 days of initiation. Nursing leadership is taking a major role in this process, and believes that by aggressively pursuing both level 1 and 2 responses they will be able to be in compliance by the time of the Monitoring Team's next visit.

The Monitoring Team notes that CMS does not separate mental health grievances from general medical grievances. As such, the nature of the grievances is not being assessed from a mental health perspective.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found that HRYCI is not in compliance with respect to mental health services and in partial compliance with respect to medical services.

2. Findings

Using the DACS reports provided to the Monitoring Team by the OHS, the Monitoring Team reviewed the timeliness of the grievance process. As of the date of the

Monitoring Team's visit, there were zero level 1 or level 3 grievances past due. However, there were 14 level 2 grievances past due. In looking at details of the grievance timelines, the Monitoring Team was able to see that there had been, up until recently, a substantial delay in responding to level 1 grievances. This delay in responding to level 1 grievances impeded the ability to perform the level 2 hearings within the required timeframe. Several level 1 grievances were not addressed for four to eight weeks. With that kind of delay, it is already outside the timeframe required for a level 2 grievance, which is within 37 days after submission.

The Monitoring Team was informed during their August 2008 visit that CMS is changing the grievance process statewide. These changes would incorporate mental health staff into the grievance process in order to make them more accountable. At the time of the Monitoring Team's visit, the current grievance log did not track the nature of the filed grievance.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found that SCI is not in compliance with respect to mental health services and in partial compliance with respect to medical services.

2. Findings

The Monitoring Team reviewed the grievance reports for the most recent time frame and on the report there were 24 Level 1 grievances that were overdue. The oldest grievance went back a little more than three weeks to October 5, 2008. With regard to Level 2 grievances, there were two overdue grievances, going back to September 10, 2008. There were no Level 3 grievances overdue. The Monitoring Team does not know the reason for this backlog. It should be resolved easily with ongoing attention to the timeliness required in the grievance process.

The Monitoring Team found that mental health staff is not directly involved with the grievance process.

F. Recommendations

At JTVCC, HRYCI, and SCI, the Monitoring Team recommends that grievances be categorized based on whether they relate to medical or mental health issues. The nature of the grievances needs to be studied with mental health staff involved in the analysis of issues related to mental health.

At JTVCC, the Quality Assurance Program should monitor the timeliness of grievance responses by using the DACS grievance report system on a monthly basis so that where indicated additional resources can be brought to bear to achieve compliance.

At HRYCI, the Monitoring Team recommends that the State ensure that level 1 grievances are responded to consistently within seven days. Additionally, the CQI program should monitor and report on the timeliness of this process at all levels on a regular basis.

At SCI, the Monitoring Team recommends that the State ensure that there is weekly responsiveness to the first and second level grievance procedures.

CHRONIC DISEASE CARE

22. Chronic Disease Management Program

A. Relevant MOA Provision

Paragraph 22 of the MOA provides:

> The State shall develop and implement a written chronic care disease management program, consistent with generally accepted professional standards, which provides inmates suffering from chronic illnesses with appropriate diagnosis, treatment, monitoring, and continuity of care. As part of this program, the State shall maintain a registry of inmates with chronic diseases.

According to the NCCHC, an adequate chronic disease[86] management program should identify patients with chronic diseases with the goal of decreasing the frequency and severity of symptoms, including preventing disease progression and fostering improvement in function. J-G-02; P-G-02. A chronic disease program should incorporate a treatment plan and regular clinic visits, according to the needs of the patient, and the generally accepted professional standards for the chronic disease(s) suffered by the patient.[87] *Id*. The clinician responsible should monitor the patient's progress during clinic visits and, when necessary, change the treatment. *Id*. The program should also include patient education for symptom management. *Id*.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

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[86] A "chronic disease" is defined as "an illness or condition that affects an individual's well-being for an extended interval, usually (at least) 6 months, and generally is not curable but can be managed to provide optimum functioning within any limitations the condition imposes on the individual. J-G-02; P-G-02. Examples of a chronic disease include asthma, diabetes, high blood cholesterol, HIV, hypertension, seizure disorder, and TB. *Id*. Each chronic disease has a separate set of clinical guidelines that apply to appropriate treatment and control of the disease.

[87] Each chronic disease has a separate set of clinical guidelines that apply to appropriate treatment and control of the disease. For example, the generally accepted professional standards for the treatment of TB can be found at the website for the Centers for Disease Control: http://www.cdc.gov/tb/pubs/PDA_TBGuidelines/default.htm.

1. Findings

The previous medical director left the facility in May, and a new medical director started full time approximately two weeks before the Monitoring Team's visit. During the transition, the person assuming the medical director position covered the facility part-time with additional patient care hours filled in by other physicians. Unfortunately, both the quality and continuity of chronic care has suffered during this transition period.

The total number of patients with chronic diseases could not be ascertained since the chronic disease logs remain incomplete or inaccurate. The Monitoring Team selected 23 records from records of patients receiving the following treatments or being treated for the following diseases: Anti-Coagulation therapy (2), Asthma (4), Diabetes (5), HIV (6), Hypertension (5) and Seizures (5). In four instances, the same patient's record was used to assess both diabetes and hypertension. The Monitoring Team focused on the 32 chronic disease clinic visits reflected in these files, and reviewed the progress notes, orders, intake screenings, laboratory data and other relevant material in the medical record.

Although the majority of patients had one chronic care visit since the last audit, few patients were seen between visits for poor control of their chronic diseases. The Monitoring Team found that, at times, treatments were changed without discussion with the patient.

The scheduling of patients for chronic care clinic is now somewhat problematic beginning at intake. Three patients of the 23 reviewed had no chronic care visit either during the current audit period or anywhere in the record. Upon reviewing intake screening of several patients selected for the audit, the Monitoring Team noted that the patients were not being seen in Chronic Care Clinic on the date that DACS had scheduled the appointment.

As there was no documentation in the records that the appointment was rescheduled, 10 additional records of patients with chronic diseases were randomly selected and audited for intake date, scheduled date of chronic disease appointment by DACS, and actual date of chronic disease appointment. In each of the 10 cases, none of the inmates were seen on the originally scheduled date. The actual appointments occurred within a range of two to five weeks later than the originally scheduled appointment.[88]

In one instance, the patient had not been seen at the time of the audit on August 20, 2008, which was five weeks after the patient's intake. The State should have its chronic disease patients going to the clinic within thirty days of intake. This is happening in only three out of 10 cases (30%). Additionally, in some cases, this lag time created discontinuity of care, as medications were not begun until the inmate was seen in the clinic. Several patients were seen for a physical by the NP in a timelier manner, but documentation was on the physical form rather than the chronic disease form as had been previously recommended.

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[88] The originally scheduled visits typically are scheduled about one week after intake. This means that, with the delay described above, appointments did not occur until three to six weeks after the intake. The State's policy provides that such appointments should take place within 30 days of intake.

Once enrolled in chronic disease clinic, patients frequently were not seen again in the timeframe requested by the physician. For example, for one patient with symptomatic asthma, the physician requested a thirty day follow-up on June 8, 2008, but as of the third week in August, she still had not been seen.

Appropriate laboratory data was ordered for patients with chronic diseases (*i.e.* HgA1c in diabetics, anticonvulsant levels in seizure patients); however, timely laboratory data was not available for a substantial number of patients although coordination of the drawing of these in conjunction with the clinic visit has improved slightly. Laboratory tests frequently were ordered at the time of the visit, but these were not reviewed in a timely manner, and patients were not called back to discuss the abnormal findings as previously had been done. Additionally, filing of laboratory and radiology results was disorganized and did not follow policy in many instances.

Disease-Specific Findings

a. Anti-Coagulation (Coumadin) Treatment

The Monitoring Team reviewed the records of the two patients on Coumadin.

- Anti-coagulation treatment was not on the problem list of either patient.
- One patient with a history of "blood clots" was never seen in chronic disease clinic, nor was her Coumadin therapy addressed in the progress notes.
- The second patient did not get to chronic disease clinic until four weeks after intake and Coumadin was not started until this time. Additionally, she had a lapse in her medications when they were not renewed in a timely fashion.
- Both patients had orders for weekly Prothombin Time ("PT") and International Normalized Ratio ("INR"),[89] but the results of the majority these were not in the record and it could not be ascertained if these were drawn as ordered.
    - The few results available in the records were not reviewed in a timely fashion.
    - Subtherapeutic medication levels were not addressed.

b. Asthma

The Monitoring Team reviewed the records of four patients with asthma, and each record reflected one visit to a chronic care clinic visit.

- Three out of four patients had peak flow results recorded at the time of the chronic disease visit.

[89] The INR measures the speed with which blood coagulates. It will be higher in patients on Coumadin therapy, but must be controlled. Otherwise, if the coagulation time becomes too long, the patient is at risk for uncontrolled bleeding.

- Two of the four patients had significant symptoms at the time of their chronic care appointment. Appropriately, another appointment in 30 days was ordered for one patient, but this appointment did not actually occur.
- The second inmate's asthma was labeled as being in fair control in spite of her waking up nightly with symptoms.
- Neither of the symptomatic patients had documentation of receiving Pneumovax although the two other patients reviewed had documentation of both Influenza vaccination and Pneumovax. The two patients who did not receive Influenza vaccine entered the facility after the recommended vaccination period for the year.[90]

c. Diabetes

The Monitoring Team reviewed the records of five patients with diabetes. From these records, the Monitoring Team was able to review the adequacy of six chronic disease clinic visits. One record reviewed was the third of three volumes, and it was not clear if all relevant data was carried forward to the current volume from the earlier volumes.

- All patients had lipid levels checked, and those levels were in excellent control in four of the five patients. One patient had a slight elevation of her cholesterol.
- All of five diabetes patients had received the Pneumovax vaccine. Four of the five had received an Influenza vaccine in the current season.
- Four out of five had well-controlled blood pressure, and were on an ACE-inhibitor.
- Microalbuminuria results from the past year were in the records of three of the five patients.
- Two of the five patients had an eye exam within the last year. Two of the five patients had eye exams previously, but not in the past year. One had no documentation of an eye exam in the current volume of her chart.
- Two patients had good control of their diabetes based upon HgA1c results.
- One patient had a very poor control based on a current HgA1c result. She was seen back in one month, and, based on finger-stick glucose results, was appropriately labeled fair control with another appointment requested in one month.[91]
- One patient's diabetes was in fair control and scheduled back in 60 days. The appointment should have been scheduled for 30 days.
- One patient showed deterioration from good to poor control. The physician ordered a thirty day follow-up towards the end of June, but as of mid-August, the patient had not been seen again.

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[90] In such a case, the Monitoring Team does not hold the State responsible for these patients not being vaccinated.

[91] This is an acceptable practice. HgA1c is a measure of blood sugar control over a three-month period. If the test is repeated in less than that period of time, there may be a trend downward, but it does not necessarily give an accurate snapshot of whether the patient's disease is under control.

d. HIV

The Monitoring Team reviewed the records of six patients with HIV. These records reflected nine chronic disease clinic visits, as well as progress notes and orders. HIV positive patients at Baylor were seen by two primary care physicians, and a physician with special training in HIV, although he was not an infectious disease specialist. One of the primary care physicians did not address HIV-related issues when seeing the patient.

- All patients had lipid levels checked.
- All patients had CD4 counts and viral loads (VL) checked, and four out of six of the inmates had current test results at the time of the chronic care visit. Physicians' sign-off on laboratory tests was not always timely.
- Patients who, according to their CD4/VL levels, should be on anti-retroviral medications, were either started or continued on such medications. Although medications were renewed at appropriate intervals, at times it was difficult to ascertain actual medication continuity.[92] In one instance, the copies of the MARs were in the chart for provider review with the Chronic Care visit.
- Two of six patients were current on both Pneumovax and Influenza vaccines, and one patient's record reflected that the inmate refused the Influenza vaccine.
- Four out of six patients were not seen for their HIV disease within appropriate timeframes, especially upon entering the facility. In three of these records, there were orders written at the time one would have anticipated a visit, but no documentation of the accompanying encounter could be located.

e. Hypertension

The Monitoring Team reviewed the records of six patients with hypertension; four of these inmates also had diabetes. These inmates' records collectively reflected six chronic disease clinic visits.

- Five of the six inmates' blood pressure was in excellent control. The one patient with a slightly elevated blood pressure reading had recently had her medication dose decreased. Her medication dose was increased back to the previous level at the visit.
- One patient was inappropriately labeled hypertensive by a physician no longer working in the system. She never took the ordered medications, but had a normal reading at her most recent chronic care visit. The current physician has ordered some additional blood pressure readings with the goal of correcting this diagnosis. This plan was not documented in the patient's record; however, it was explained when the patient was seen by the physician.

[92] The only way to know if a patient actually received medication or was compliant with taking the medication is if the MAR is filed in the patient's health record or if there is a note in the record that the physician reviewed the MAR.

f. Seizures

The Monitoring Team reviewed the records of five patients with seizures. These records collectively reflected five chronic disease clinic visits.

- Two of the five patients who reported having been diagnosed with seizure disorder had their diagnoses verified at intake. Based upon a review of the records, it appears questionable that three of the other patients actually had seizure disorder, as no verification was obtained. Two of these patients had Dilantin prescribed to them without examination or evaluation.
- Only two out of the five inmates' records reflected that they had received neurological exams.
- One of the patients had come into the facility on June 29, 2008, but had not been scheduled for a chronic care clinic visit (this is usually done by DACS), and had not been seen in the clinic at the time of the Monitoring Team's visit. This patient was noted to have a subtherapeutic Dilantin level, and her Dilantin dose was increased even though she had not been seen.
- Three of the four inmates who were taking Dilantin had their Dilantin levels tested; however, current test results were not available at the time of their clinic visits. One patient was clinically Dilantin toxic at the time of the visit although the most recent level two weeks before the visit was subtherapeutic. The inmate's Dilantin level was held at the same level. A subsequent test for Dilantin levels reflected extremely high levels, but a physician was not immediately notified of this result, and sign-off on the results did not occur until a week later.
- Two of the patients did not have their Dilantin level tests ordered until a week after their intake.
- One patient had an elevated blood pressure reading at intake that was not addressed.

C. JTVCC

1. <u>Assessment</u>

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team selected charts of inmates from both general population and special management areas because different physicians provide care in these areas. There is one physician covering patients in general population, which is inadequate for the patient load and the systems currently in place. A second physician is responsible for primary care in special management, which has a smaller patient case load. There are also two NPs at the facility. In addition, a physician from another facility consults on HIV-positive patients in both areas of JTVCC.

Twenty-seven records from general population were audited for the following categories: Anti-Coagulation Therapy (5), Asthma (4), HIV (5), Diabetes (5), Hypertension (7), and Seizures (4). In these records, 68 encounters (chronic care clinics and progress notes) were

reviewed, as well as doctor's orders, laboratory reports, consultant reports and other miscellaneous documents.

Twenty-four records from the special management were audited for the following categories: Anti-Coagulation Therapy (1), Asthma (6), HIV (5), Diabetes (5), Hypertension (5) and Seizures (4). In these records, 32 encounters (chronic care clinics and progress notes) were reviewed as well as doctor's orders, laboratory reports, consultant reports and miscellaneous documents. Some records were used for more than one disease entity. An accurate tabulation of patients with each of the chronic diseases was not available because the State's means of tracking chronic disease is not accurate.

General comments for all disease entities

Patients were seen in chronic care clinics with documentation on forms developed for this purpose. These forms encompass a variety of chronic diseases and include a comprehensive review for the initial visit and a more abbreviated form for follow-up visits. Since the Monitoring Team's last visit, there has been some improvement in the adequacy of the completion of these forms, although there is inadequate space for providers to write substantive documentation, especially when the patient is being seen for more than one chronic disease. Providers documented discussing test results with patients, educating them to their medical conditions and the importance of their medications.

It appears that providers are attempting to provide quality care; however, this is hampered in general population by the number of patients assigned to be seen in one day (over 30 chronic care and sick call referrals combined). That amount of appointments does not include emergencies that arise, or time spent reviewing the work of mid-level practitioners, incoming laboratory reports or other documents as is expected by the standards. That amount of appointments also did not include time for phone calls to specialists who may have seen the patients. Additionally, even when appropriate care and follow-up was ordered, this did not always occur in the timeframe specified. In some of the records pulled for review, ordered chronic care appointments had not occurred during this audit period. There were also problems in continuity when patients were transferred between special management and general population or vice versa.

Problem lists were incomplete, and sometimes did not even include the patient's chronic disease. Medications were not always ordered before a prescription lapsed (this may have resulted in prescription medications being provided illegally); however, it appeared from review of the MARs that, in most instances, medications for chronic diseases continued. There was documentation in several records that a patient stated his medications had run out with a resultant deterioration of disease control. In essence, the current systems in place to assure continuity of both appointments and medications were not effective and physicians were overloaded by the number of patients assigned.

Degree of disease control and statement of patient status (improved, stable, worse) were sometimes inconsistent with the objective findings documented or there were no objective findings in the note upon which these were based. At times, this led to no plan stated

for improving disease control or for further monitoring. There has been some improvement in availability of laboratory test results necessary for an appropriate treatment plan to be formulated. Although laboratory data is ordered at the visit, often the results are not reviewed in a timely manner and providers were not consistently notified of critical values in the appropriate timeframe.

Although there was a nurse assigned as the chronic care nurse, her primary duty was to take off the orders of the patients seen in the clinic rather than oversight of the clinic.

Disease-Specific Findings

a. Anticoagulation (Coumadin therapy)

- Anti-coagulation therapy (Coumadin Treatment) was listed on the problem list on two of the six charts reviewed (improved from zero as reported in the Third Report).
- Four out of six patients had the presumptive condition for which they were on anti-coagulation identified, although target INR was not stated. In one case, it was difficult to ascertain when and why the patient was placed on Coumadin.
- Two patients who were on Coumadin for problems that did not require long term therapy had it discontinued; however, for one of the patients, this should have occurred five to six months prior.
- Three of five patients in general population had been reviewed in the previous audit. There was marked improvement documenting blood draws for PT/INR testing and except for the most recent ones, results were in the record.
- The one patient on Coumadin in special management also was audited in the last period. He was seen in chronic care in April 2008, and although a return visit was ordered for August, he did not have a follow-up visit until October, when his Coumadin was discontinued. During this period, he had documentation of PT/INR blood draws, but many of these were not in the record. Sign off on those test results that were available was not timely. Additionally, there were orders in the record which were not scheduled or performed by nursing.
- Although PT/INRs were ordered in appropriate timeframe, there continued to be lapses in the blood draws as ordered (as long as six weeks for a patient with weekly draws ordered).
- When a critical value was called to a nurse, a provider was not notified immediately. A note was left in the chart for the NP to review, but she did not receive the note until four days later.
- Documentation of provider review of PT/INRs continues to be delayed. There were instances when there was no documentation of review on the laboratory test result, but there was a notation in the progress note and an appropriate response to a high value in one record.
- There was no comment on review of MARs when laboratory values were subtherapeutic. One would expect this commentary in the progress notes and along with a plan of action in response to the abnormal values (*i.e.*, if the MAR reveals that the patient is taking their medication, the provider might plan to meet with the patient and increase that does of medication). If the MAR review reveals that the patient is missing doses of the medication, the provider might schedule the patient for an appointment to counsel them on the importance of taking their medication.

b. Asthma

- None of the asthmatic patients reviewed had an acute asthmatic attack during this audit period.
- All were using less than one canister of reliever medication per month and only one reported some night-time wakening with symptoms.

Special management

- Of the four chronic care visits, peak flows were noted only once. Peak flows should be noted at each appointment.
- There was no chronic care visit in this audit period in two of the records selected from asthmatic patients on inhaled steroids. Both of these patients were last seen in June 2008.[93]

General Population

- Of the eight chronic care visits in general population, peak flows were noted only two times.

c. Diabetes

- Special Management
  - Diabetes was not on the current problem list of one patient although it was listed on the previous one.
  - The flow sheet for recommended care was present in one record, but it was not up to date.[94]
  - Three of five patients had HgA1c in the record for the current audit period.
    - In one case, an elevated HgA1c from July had not been repeated, but there was evidence that blood glucose finger sticks were reviewed and had significantly improved.
    - Of the two patients who did not have HgA1c tests performed during the monitoring period, one had refused his tests and the other had the test ordered twice since his relatively recent admission, but it had not yet been obtained.
    - One patient showed improvement in his HgA1c test results when his February 2008 test results were compared with his October 2008 test results.
  - Three of the five patients were on an ACE inhibitor. All of these patients should be on ACE inhibitors, or, if not, there should be a note in the file documenting the reason why the patient is not on an ACE inhibitor.
  - Blood pressures were recorded at every visit. These were in the recommended range for three of five patients. For one patient who had fair control of blood pressure noted on two visits, no action was taken.
  - There were lipid levels in the records of four out of five patients. All of these had good control of cholesterol, but triglycerides were elevated in some. One patient, who with the doctor's encouragement, lost 22 pounds since April, showed marked improvement in both his lipid levels and glucose control.

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[93] These visits should take place every 90 days, or more frequently, if clinically indicated.

[94] A flowsheet tracks all the items a diabetic patient should receive (*i.e.*, yearly eye exam, yearly microalbuminuria, HgA1c, etc.). This is a well-designed form and should be completed.

- Microalbuminuria was checked in four of the five patients.
- Eye exams were ordered in four of the five patients. The exam report was present in only one record. One patient had an eye exam previously, but it was more than a year ago.
- One patient with diabetes was admitted to the facility, and there was an order for a chronic care visit and test for him approximately six weeks later. Tests previously ordered had not been obtained. He was seen in the clinic, but the initial chronic care form was not dated.
- There was documentation that the provider discussed disease management with the patients.

- General Population
  - Diabetes was not on the problem list for two of the five patients. A third patient did not have a problem list in the chart at all.
  - The flow sheet for recommended care was not in use in any of the records.
  - Four of five patients had HgA1c test results in the record for the current audit period
    - The one patient without HgA1c tests in this audit period had not had one since January 2008 and there was no mention of a review of fingersticks in its stead.
    - One patient whose HgA1c was incorrectly labeled as having his disease in fair control rather than poor. An order was written to notify a provider when fingerstick readings were over 500, a higher than standard value for this type of notification.
    - One patient had two very different readings five days apart in August 2008. This indicates that one of these readings is suspect, but a repeat level was not ordered to be drawn until 90 days later.
    - Another patient had an HgA1c test result on August 15, 2008, with a repeat test ordered on October 6, 2008. This had not been obtained at the time of the audit on November 21, 2008.
    - Another patient had a reading on August 18, 2008. A 30-day follow-up was ordered, and he was seen on September 16, 2008, but his diabetes was not addressed.
    - One patient had newly diagnosed diabetes. He had a blood sugar test result noted in February 2008, and a HgA1c test was ordered; however, this was not obtained until August 2008.
  - Three of the five patients were on an ACE inhibitor
  - Blood pressures were recorded at every visit, but elevations out of the recommended range for diabetic patients were not consistently addressed.
  - There were lipid levels in the records of four out of five patients.
    - In one patient with new elevations, this was addressed.
    - In one patient, elevated lipids were not addressed.
  - Microalbuminuria was checked in two of the five patients.
  - Eye exams were ordered for three of the five patients (in December 2007, August 2008, and October 2008), but the exam reports were not found in the record of any of the patients.
  - There was documentation that the provider discussed disease management with the patients.

d. HIV

As noted above, HIV positive patients were followed by both the primary care provider on site as well as a consulting physician with additional training from another facility. There seemed to be some confusion regarding the responsibilities of each provider, such as who was responsible for following lipid levels, assuring that labs were ordered and reviewed, etc.

- Eight out of 10 patients had relatively recent CD4 counts and viral loads in the record.
  - One patient without a current CD4 count and viral load had labs ordered, but was refusing his blood draws. The other patient had these ordered on October 17, 2008, but they were not obtained as of November 20, 2008.
  - Except for one patient, all available CD4 counts were above 700.[95]
  - Five out of 10 patients had viral load less than 75.
  - In the five patients where comparisons were available, there were increases in CD4 count.
- Nine out of 10 patients had lipid levels checked; however, in many instances elevated lipid levels, especially of triglycerides, were not addressed.
- Four of five patients with HCV co-infection either had vaccination for Hepatitis A and B or notation of immunity to these diseases. This is a positive result.
- There was significant discontinuity of care with the HIV provider as the patients were not returning to see him in the timeframe requested. In several instances, there were lapses of four to seven months between appointments. For appointments requested in less than 90 days, in one instance when a reappointment with labs was requested in two weeks, the return did not occur for two months and in another with a 30-day follow-up requested in August 2008, the patient had not returned to the clinic at the time of the audit in November 2008.

e. Hypertension

- Special Management
  - Most patients had good control of their blood pressure. When there was an elevation, it was appropriately noted and action was taken.
  - All but one patient had appropriate lab testing in the record. The one patient without lab values in the record had these ordered twice, but tests were not obtained.
  - All but the one patient noted above had lipids checked and in good control.
- General Population
  - Patients with fair or poor control were labeled incorrectly as being in good control three times. There was no change in treatment in two of these patients; it was noted in one of these patients that he had run out of medications. One patient did get a change in regimen in spite of being labeled good control. In one instance, there was no labeling of an elevated blood pressure in a diabetic patient and no action was taken.
  - Ordered labs were not always available in the record. It is not known whether these tests were completed or if the absence is due to delayed filing.

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[95] A patient with CD4 counts above 700 generally will not be started on HIV medication. HIV medication generally is not commenced unless the patient's CD4 level is 350 or below, and, once the medication regimen is commenced, it cannot be discontinued, even if the CD4 count improves.

- Most of these patients also had hyperlipidemia which was being treated.

f. Seizures

- Special Management
  - Patients with seizures were managed appropriately except that in three of four cases no documentation of a lower bunk accommodation could be found.
  - Three of the four patients had not had a seizure during this monitoring period. One patient who had a seizure was non-compliant with medications and was refusing tests for anti-epileptic drug ("AED") levels.
  - Three of four patients reviewed had appropriate documentation that a seizure disorder existed. The fourth patient was labeled as possible pseudo-seizures and was in the midst of an evaluation.
- General Population
  - The diagnosis of seizures was questionable in the four records reviewed for this diagnosis. All patients had subtherapeutic Dilantin levels for a considerable period of time (as long as 2 years) yet never had a documented seizure.
  - No verification of seizure disorder at intake was found on three of these patients. The fourth had a multivolume chart and intake information was not available.
  - Lower bunks were ordered on three of the patients.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team attempted to review information primarily from August and September 2008 because only four months had lapsed between the monitoring visits. It appears that several processes have been put in place which has had a positive impact on organizational issues. Patients with chronic diseases are getting to the clinic more quickly. The Monitoring Team reviewed 12 charts to assess the time between intake and Chronic Care Clinic ("CCC"). Eight of the 12 entered the facility after July 30, 2008. All eight patients were seen in CCC within 30 days of intake, and seven of these were seen in nine days or less. This is in striking contrast to the four patients who came in prior to this time, where one was never seen, two were seen in five to six weeks and one in three weeks.

There also appears to be better coordination between the staff doing health assessments and those following patients in CCC, which has decreased the duplication of services. Current management staff also related that there were plans to make additional changes to the process, which had not yet been implemented. It also appears that patients are now returning to the clinic within the timeframe requested by the provider more often than before.

The medical record continues to be a significant barrier to improvement in the continuity and quality of care because of the multiple sections for clinical care in addition to misfiling and late filing of critical documents, such as laboratory reports and information from off-site visits. At times, documents could not be located at all. Additionally, when inmates were released, charts were archived prior to placing any loose filing in the records, resulting in two bins of unfiled documents of inmates who have left the facility. There also seemed to be a problem with having the medical records available for providers at clinic visits, as there were several notations stating "seen without record."

In spite of the systemic improvements, there were still some concerns regarding the clinical care of the patients. Within the last few weeks, the providers in CCC began completing the patient history; however, there continued to be a lack of elaboration on positive findings. Patients still were not carefully assessed for accuracy of diagnosis. Diagnoses were questionable in two out of five (40%) patients identified as hypertensive and four out of six (66%) identified as having a seizure disorder. Misdiagnosis is problematic because patients will receive medications that they do not need, and the time spent on these patients takes time away from those who truly have serious chronic needs.

Disease-Specific Findings

a. Anti-Coagulation (Coumadin) Treatment:

The records of the two patients currently in the facility receiving Coumadin were reviewed.

- The first patient had weekly anti-coagulation studies ordered; however, only one subtherapeutic result from July 11, 2008 was in the record. This was not reviewed until July 25, 2008, and no action was taken.
- The second patient had monthly studies ordered, but there were only three in the chart: one from May 30, 2008, an elevated value from July 14, 2008, which was circled, but neither signed nor dated, without orders or notes reflecting that it was addressed, and a third from August 1, 2008, which was therapeutic.
- Standard of care dictates that a patient should be on weekly PT/INR checks until it is established that he or she is stable on medications, but this was not done in either case.

b. Asthma:

Five records of patients with asthma requiring a steroid inhaler were randomly selected and reviewed. Four of the five had been in the facility six months or longer.

- None of these patients required treatment for an acute asthmatic attack.
- Peak flow levels were obtained on these patients each visit; however, for the most part, it does not appear that these were used to direct treatment changes.

- For example, in spite of a decrease in peak flow from the previous visit, one patient was labeled as having good control with an improved status.
- Another patient was labeled as having good control, stable status in spite of a decrease in peak flow and an increase in inhaler use.
- There is no discussion documenting how these conclusions were reached.
- One patient who had worsening symptoms during allergy season had a steroid inhaler added with a significant reduction in symptoms and improvement in peak flow.

c. Diabetes:

The medical records of five diabetic patients currently in the facility were reviewed. All of these patients were in the facility six months or longer.

- All records had a flow sheet to track diabetic care present and completed.
- All patients were on an ACE inhibitor (lisinopril). One patient was refusing to take it, but there was no documentation that the importance of this medication and blood pressure control was discussed with the patient.
- All patients had yearly eye exams addressed, although the reports of two could not be found in the record and one patient was a month late for this year's exam.
- Blood pressures were checked at each visit and were in expected control for three of the four patients taking their medications. The one elevated reading was addressed appropriately with an increase in medications.
- All patients had lipid testing, and medications were started when appropriate.
- Four out of five patients had microalbuminuria levels checked within the last year.
- Poor control of blood sugars was not appropriately labeled or addressed.
  - In only one patient's record was there a substantive discussion that documented working with the patient in an attempt to achieve better glucose control. For the others, rather than working with these patients and seeing them more frequently, they were routinely appointed back to the clinic in two to four months with no evidence that their blood sugars were reviewed between appointments. This included three patients with HgA1c levels well out of the range of being good control.
  - In only one instance was a relatively current HgA1c level available at the time of the clinic appointment.
  - Assessment of degree of control was made with no data related that would support the assigned degree.
  - Although finger-stick glucose readings were obtained twice daily, on all but one of the patients who refused this, there was no notation on the clinic encounter that these were reviewed and no sign offs on the flowsheets.

d. HIV:

The records of five HIV positive patients were reviewed. Three of these were relatively new intakes.

- At the time of the Monitoring Team's visit, HIV positive patients were followed by an HIV-trained primary care provider with oversight by an infectious disease specialist. The primary care providers at the facility see the patients between these specialty visits and follow other chronic diseases that the patient may have.
  - For three of the five patients, there was considerable delay before they were seen by the specialists (as long as five months) and one patient who entered in July 2008 had not yet been seen at the time of the audit in September.
  - Once seen, the time between appointments seemed excessive given that the primary care providers do not deal with the HIV disease once the patient has been seen by the specialist.
  - The primary provider started two patients on HIV medications with suboptimal treatment.
- All patients had relatively current CD4 counts and Viral Loads available; however, since a lab summary of these values was used to identify the patients, one cannot assume that all HIV positive patients are having these tests followed as per standard recommendations.
  - Current values were not consistently in the record at the time of the clinic visits.
- All patients had lipid levels checked; however, elevated levels were not addressed.

e. Hypertension:

The records of five patients with a diagnosis of hypertension were reviewed. Since the degree of acceptable blood pressure control is different for diabetic patients, the records of three patients who were also diabetic were included in this audit.

- Two of the three diabetic patients were in acceptable control. The third diabetic patient was not within the acceptable range and it was noted that he was not taking his medication. There was no documentation that the seriousness of hypertension with diabetes was discussed with the patient.
- In the two patients who did not have diabetes, the diagnosis of hypertension was questionable or given the best interpretation, not fully investigated.
  - One patient was given the diagnosis of hypertension and started on medication on the basis of one elevated blood pressure reading.
  - The other patient came into the facility with a diagnosis of hypertension, and, in spite of an excellent blood pressure reading, had his medication increased resulting in a transfer to the infirmary for hypotension.

f. Seizures:

The medical records of six patients identified with a seizure disorder were reviewed. This diagnosis was questionable in four of the patients, yet medications were continued on all of these patients, including two who had documentation in the record that they did not have a seizure disorder.

- None of the patients had verification of a seizure disorder at intake.
- At intake, three patients were either given a bottom bunk or placed in the infirmary because of multiple medical problems.
- The two patients who had seizures while in the facility had the acute event treated appropriately; however, follow-up AED levels were not consistently obtained, resulting in subtherapeutic levels and recurrent seizures in one patient.
- AED levels were not drawn so that there was a contemporaneous level in the record at the time of the CCC appointment. Follow-up levels were not in the medical record and it is unclear whether these were drawn.
- The patients who had seizures in the facility were seen frequently. The four patients with a questionable diagnosis were continued on medications, but three had not been seen since July 2008, and one had not been seen at all.
- When a patient reported having had a seizure since the last visit, there was no evidence that the record was reviewed to verify this.
- There was poor continuity of care amongst providers (*i.e.* it did not appear that a provider seeing a patient for the first time reviewed the previous provider's notes).

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

Overall, control of the primary disease entity was good; however, there was not always documentation of tracking for other recommended care, such as eye examinations for diabetes, or lipid levels in hypertensive patients. Staff members at the facility were unaware that forms for this purpose existed. The exact number of patients with each disease entity is not known. Although DACS can provide a list of patients identified with a particular disease, the lists were not consistently accurate. In several records pulled for audit from these lists, the patient did not actually have the stated disease. In other cases, patients with the disease were not on the list and were found serendipitously when the Monitoring Team pulled files relating to other provisions of the MOA.

The most serious problem with the chronic disease program is access. Few patients were sent back to the clinic in the time requested by the provider. Appointments were rescheduled in the DACS system with no documentation in the record of the reason for rescheduling. Once this pattern was recognized, this was formally reviewed. Of the 13 patients tracked, two were seen in three months for their last appointment (15%); seven were seen in four months (54%); two were seen in five months (15%) and two in six months (15%) meaning nearly 85% of patients were not in compliance with the recommended standard, which is within 30 days of intake, and 90 days (or as indicated) thereafter. Since the majority of patients reviewed had been in the facility for years, tracking of time from intake until the first chronic care appointment could not be assessed. Anecdotally, it should be noted that one seizure patient who arrived on August 20, 2008, and had a chronic care visit scheduled in DACS on August 27, 2008, did not have his first visit until October 23, 2008, although he did get care and an adjustment of his medications before this time.

As noted above with regard to staffing, although the medical director and other providers are listed collectively as 2.6 FTEs, this is not the reality of the clinical coverage. The Medical Director (1 FTE) is pulled to other facilities to provide assistance in infectious disease care as well as to provide vacation coverage. NPs are also pulled to cover other sites. This problem is compounded by the fact that coverage for vacations and leave has been extremely limited, resulting in a significant backlog of chronic disease clinic appointments. Additionally, the Medical Director has had insufficient time to provide adequate supervision of the mid-level practitioners and other site physicians.

Although current laboratory results necessary to make clinical decisions were generally available when the patients were seen in clinic, the system for physician review of laboratory test results, procedure results and other offsite visits creates a delay in review of these documents. Additionally, staff was unaware of the requirement for review of these documents within 24 to 72 hours, and medical providers were not consistently notified of abnormal values or an inability to run tests.

Orders were not taken off in a timely fashion in some cases. In one instance, there was a delay of five days for an order to be taken off by a nurse, and at the time of the review seven days later, there was no evidence that the order had been carried out. Although providers addressed acute complaints at the time of the chronic care visit, the forms used for chronic disease provide little space for them to write substantial elaboration about these issues.

Disease-Specific Findings

a. Anti-coagulation

The medical records of the five patients currently in the facility who were identified as being on anti-coagulation treatment were reviewed. It should be noted that an additional two patients who were receiving anti-coagulation therapy were found subsequently in audits of other provisions of the MOA; however, these patients were not listed on the original list of patients for this treatment.

- Four out of five patients were maintained within the therapeutic range for the underlying disease entity being treated, and if values went out of this range, the medical director responded appropriately in a timely manner.
  - One patient with atrial fibrillation was seen by a new NP who did not address his anti-coagulation therapy at the time of the clinic appointment, resulting in poor follow-up and erratic control of his coagulation status.
- Three of the five patients had weekly or biweekly drawing of blood for PT and INR ordered and obtained.
  - The results of the majority of PT/INR test results were in the record, but the filing of the more recent results was not up date in two of the patients.
  - Although sign off on the laboratory results was not always timely, it appears that addressing of abnormal values by the site medical director was timely and appropriate when notified.
  - When a report from the laboratory returned stating that there was inadequate sample to run and requesting resubmission, this was not done nor was it referred to the physician. This led to a significant delay in obtaining laboratory values in patients whose medication adjustment depended on them.
  - One patient who was on long-term anti-coagulation treatment had only quarterly PT/INRs ordered, rather than monthly as per standard recommendations.
- Four of the five patients had the reason for anti-coagulation therapy listed on the problem list.
  - Anti-coagulation treatment was not listed.
  - The one patient who did not have the reason listed had relatively recently developed a DVT and a pulmonary embolus which had not been added to the problem list.
- For the most part, anti-coagulation treatment was not addressed within the context of the CCC.

b. Asthma

The medical records of five patients with asthma were reviewed.

- All were in good control as determined by their peak flow values and none had an acute attack documented.
- The section for symptoms was not completed consistently although assessment and treatment of acute problems was documented.

c. Diabetes

The medical records of five patients with diabetes were reviewed.

- Overall, control of blood glucose was good. Based on the HgA1c reports of 56 patients tested in July and August, 64% were in good control, 30% in fair control and only 5% in poor control.
  - This is in line with the 2008 NCQA guidelines, which state that to be considered as providing excellence in diabetic care, at least 40% of diabetic patients should be in good control and less than 15% should be in poor control.
- The diabetic monitoring sheet for items such as eye exams, use of ace inhibitors, etc. was not in use on any of the patients.
- One patient who was housed in the infirmary did not have his chronic disease issues specifically addressed. This was discussed with the Medical Director, who will take action.
- Four of the five patients had blood pressure recorded, with three of the four in good control.
  - The one patient that did not have his blood pressure recorded at the CCC visit had multiple good readings on previous visits and on multiple sick call visits.
  - The one patient considered in fair control had only a diastolic blood pressure slightly higher than recommended.
- Two patients had eye examinations within the last year.
- Two patients had microalbuminuria checked or ordered within the past year. One of these patients had elevated creatinine and blood urea nitrogen levels which were not addressed. The patient also had elevated levels reported about two weeks before.
- Three patients were on ACE inhibitors.
- All patients had lipids levels checked.
  - Four of the five had good levels of cholesterol.
  - The one patient whose cholesterol level was elevated was started on medication.
  - Three of the five had good levels of triglycerides.
  - One of the patients with poor control was the patient with elevated cholesterol who was started on medication.

d. HIV

The medical records of five patients with HIV disease were reviewed. One patient had co-existing Hepatitis C.

- All patients were on antiretroviral treatment and had non-detectable viral loads. Four of the five had CD4 counts greater than 500 and the remaining patient had a CD4 count of 350.
- Records indicated that the physician inquired about and addressed any symptoms that the patient was having.

- Four of the five patients were current on Influenza and pneumococcal vaccine (received or recently ordered) and three of the five had received Hepatitis vaccination including the patient with Hepatitis C co-infection.
- All patients had their lipid levels checked and four of the five had good levels.
  - The one patient with elevated levels did not have this addressed at the clinic visit.
- Patients with other chronic diseases had these addressed at the time of the visit.
  - There was one patient with an elevated thyroid stimulating hormone level from February 2008 which was never repeated nor addressed.

e. Hypertension

The records of eight patients, four with diabetes and four without, were reviewed for hypertension.

- All patients were in good control except for one diabetic patient with an elevated diastolic value, but a systolic reading within in the desired range.
  - There were two non-diabetic patients who were labeled fair control by a new NP, with elevated blood pressure readings. She proceeded to add additional medications and ordered frequent blood pressure readings. This was discussed with the Medical Director who will be retraining her.
- All patients had appropriate laboratory tests ordered and abnormalities appropriately addressed.
- Two non-diabetic patients identified as also having a risk factor of hyperlipidemia were on medications with good control of their lipids. Lipid control of the diabetic patients has been discussed previously.

f. Seizures

The medical records of four patients identified with seizures were reviewed. These were the only patients in the facility indentified with seizures whose charts were available for review.

- In all four cases, this appeared to be an accurate diagnosis. Three had had seizures while at the facility and one had seizures verified on previous intakes.
- At the time of the audit, all had been seizure free for at least six weeks.
  - In one patient who had been refusing to take his medications and subsequently had seizures, the record documents that the medical providers worked with him, convincing him to take the medications and that he had been seizure free since that time.
- Tests for AED levels were drawn, although sign-off on the test results was not always timely. Results generally were available at clinic visits.

F. Recommendations

At Baylor, the Monitoring Team recommends the following:

- An accurate tracking system for chronic care appointments should be developed. This should start at intake as discontinuity of care developed for several patients at this point.
- Physician review of the records of all patients with chronic disease identified at intake should occur on the next business day.
- This system should also assure that patients with poor disease control are seen in the timeframe ordered by the physician.
- Missed appointments and no shows should be investigated with notation in the record documenting the reason for the missed visit and the date of reappointment.
- When the NP sees a chronic disease patient for a physical, this should be documented on the chronic disease form rather than the physical form. If necessary, she should start or consult with a physician about starting medications if these were not started at intake.
- A tracking system for patients on anticoagulation treatment should be developed. The system should assure that weekly results of PT/INRs are obtained, placed in the medical record and reviewed by a provider in a timely fashion.
- Laboratory tests necessary to make clinical decisions should be drawn in a timeframe prior to the chronic care clinic that assures the results are both current and available to the provider at the clinic visit. Although there was slight improvement in this area from the last audit, more work needs to be done so that this is the rule rather than the exception.
- A system to assure all ordered laboratory results, radiology results and outside consults including emergency room visits are obtained, reviewed (with date of review and signature of reviewer noted) and filed in a timely manner.
- For some tests, this may mean documenting a telephone preliminary report in the progress notes.
- The system should also assure that critical results are immediately called to a physician with documentation in the progress notes of the interaction.
- Abnormal results requiring action should have a commentary written in the progress notes as well as actions to be taken in the orders. Patient should be seen and informed of the above as well as when any medication changes are made.
- Ongoing audits should be performed to assure that laboratory and radiology results are being filed in accordance with policy.
- The State has an excellent diabetic flow sheet to track various recommended treatments. Use of this form should be instituted at Baylor to assist in appropriately following diabetic patients for eye exams, microalbuminuria, etc.
- Patients entering with a diagnosis of seizure disorder should have clear documentation of this diagnosis.
- Patients with drug or alcohol induced seizures should not be started on AED because it is not of proven efficacy in these entities.
- Those with a history of alcohol withdrawal seizures should have this written on the problem list so that on re-incarceration prompt evaluation for current risk can be assessed and withdrawal treatment started prophylactically if there is a recent drinking history.

At JTVCC, the Monitoring Team recommends the following:

- All clinic staff should be educated to the use of the problem list and have the ability to add information to it.
- Training of nursing staff to lab values, vital signs and other signs and symptoms requiring immediate physician notification should occur. A list of entities requiring immediate notification should be posted in nursing stations and other designated areas so as to provide ready reference.
- Education of providers to degree of control of various chronic diseases should occur and a chart listing these criteria should be posted in the exam rooms.
- There should be clear delineation of the roles of the primary care providers and the HIV consulting physician.
- Personnel other than the chronic care nurse should be responsible for taking off orders. The chronic care nurse should be charged with clinic oversight. A clear list of expected duties for this oversight should be developed jointly with nursing and provider staff.
- As many patients have well-controlled uncomplicated chronic diseases, an alternative method of appropriately following these patients should be developed so that physicians have adequate time to appropriately follow the sickest and most complicated patients as well as to perform other expected duties (*i.e.* reviewing encounters of mid-level providers, incoming labs, etc.).
- Patients, who after an evaluation do not have the chronic disease initially claimed or whose disease status has changed, should be discharged from the clinic.
- If the above two recommendations cannot be accomplished, consideration should be given to hiring a second full-time physician.
- Use of the existing provider flow sheets for diabetic patients should be implemented.
- Accurate logs of patients with various chronic diseases should be maintained.
- A system for medication renewal should be developed.
- A system should be developed to assure that patients transferred between units are not lost to follow-up. This might include a transfer of care form containing a review of records of all patients transferred between General Population and Special Management by the chronic care nurse in each area to assure that the patient is placed in CCC in the appropriate time frame at the new location. The laboratory results in each record should be reviewed to assure that ordered labs have been obtained and are present in the record. Action should be taken on those whose laboratory data is not current.

At HRYCI, the Monitoring Team makes the following recommendations:

- Since the new Medical Director is new, the Regional Medical Director should review performance with individual providers (perhaps with the Medical Director present) and set expectations for patient care. Subsequent audits of performance should occur with regular feedback by either the facility or Regional Medical Director. This was discussed with both the Facility and Regional Medical Directors.
- Providers should be assigned a panel of patients and see these patients for all their needs unless an urgent event occurs when that provider is unavailable.

- All clinical encounters should be in chronological order rather than in separate sections by the type of encounter.
- A procedure should be developed for coordination between drawing, obtaining and filing of results of laboratory data necessary to make clinical decisions with the CCC appointment. Staff should be trained to this procedure and ongoing compliance audits performed to assure that providers have the necessary information to treat patients appropriately.
- Appointments for HIV positive patients to the Infectious Disease specialists should be expedited.
- A procedure to verify seizures disorders at intake should be developed and staff trained to the procedures. This should include what additional actions to be taken for these patients at intake such as ordering a lower bunk, drawing of AED levels, etc.

At SCI, the Monitoring Team recommends the following:

- The SCI Medical Director and other providers should remain exclusively at the site. Vacation coverage for him as well as other providers at this site and others should be accomplished by having an adequate number of PRN physicians or mid-level providers available. Assistance with HIV care at other sites should be by an infectious disease specialist.
- The Medical Director should provide oversight and training of the other physicians and the NPs. This has been discussed with him and he plans to do so.
- A new system for sign off of laboratory values, procedure results and off-site visits should be developed to assure documented review in 24-72 hours.
- Training of all medical staff to customary standards should occur.
- A nurse run anti-coagulation clinic with physician oversight should be developed. There should be protocols approved and/or developed by the Medical Director for this clinic.
- Consider expanding the chronic disease forms so that there is additional space to elaborate on patient complaints. Encourage providers to address all sections on the forms.
- Especially for diabetes, use of a form which tracks recommended tests and treatments should be used. This was discussed with the Medical Director who was unaware such a form existed. The Regional Director stated that these would be brought to SCI.

23. Immunizations

A. Relevant MOA Provision

Paragraph 23 of the MOA provides:

The State shall make reasonable efforts to obtain immunization records for all juveniles[96] who are detained at the Facilities for more than one (1) month. The

[96] The term "juveniles" means "individuals detained at a facility who are under the age of eighteen (18)." *See* MOA II.H.

> State shall ensure that medical staff members update immunizations for such juveniles in accordance with nationally recognized guidelines and state school admission requirements. The physicians who determine that the vaccination of a juvenile or adult inmate is medically inappropriate shall properly record such determination in the inmate's medical record. The State shall develop policies and procedures to ensure that inmates for whom Influenza, pneumonia and Hepatitis A and B vaccines are medically indicated are offered these vaccines.

This provision of the MOA requires that the State make reasonable efforts to obtain immunization records for all juveniles who are detained at the Facilities for more than one month. This requirement means that the State will need a system to track which juveniles have been detained for more than one month. Although there are no official guidelines available to determine what reasonable efforts would be under these circumstances, the Monitoring Team believes that reasonable efforts would consist of an attempt to acquire the juvenile's school records, and records from any health care providers in the community that have provided care to the juvenile that the State is able to identify after asking the juvenile. The MOA further requires that, for juveniles, the State ensure that medical staff members update immunizations for such juveniles in accordance with nationally recognized guidelines and state school admission requirements. Those guidelines and admission requirements were attached to the Second Report as Appendix III.

This provision of the MOA also requires that the State develop procedures to ensure that inmates for whom Influenza, pneumonia and Hepatitis A and B vaccines are medically indicated are offered these vaccines. For example, Influenza vaccine is recommended to be administered in adults aged 50 and older unless there is evidence of immunity or prior vaccination. *See* http://www.cdc.gov/mmwr/pdf/wk/mm5641-Immunization.pdf. Further, if a physician determines that vaccination of a juvenile or adult inmate is medically inappropriate, the physician shall properly record such determination in the inmate's medical record. An example of when a vaccination might be medically inappropriate is in the case of a pregnant female and a vaccination that has not been deemed safe for pregnant females to have.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team reviewed immunization status in connection with its review of chronic disease care. Documentation was based on entries in the designated portion of the flow sheet at the front of the chart. It is possible that additional patients received these vaccinations, but this was not documented in the appropriate way. Out of the files reviewed, the immunization rate was as follows:

- Influenza vaccination rate 53% (nine out of 17)
- Pneumovax rate 59% (10 out of 17)

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

All of the records of patients on anti-coagulation treatment and those with asthma, diabetes and HIV were reviewed for having received Pneumovax, and, if HCV positive, for vaccination for Hepatitis A and B. As vaccination for Influenza has just started for the current Influenza season, meaningful statistics on Influenza vaccination could not be obtained, although it was noted that ordering and administration of this vaccine had begun.

Documentation of vaccination was recorded on a flow sheet in the record; however, it is not known if other methods of documentation were used, but not captured on the flow sheet. Additionally, in patients whose charts spanned several volumes, it is not known if all flow sheets that contained the information were carried forward.

- Pneumovax
  - In General Population, nine out of 18 patients for whom it was indicated had received the vaccine within the past five years (50%).
  - In MSB, eight out of 17 patients for whom it was indicated had received the vaccine within the past five years (47%).
- Hepatitis A and B vaccination
  - In General Population, three out of four patients who had Hepatitis C infection (75%) received the vaccination. Two out of three of these patients had HIV co-infection.
  - In MSB, one out of two who had Hepatitis C infection (50%) received the vaccination. Both of these patients had HIV co-infection.
  - In neither group did HIV positive patients without HCV co-infection receive the vaccination.
  - It should be noted that these numbers are small such that statistical certainty cannot be determined, but trends can be noted.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed 10 charts of juveniles in order to determine whether they were processed appropriately and whether their immunization status was responded to appropriately.[97] All of the charts indicated that the patients did have their immunization status assessed utilizing the state Department of Health database.

Because of the timing of the audit, assessment of Influenza vaccination was limited to those patients who had been in the facility during the previous Influenza season. Of 10 patients who fit this criteria, five (50%) had received the vaccination. Of the 17 patients who met criteria for Pneumovax, 11 (65%) had received it; however, four of the six who did not receive it had only been in the facility a short period of time. If these individuals are eliminated from the statistics, the compliance rate increases to 85%. The one patient in the facility for a time period adequate to assess the need to receive Hepatitis immunization had received it. It is due to the findings with regard to these patients that HRYCI is found to be in partial compliance with this provision of the MOA.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The majority of records reviewed were of chronic care patients who had been in SCI a considerable period of time and many had records consisting of multiple volumes. For vaccinations that are not given yearly, it is not known whether there was vaccination documentation in previous volumes which was not brought forward to the latest volume.

- Influenza
  - This was considered as given if the patient received it in last year's cycle or the recently begun cycle for this year.
  - Twelve out of 18 for whom it was appropriate had received Influenza vaccine (67%).
  - For the current season's Influenza vaccine administration, logs of patients to receive the vaccine were created.
    - It is uncertain if some of the documentation was on the logs, but not transcribed into the record.

[97] The Monitoring Team notes that, of the 10 charts reviewed, five had been performed by LPNs, and lacked the required countersignature. In fact, two of the 10 lacked a physical exam within the required time frame. One of the 10 charts lacked TB testing.

    - It was also learned that the nurse in charge was unaware that she needed to obtain a refusal for those patients who declined the vaccine.
- Pneumococcal Vaccine
  - This vaccine is recommended every five years. Many of the records reviewed did not go back this length of time.
  - For five out of 18 for whom it was appropriate, there was documentation in the record that they had received Pneumovax (28%).
- Hepatitis
  - Four out of six patients for whom Hepatitis vaccination would be considered critical received this vaccination (66%).

F. Recommendations

At Baylor, the Monitoring Team makes the following recommendations:

- Assure that all documentation is on the problem list.
- Develop a system to improve immunization rates.
- The State should conduct a nursing in-service regarding the use of the infirmary log and should stress the importance of accurate documentation.
- Staff should begin writing daily progress notes on patients in the infirmary for acute problems.
- Use of the previously developed infirmary forms should be reinstituted with education of all staff including providers. Staff should be educated to the use of these forms and all expected infirmary documentation.
- When a patient leaves the infirmary and is admitted to the hospital, this should be documented in the progress notes. If the patient stays more than overnight, there should be regular updates on the patient's status in the progress notes.

At JTVCC, the Monitoring Team recommends the following:

- A standardized system for tracking and administering immunizations should be developed.
- As many of the patients at this facility are in for long periods of time, a method of documenting that spans longer periods would be desirable.

At HRYCI, the Monitoring Team recommends the following:

- Insure that RNs are countersigning all screens performed by LPNs.
- Monitor the process for the juveniles to insure that the physical exam is performed timely.

- Continue to receive the report from the state regarding whether or not patients are up to date for their immunizations and use that to insure necessary vaccines are ordered at the time of the intake physical exam.

At SCI, the Monitoring Team makes the following recommendations:

- For patients with significant stays in the facility, it may be useful to develop a vaccination tracking system that allows continuity over a lifetime as the current form only allows a limited number of vaccines to be recorded. This should include inquiry as to whether the patients had received any of these vaccinations outside the facility;
- Efforts should be made to assess the need for Pneumovax and Hepatitis vaccination in all patients for whom it is appropriate. Patients identified above should have these vaccines administered. A process for readily accessible documentation should be developed;
- The nurse with oversight of vaccinations should be trained to the federal regulations for vaccine administration including the educational materials that must be given to the patient, releases necessary to be obtained and proper vaccine documentation. She should assure that all persons who administer vaccines comply with these regulations.

MEDICATION

24. Medication Administration

A. Relevant MOA Provision

Paragraph 24 of the MOA provides:

> The State shall ensure that all medications, including psychotropic medications, are prescribed appropriately and administered in a timely manner to adequately address the serious medical and mental health needs of inmates. The State shall ensure that inmates who are prescribed medications for chronic illnesses that are not used on a routine schedule, including inhalers for the treatment of asthma, have access to those medications as medically appropriate. The State shall develop and implement adequate policies and procedures for medication administration and adherence. The State shall ensure that the prescribing practitioner is notified if a patient misses a medication dose on three consecutive days, and shall document that notice. The State's formulary shall not unduly restrict medications. The State shall review its medication administration policies and procedures and make any appropriate revisions. The State shall ensure that medication administration records ("MARs") are appropriately completed and maintained in each inmate's medical record.

Medications are appropriately prescribed if they are prescribed upon the order of a physician, dentist, or other legally authorized individual, and only when clinically indicated. J-D-02; P-D-02. Administration of medications should be done in a manner that complies with federal and State of Delaware laws. J-D-01; P-D-01. The NCCHC recommends that institutions maintain a self-medication or KOP program,[98] which permits inmates to carry medications necessary for the emergency management of a condition as appropriate. J-D-01; P-D-01.

This provision of the MOA further requires that the State develop and implement policies and procedures for medication administration and adherence. Also, the State shall review its medication administration policies and procedures and make any appropriate revisions. The Monitoring Team finds that the State has adopted appropriate policies. *See* State Policy D-02**.**

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

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[98] "Self-medication programs" are programs which "permit responsible inmates to carry and administer their own medications." J-D-02; P-D-02.

2. Findings

The Monitoring Team evaluated compliance with medication administration by reviewing the order transcription process, assessing medication administration procedures, observing nurses prepare medications, and reviewing MARs.

The Monitoring Team observed a nurse administering medications to 5 to 10 inmates. In general, the nurse was very professional and followed proper nursing procedures for administering medications. The Monitoring Team did observe, however, that the nurse did not consistently have the inmate show proper identification.

Medication administration is performed three times daily 0900, 1300 and 2100 hours. The morning medication pass, which lasts from approximately 0730 (for kitchen workers) to 1100 hours,[99] does not meet standard nursing practice to administer medication within one hour (before or after) a designated time. Medications administered from 0800 to 1000 would be in compliance with a 0900 medication administration. The evening medication pass lasts from 1900 to 2200 hours. These extended time frames result from the combination of volume and down time for counts.

The Monitoring Team reviewed 10 records of patients with chronic illnesses to review the timeliness and accuracy of both order transcription and medication delivery during the period of May to August 2008. As noted above in the discussion of paragraph 4, the nursing component of order transcription continues to be problematic. With respect to order transcription, only four of 10 orders were transcribed the day the order was written. Five of nine orders were transcribed two to four days later, and, in one of nine records, the nurse did not date or time order transcription.

The Monitoring Team had difficulty evaluating the accuracy of transcription and timeliness of medication delivery because, in 5 of 10 records reviewed, the MARs were not filed in the record. Of the remaining five records, in three of five, the MARs showed that medications were started within 48 hours of the order being written. One of the remaining two records reflected that the patient's medication was started four days later, and one was started 12 days later (a non-formulary medication).

Even when nurses transcribed medication orders in a timely manner, new medication orders were not faxed to the pharmacy in a timely manner on a consistent basis. The Monitoring Team found that a form used to notify Pharmacor of new medication orders dated August 11, 2008, showed two medication orders from July 28, 2008, almost two weeks old. Another form dated August 19, 2008, showed two new medication orders dated July 21, 2008, almost four weeks old. A third form dated August 19, 2008, showed two orders dated August 15 and 16, respectively.

[99] There is a 1000 inmate count during medication administration.

Another significant concern that arose during the Monitoring Team's review is the use of multiple 'Post-it' notes on MARs advising nurses to fill the administration status for dates earlier in August. One MAR book contained 21 'Post-it' notes advising nurses either to fill in administration status for blank dates or to perform noncompliance notification. Nursing documentation of medication doses weeks later raises serious questions regarding the validity and accuracy of the MAR and should not be done. Nurses should document the administration or refusal of medications at the time it occurs. At the conclusion of medication administration, nurses should investigate and document the status of patients who did not appear at medication pass to receive their medication (*i.e.* a "no show"). Blank entries on the MAR should be treated as a medication error of omission and an incident report written.

In five of five records of patients who missed their psychotropic medications for three consecutive days, there was no documentation in the record that the mental health provider was notified.

The Monitoring Team was informed that implementation of the medication noncompliance process had occurred, but there have not been any CQI studies performed relevant to this issues. Staff members reported receiving very few referrals regarding medication noncompliance issues and mental health staff reported to have assessed inmates who were refusing psychotropic medications.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in not in compliance with this provision of the MOA.

2. Findings

Medication administration is problematic. In the main compound, medication administration takes place over a 24 hour period and nurses did not adhere to standard nursing practice with respect to administering medications.

Changes have been made to the medication administration process in the main compound so that there are now three medication passes at 0400, 1600, and 2100. Three LPNs are dedicated to each medication pass. According to the HSA, this has enabled staff to complete each medication administration process within 60-75 minutes. The Monitoring Team was advised that this was accomplished without hiring additional staff members.

In the Supermax Housing Unit ("SHU") and the Maximum Housing Unit ("MHU") medication times have been changed to match the main compound. An LPN is assigned to each unit, and progresses through each building until medications have been delivered. However, the Monitoring Team's review showed that the process in each unit takes two to three hours, rather than the 60-75 minutes in the main compound. This does not include

the time the nurse spends to pre-pour medication. Therefore, it is likely that additional staff is needed in order to complete medication administration in a timely manner.

The Monitoring Team also found that nurses still do not adhere to standard nursing practice. For example, the nurse who pours narcotics is not the same nurse who administers the dose to the patient. The Monitoring Team observed a nurse pour narcotics from pharmacy-dispensed blister packs into improperly labeled envelopes, document this in the narcotic log, and then give the envelopes to other nurses who were administering medications in the housing units. Thus, the nurse who gave the medication did not personally pour the medication. This is not consistent with generally accepted medication administration standards.

With respect to non-controlled medications, the Monitoring Team observed nurses pre-pour medications from properly-labeled blister packs into improperly labeled envelopes using the MAR. The medication envelopes were packed in canvas bags and taken to the various buildings for administration. The MAR books remained on the medication carts in the medication room. The nurses indicated the MARs would be signed when they returned from the other buildings. The nurses indicated that they would know which medications were given because the envelopes would be empty. Nurses should document administration (or refusal) of medications at the time the medication is actually administered. This could be accomplished by transporting the MARs with the nurse, having the inmates come to the main compound window, or having medication rooms established in other locations in the facility.

The Monitoring Team observed a nurse administer medication to 21 inmates from the main compound medication window. The nurse did not document medication administration at the time of administration. The use of one stock medication was not documented because the nurse could not find the log book in which to document this. The other two nurses did not know where this book was either. It took the nurse 45 minutes to pour the medications, and another hour to pass the medications. The nurse indicated that medication administration had to be completed by a certain time so meals could be served by a certain time.

In the SHU, the Monitoring Team also noted problems with medication administration. A nurse pre-pours medications in the morning for the 1600 medication pass. The nurse punches medications from pharmacy-dispensed blister packs into improperly labeled cups or envelopes that are placed in a tray on top of the medication cart. The nurse documents administration of the medication at the time the nurse pours the medication and not as the nurse administers the medication to the inmate. This is not in accordance with standard nursing practice. The nurse and security staff indicated the medications were poured early to save time in the afternoon.

The Monitoring Team observed the medication administration process. At the designated time, the nurse, accompanied by the correctional officer, went from cell to cell to administer medications. The nurse sometimes identified inmates by name and other times not at all. There was no inmate ID on the cell door. Security staff indicated that inmate identification cards are collected and kept in the control room when an inmate is admitted to the SHU. The nurse indicated she visually identified the inmates. No oral cavity checks were performed by the nurse or correctional officer. As noted above, the nurse documents administration on the MAR

with her initials at the time of the medication pour in the morning. If the inmate refuses a medication at the actual administration between 4:00 to 5:00 p.m., the nurse added a circled R to her initials on the MAR when she returned to the medication room.

Documenting administration of medications in advance of doing so is not in accordance with standard nursing practice, and raises questions regarding the credibility of the MAR. For example, during a tour of the Special Needs Unit (SNU) in the MHU, which houses inmates with mental health disorders, the Sergeant in charge of the unit told us about each inmate, including those refusing their medications. The Monitoring Team then reviewed the MARs to identify inmates who might need noncompliance counseling. However, with a single exception, the MARs showed that none of the patients were refusing their medications. This was not consistent with the information provided by a very knowledgeable staff member. Although not conclusive, the Monitoring Team recommended that the health care leadership investigate this further to determine whether inmates were in fact refusing medications.

Narcotic medications are double locked in the SHU clinic office; one medication card in a sample of six revealed a shortage of one pill.

The Monitoring Team was informed at the time of its December 2008 visit that a recent CMS audit had highlighted a variety of medication management issues at the facility. This audit resulted in a recent site visit by Pharmacor to help train and formulate remedies, but it was too soon to assess whether these remedies would be helpful.

Specific problems identified by the audit and through the Monitoring Team's discussions with staff include nursing staff not generating noncompliance referrals to mental health, psychiatrists not receiving contemporaneous copies of MARs, and one case where psychiatrists were not addressing noncompliance issues when the filed prior months records indicated consistent refusal of doses.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated compliance with medication administration by observing nurses prepare and administer medications and by reviewing health records, including the MARs.

The Monitoring Team observed two nurses administer medications to 20 inmates on the east and west sides. Nurses administering medications conformed to accepted nursing practice. With respect to oral cavity checks, nurses met policy and procedure requirements for nine of 20 patients.

However, medications are not consistently administered in a timely manner (*i.e.* one hour before or after the designated time on the MAR). The designated time for administering morning medications is 8:00 a.m. During the Monitoring Team's visit, medication administration was started late due to a staff meeting and an institutional incident. As a result, some of the medications still were being given between 10:00 and 11:00 a.m. Failing to adhere to designated administration times not only is inaccurate with respect to medical record documentation, but also presents a risk of insufficient time between dosing and may increase medication side effects.

The Monitoring Team was informed that nursing staff had implemented a new medication refusal form on the back of MARs, which makes the nursing follow-up more timely. This form makes it easier to identify inmates who are non-adherent with medications, which then facilitates appropriate nursing follow-up. Additionally, the DON at HRYCI reviews all intakes in order to attempt to provide timelier follow-up.

Regarding the medication renewal process, the psychiatrists now do the ordering and reordering on a new medication form and refill order form as part of a recently implemented corrective action plan. It is too soon to assess the effectiveness of this process.

Nursing staff reported to the Monitoring Team that HS medications[100] are being administered after 8:00 p.m. However, information obtained from inmates and a review of custody logs revealed that HS medication pass is beginning between 5:00 and 6:30 p.m. for the general population and 4:30 in the special needs unit.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

There continue to be significant problems with the medication administration processes resulting in patients not receiving medications in a timely manner. The Monitoring Team found frequent delays in transcription of medication orders (*see* discussion of paragraph 4 of the MOA). In addition, in the Monitoring Team's previous report, problems with violations of nursing practice were identified with respect to medication administration, and no significant changes have been made to this process.

The Monitoring Team observed an LPN administering medications to inmates in

[100] HS meds are those which are prescribed to be administered during the evening hours.

the MSB dining hall and segregation. The nurse did not consistently identify inmates by requiring an ID badge or asking the inmate to state his full name. The nurse had pre-poured the medications into envelopes that were not properly labeled with the full inmate name and medication information. The MARs were not available to document administration at the time she gave the medication. In segregation, the nurse poured the medication from the envelope into the inmate's hand and one of several pills fell onto the floor. These practices are not in conformance with nursing practice.

As reported in previous visits, MSB nursing staff are required to deliver medications to the housing units for the morning and evening medication administration pass, although most of these inmates come to the medical unit during the mid-day medication passes. The requirement to deliver medications to the housing units was reportedly to avoid inmate movement during darkness. However, the preparation for this decentralized approach has resulted in nurses violating standard nursing practices as described above. This includes pre-pouring medication, transferring medications from properly labeled containers into improperly labeled envelopes. The nurses also document medication administration in advance of doing so. The nurses' stated intent has been to return to the health care unit after medication rounds to reconcile the MAR and document medication refusals or medications not given. However, circumstances may result in this not occurring and the practice of prior documentation of medications raises serious questions about the credibility of the MARs. Nurses should document medications (or any action) only after they have been implemented. The Monitoring Team understands that the State is exploring the centralization of medication administration, which would facilitate nurses administering medications in accordance with standard nursing practices.

The practice of pre-pouring medications also results in controlled substances not being securely maintained until they are administered. As noted in the Monitoring Team's previous visit, when the Monitoring Team inspected the medication room, it found a controlled substance (Vicodin) in a medication cup labeled with an inmate's name unsecured on the counter.

Review of the MARs showed that they were neat and legible. However, only one of nine MARs showed that nurses documented administration status for every dose.

The Monitoring Team learned that asthma patients in segregation or isolation were not permitted to keep short-acting (rescue) inhalers on their person. This presents a risk that inmates will not receive their medications in a timely manner, which could exacerbate their condition.

In the Third Report, the Monitoring Team expressed serious concerns about the large number of notations in records that medications were noted as being out of stock. During its October 2008 visit, the Monitoring Team was informed by staff at the facility that the out of stock issues had decreased. The Monitoring Team did not observe any out of stock notations in its review of MARs.

Additionally, the definition of medication noncompliance at SCI was reported to

be broadened, and now was defined as three or more missed dosages of a medication during a month period of time. The nursing staff was using a noncompliance form similar to that used at HRYCI. The Monitoring Team's review of charts indicated that medication noncompliance was being identified by nursing staff, however, mental health referrals were not always initiated as a result of medication noncompliance.

F. Recommendations

The Monitoring Team recommends that health care leadership ensure that orders are transcribed in a timely manner. The medication administration process should be centralized to facilitate nurses administering medications in accordance with standard nursing practice. Nurses should follow standard nursing procedures with respect to administering medications. This includes administering medications from properly labeled containers, pouring medications for administration immediately prior to administration, properly identifying the patient at the time the medication is give, and documenting medications onto the MAR at the time they are administered. Inmates in segregation should be permitted to self-carry inhalers.

At HRYCI, the Monitoring Team recommends:

- Health care leadership should ensure that medication administration is consistently given at the same time each day and within the timelines for acceptable nursing practice (i.e. medications are given one hour before or after a designated time).
- Oral cavity checks should be performed in accordance with policy requirements. Typically this is a joint nursing/custody function in which the nurse administers the medication and either the nurse or officer uses a penlight to check the oral cavity.

25. Continuity of Medication

A. Relevant MOA Provision

Paragraph 25 of the MOA provides:

> The State shall ensure that arriving inmates who report that they have been prescribed medications shall receive the same or comparable medication as soon as is reasonably possible, unless a medical professional determines such medication is inconsistent with generally accepted professional standards. If the inmate's reported medication is ordered discontinued or changed by a medical professional, a medical professional shall conduct a face-to-face evaluation of the inmate as medically appropriate.

This provision of the MOA is meant to ensure continuity of care from the entry of an inmate into a facility. J-E-12; P-E-12. Further, this provision can assist with preventing adverse patient outcomes, which are more likely to happen with respect to medication services practices when a provider frequently changes orders, the provider fails to review patient

medication histories, or treating staff are unaware of each other's prescribing behaviors. J-D-02; P-D-02.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated this provision by reviewing health records of inmates who were prescribed chronic or psychotropic medications, and the system for reordering chronic medications.

The Monitoring Team found continued problems with medication continuity. The problem appears to be multi-faceted, beginning with the patient's arrival at the facility. The Monitoring Team's review of intrasystem transfers showed that of four patients who were taking essential medications[101] upon arrival, none were continued in a timely manner. A review of chronic disease management records showed that three of 10 (30%) patients were not seen within 30 days of arrival and medications were not continued until this clinic visit. Although the DACS scheduling system is to automatically schedule patients for a chronic disease appointment in a timely manner, a random review of 10 records showed that none of the patients were seen on the day they were scheduled with a range of two to five weeks later. The Monitoring Team reviewed a chronic disease patient's record, which showed that her medications were ordered on January 16, 2008, for 120 days, but were not renewed until June 11, 2008, and the patient's June MAR shows that she did not receive her medication until June 14, 2008, a lapse of almost a month.

These findings are consistent with verbal feedback from a group of 8 long-term[102] inmates with chronic diseases, most of whom complained of problems with medication continuity. One diabetic patient reported that she had run out of her diabetes medication two months in a row, and had not had any since the previous Sunday. Medication order forms show lapses of two to four weeks from the time the medication was ordered until it is faxed to the pharmacy for filling.

With respect to mental health services, the Monitoring Team noted an improvement with respect to bridging orders, but there are still problems evident with the continuity of medications for inmates. The Monitoring Team reviewed the charts of seven inmates and found delays in obtaining bridging orders in three of those charts.

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[101] Mental health, antibiotics or chronic disease such as antihypertensive medications.

[102] Range of incarceration was from two to 17 years.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is not in compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated this provision by reviewing health records of inmates who were prescribed psychotropic medications or medications to treat chronic diseases. The records were randomly obtained from: (a) inmates who were newly arrived or transferred into the facility; (b) chronic disease rosters; and (c) sick call.

The Monitoring Team's review of the records showed that for newly arriving inmates, 5 of 20 patients who came in with chronic problems did not receive medications within 48 hours. Thus, 20% did not receive their medications within 48 hours. With respect to continuity of chronic disease medications, the Monitoring Team noted that medications were not always ordered before a prescription lapsed; however, it appeared from review of the MARs that, in most instances, medications for chronic diseases continued. This raises a question as to whether medications are continued without a valid order. Moreover, there was documentation in several records that the patient stated his medications had run out with a resultant deterioration of disease control. In essence, the current systems in place to assure continuity of both appointments and medications were not effective.

In a review of medication continuity for records of inmates with medication orders and medication-related health services requests, 8 of 13 showed discontinuity of chronic disease medications. Included in this sample were several HIV patients who were overdue for an appointment with the doctor as well as other patients with chronic diseases who were overdue for their scheduled appointments.

Regarding mental health medication continuity, the Monitoring Team found no significant changes with respect to this provision. A recent DOC audit suggested that bridging orders are not requested consistently, and there is a lag in their initiation beyond the appropriate timeframes.

Based on the Monitoring Team's review of 23 cases, three men admitted to JTVCC within the last six months had significant problems receiving bridging medications. For example, one man arrived from a psychiatric hospital with active prescriptions that were bridged, but medication was not administered until one week later. This is an unacceptable delay in continuity of care. Another inmate was referred to psychiatry because of a history of psychotropic medication but was not seen until he put in a sick call request a month later. A third man had a 30-day delay before mental health assessed his referral when his medications were not verified. These cases highlight significant problems in the intake system and thus far, the State and the vendor have not substantially demonstrated that the intake process is working reliably.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated this provision by reviewing health records of inmates who were prescribed chronic or psychotropic medications to determine continuity of medications. The records were randomly obtained from: a) inmates who were newly arrived or transferred into the facility; b) chronic disease rosters; and c) sick call.

The Monitoring Team found continued problems with continuity of mediations. For newly arriving patients, there may be delays in the initial renewal of medications due to lack of referral to a provider, or delays in transcription of medication orders with subsequent delays in delivery of medications. For example, a chronic disease patient arrived on medications for his chronic disease and mental health. Although an order was written to renew his medications upon his arrival, the order was not transcribed for two days, and he did not receive his medications for four days after his arrival. Another patient arrived and a clinician ordered a medication, which, according to the MAR, he had not received at the time of the Monitoring Team's review eight days later.

In other cases, patients with chronic diseases may arrive without having recently taken their medication but are not evaluated in a timely manner to assess their condition and the appropriateness of renewing their previous regimens. For example, in July 2008 a patient arrived who reported having a chronic disorder, and told the nurse that he had taken medications before, but had not had any in three months. The nurse placed the patient in the infirmary for evaluation by the physician the following day. The physician saw the patient, but did not address the patient's reported disorder. The patient did not receive a history and physical within seven days, and was not seen in the chronic care program until approximately two months after his intake, when his medications were ordered.

In another case, a diabetic and hypertensive patient arrived and told the nurse that he took insulin for his diabetes, but had not had any in the past 30 days. The nurse did not obtain a finger stick blood sugar test to assess the status of his diabetes. The nurse did not refer him to a clinician upon arrival, and DACS automatically scheduled him for a chronic disease visit one week later. Thus, he was not evaluated for chronic disease control and medications for a week after his arrival, even though an intervention at the time of intake would have been appropriate.

With respect to mental health services, the Monitoring Team was informed by staff at HRYCI that newly-arrived inmates are screened by nursing staff within two hours of their arrival. Inmates who are on psychotropic medications that can be verified are to be bridged

by the on-call psychiatrist. For inmates who arrive at night, the on-call psychiatrist is contacted the following morning.

A June 2008 CQI study indicated that bridging of psychotropic medications at intake is not occurring routinely and that training is required to address this issue. This audit revealed that bridging medication orders for verified medications were obtained less than half of the time. The Monitoring Team spoke with inmates who also reported problems with bridging orders and untimely renewal of medications.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

Continuity of medications is evaluated by determining whether patients who are on chronic medications for medical or mental health reasons have their medications continued without interruption. The Monitoring Team found that delays in initiating medications for newly arrived patients, delays in transcription of medication orders, and delays in chronic disease follow-up visits all contribute to discontinuity of medications. For example, an inmate arrived in June 2008 with a history of chronic disease. He was taking two medications prior to his arrival but this was not identified at intake. It was not until he was seen in chronic disease clinic in August 2008 that his medications were restarted for a 10-day period. He was lost to follow-up however and his medications were not restarted again until late October 2008.

In addition, review of medication administration records showed that in only one of nine MARs was the administration status recorded for each dose of medication.

The Monitoring Team reviewed audits conducted by CMS and the State relevant to bridging orders. These audits revealed significant problems with bridging orders, including the fact that bridging orders were frequently not obtained. However, the methodology of these audits was problematic which meant that the extent of the problems or the cause of the problem are not clear. Specifically, the methodology was problematic because the sample size was small, the selection process was unclear and not necessarily representative.

The Monitoring Team was unable to conduct an independent review of bridging orders, because the facility does not maintain a log of inmates entering the facility claiming to be on medications.

Additionally, inmates had been experiencing significant delays in receiving medications that were prescribed to them via the telepsychiatry process. These delays were due to delays in receiving the faxed orders.

3. Recommendations

At all Facilities, the Monitoring Team recommends that health care leadership review systems to ensure that the following takes place:

- Nurses schedule patients with chronic diseases in accordance with clinician ordered follow-up visits, and patients are seen as scheduled;
- Clinicians renew or change their medications in accordance with disease control;
- Nurses transcribe orders in a timely manner and fax the order to Pharmacor;
- The pharmacy dispenses and ships the medications in a timely manner; and
- Nurses administer the medications from the stock supply until the patient's medications arrive from Pharmacor.

These same principles apply to continuity of medications for newly arriving or transferring inmates, and mental health patients.

26. Medication Management

A. Relevant MOA Provision

Paragraph 26 of the MOA provides:

> The State shall develop and implement guidelines and controls regarding the access to, and storage of, medication as well as the safe and appropriate disposal of medication and medical waste.

According to the NCCHC, the guidelines and controls developed by the State should include the following components:

- The facility complies with all applicable state and federal regulations with regard to prescribing, dispensing, administering, and procuring pharmaceuticals;

- The facility maintains a formulary for providers;

- The facility maintains procedures for the timely procurement, dispensing, distribution, accounting, and disposal of pharmaceuticals;

- The facility maintains records as necessary to ensure adequate control of and accountability for all medications;

- The facility maintains maximum security storage of, and accountability by use for, Drug Enforcement Agency ("DEA")-controlled substances;

- The facility has an adequate method for notifying the responsible practitioner of the impending expiration of a drug order, so that the practitioner can determine whether the drug administration is to be continued or altered;

- Medications are kept under the control of appropriate staff members;

- Inmates do not prepare, dispense, or administer medication except for self-medication programs approved by the facility administrator and responsible physician (*e.g.*, "keep-on-person" programs). Inmates are permitted to carry medications necessary for the emergency management of a condition when ordered by a clinician;

- Drug storage and medication areas are devoid of outdated, discontinued, or recalled medications;

- Where there is no staff pharmacist, a consulting pharmacist is used for documented inspections and consultation on a regular basis, not less than quarterly;

- All medications are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Antiseptics, other medications for external use, and disinfectants are stored separately for internal and injectable medications. Medications requiring special storage for stability (*e.g.*, medications that need refrigeration are so stored);

- An adequate and proper supply of antidotes and other emergency medications, and related information (including posting of the poison control telephone number in areas where overdoses or toxicological emergencies are likely) are readily available to the staff.

J-D-01; P-D-01.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team evaluated this provision by inspecting the medication room and assessing access to, storage of, and safe and appropriate disposal of medication and medication waste.

The Monitoring Team found that the pharmacy/medication room is small and cramped, but cleaner and more organized since the Monitoring Team's last visit. The cabinets are still in disrepair with missing cabinet doors and drawers with broken locks, however. The

medication room has a valid DEA license, which expires in 2009.

As reported in the Third Report, the Monitoring Team found that there is no accountability system for stock (versus patient-specific) prescription medications. This lack of accountability is problematic because of the potential for drug diversion, or the administration of medications without a valid order.

With respect to narcotic accountability, the Monitoring Team randomly selected seven narcotics blister packs, and compared the amount remaining in the blister pack with the amount recorded in the narcotic book. The Monitoring Team found that five out of seven counts were accurate. The nurse had administered narcotics to two patients that morning and had not yet signed out the medications. Staff corrected this discrepancy during the same shift.

The Monitoring Team also found a discrepancy with the needle and syringe counts,[103] but staff later reported that they were able to account for the syringes. The Monitoring Team believes that these discrepancies are due to staff not signing out narcotics and needles at the time they are used. The bulk syringe and contraband perpetual inventory record is used primarily for bulk needles and syringes, but also appeared to be used for individual needles as well. This book requires two nurse signatures each time needles were removed, but this did not consistently occur.

The Monitoring Team found that the medication refrigerator was clean and contained no expired medications.

The Monitoring Team learned that asthma patients in segregation/isolation were not permitted to keep short-acting (rescue) inhalers on their person. This presents a risk that inmates will not receive their medications in a timely manner which could exacerbate their condition.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is not in compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated this provision by inspecting the medication room and assessing access to, storage of, and safe and appropriate disposal of medication and medication waste.

[103] The count showed 35 insulin syringes remaining but the book only accounted for 37 insulin syringes. There were 50 tuberculin syringes but the book documented 30 insulin syringes. A staff member had made an error in documentation in the book.

As noted at the previous visit, the pharmacy/medication room is of insufficient size for pharmacy operations and medication administration, resulting in a cramped, cluttered and disorganized environment. The floors were very dirty and did not appear to have been cleaned for some time. Staff verified that inmate porters are not allowed in this area, and although staff is expected to clean the area, there is so much clutter on the floors and on cabinets that it is not possible to access all surfaces in order to clean them. Counter tops are full of log books which make it difficult to perform sanitation/infection control activities. Biohazard waste (*e.g.* full sharps containers) was placed on the counter beside new medication blister packs. This is an unsanitary environment in which to store, prepare and administer medications.

The Monitoring Team found that narcotics and other controlled substances were maintained in double-locked cabinets. Narcotics are being administered from stock supply instead of patient specific blister packs, which should greatly decrease the amount of staff time counting narcotics. However documentation revealed that controlled substances were not counted at every shift. The controlled substances log book showed that from August 29, 2008 to November 19, 2008 there were 30 missing signatures. The Monitoring Team observed a narcotic count and noted that there was one narcotic pill missing according to the log and medication blister pack. The DON was notified of the missing narcotic.

At the last visit, the Monitoring Team noted that there was no accountability (*i.e.* sign out system) for the large quantities of stock (versus patient-specific) prescription medications. This is problematic because of the potential for drug diversion or administering medications without a valid order. At this visit, the Monitoring Team noted that in some of the SHU/MHU clinic and medication rooms there is a method to document usage of stock medications but it is not consistently used – two of the six randomly selected stock medication blister packs revealed documented usage that did not match the number of pills in the blister pack.

In all medication rooms, the Monitoring Team conducted a random inspection of stock supplies of medication and found that none were expired. This is an improvement from the Monitoring Team's last visit.

Staff reported that plans are being made to restructure the medication room that includes installation of new cabinetry and reorganization of the medication room. The plan does not address the inadequate size of the pharmacy/medication room. The Monitoring Team discussed this with OHS Leadership who indicated they would explore the possibility of pharmacy expansion with the facility leadership.

D. HRYCI

1. <u>Assessment</u>

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated this provision by inspecting the medication room and assessing access to, storage of, and safe and appropriate disposal of medication and medication waste. The Monitoring Team found significant improvements in medication management and this area is close to being in substantial compliance.

During this visit, the Monitoring Team found the medication room to be very well-organized. The pharmacy technician should be commended for the excellent organization. Shelves storing medications are labeled clearly and internal and external drugs are appropriately separated from one another.

The refrigerator was clean. However, the floor and sink were dirty, and excess medical equipment is being stored in this area (*e.g.* oxygen concentrators and blood pressure monitoring equipment, etc.), which adds clutter to the room. The Monitoring Team notes that inmate porters are not permitted in this area. While this is an understandable policy, this might be the source of the sanitation issues and the State needs to find a means of maintaining sanitation in spite of that policy.

Inspection of medications showed that 12 out of 12 opened multi-dose vials had been dated when opened, and none were expired. Of five over the counter medications sampled, none were expired.

The Monitoring Team previously has expressed concerns regarding the management of narcotics and other controlled substances. Just prior to the Monitoring Team's visit, 58 methadone tablets were discovered to have been stolen. An investigation was initiated rapidly, and a staff member was arrested. Subsequently, changes in procedures for managing controlled substances were implemented. In reviewing controlled substances, the Monitoring Team randomly selected five blister packs of controlled substances and compared them with the log book count and all five were correct. Two nurses are to verify the narcotic count at the beginning and end of each shift. However, the Monitoring Team noted that one nursing signature was missing from the narcotics count log the week of the Monitoring Team's visit.

In the booking area clinic, there were patient-specific blister packs of controlled and abusable medications (*i.e.* Clonazepam, Tramadol) sitting on the shelves, instead of in double locked cabinets. Also, there were blister packs of stock medications in cabinets but no inventory or accountability system. The refrigerator was clean but vials of insulin and TB testing serum (purified protein derivative) were open and undated.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

Review of medication management showed that there were improvements in the pretrial area, but significant improvements are needed in MSB to achieve substantial compliance. These improvements should be significantly advanced by the planned expansion of the medication room.

In the pre-trial area, the medication room is of adequate size and is well organized. The medication refrigerator is clean and contained no expired medications. However, a random check of stock medications revealed several that were to expire at the end of the month (within three days). A random sampling of three narcotics showed that counts were accurate. Review of MARs showed that they were neat and legible. There were several envelopes on the counter used to pour medications into for administration to inmates in segregation. These envelopes contained only the names of the inmate and not the name, dosage, and start and stop dates of the medications contained in the envelopes. Sanitation in the medication room was fair but could be improved.

In the MSB area, the room is small and cramped, with makeshift storage shelving for inmate and stock medications. Currently, there is no system for accountability of stock prescription medications. A random sample of several blister packs showed several that were to expire in November 2008. The counters and floor were unsanitary.

Narcotics are stored in a locked cabinet and are counted during each shift. However, as noted in the Monitoring Team's last visit, there was an unsecured medication cup filled with a narcotic (Vicodin) when the Monitoring Team entered the medication room. This reflects the nurses' practice of pre-pouring medications in advance of administering the medication. A random check of narcotic counts showed that the nurse did not sign out this medication at the time it was pre-poured. In addition, the Monitoring Team noted an irregularity with a blister pack of stock Phenobarbital, a controlled substance. The package appeared to have been tampered with, as evidenced by notation of tears in the aluminum foil behind several doses of the medication that subsequently had been taped shut. This may be a result of nurses pre-pouring medication and then returning the medication to the blister pack if not administered instead of wasting the medication. Both of these circumstances present a risk of diversion and should be further explored by health care leadership at the facility.

With respect to medication disposal, staff members reported that a Pharmacor representative recently picked up discontinued narcotics and unused medication.

F. Recommendations

At Baylor, the Monitoring Team recommends the following:

- The medication room space should be expanded or relocated in order to permit storage of all pharmaceuticals, and broken cabinets should be repaired or replaced.
- The health care leadership should develop an accountability system for stock medications

that is periodically checked to detect diversion or improper administration.

- Staff should sign out all narcotics and syringes at the time they are removed
- Permit inmates in segregation to have rescue inhalers.

At HRYCI, the Monitoring Team recommends that:

- Health care leadership should monitor compliance with the new procedures for control of narcotics.
- Establish an accountability system for stock medications in all areas of the facility.
- Sanitation in this restricted area should be improved; excess medical equipment should be stored in another area if at all possible.

At SCI, the Monitoring Team recommends that a system be put into place to provide strict accountability for stock medications (*i.e.*, a nurse signs out each dose of medication and documents which patient received the medication). Narcotics should be removed and signed out when the patient presents to the medication window to receive the medication. There should be a schedule of sanitation activities that is monitored and enforced. Plans to expand the medication room should ensure that it is of sufficient size to store and secure pharmacy related items. Installing above and below lockable cabinets should facilitate expanded storage. Internal medications should be separated from external medications and the respective shelves or cabinets labeled. Facility health care leadership should continue to work with Pharmacor to ensure consistency in picking up medications and controlled substances for credit and/or disposal.

EMERGENCY CARE

27. Access to Emergency Care

A. Relevant MOA Provision

Paragraph 27 of the MOA provides:

> The State shall train medical, mental health and security staff to recognize and respond appropriately to medical and mental health emergencies. Furthermore, the State shall ensure that inmates with emergency medical or mental health needs receive timely and appropriate care, including prompt referrals and transports for outside care when medically necessary.

The NCCHC recommends the provision of 24-hour emergency medical, mental health, and dental services. J-E-08; P-E-08. In order to ensure timely and appropriate emergency services, the NCCHC recommends that institutions have a written plan including arrangements for emergency transport of the patient from the facility, use of an emergency medical vehicle, use of one or more designated hospital emergency departments or other appropriate facilities, emergency on-call physician, mental health, and dental services when the emergency health care facility is not located nearby, security procedures for the immediate transfer of patients for emergency medical care, and notification to the person legally responsible for the facility. *Id*. Further, emergency drugs, supplies, and medical equipment should be regularly maintained. *Id*.[104]

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found that Baylor is in substantial compliance with respect to mental health services and in partial compliance with respect to medical services.

2. Findings

The Monitoring Team reviewed medical and mental health emergencies that were treated onsite, and those emergencies that were treated offsite. The Monitoring Team reviewed seven records of patients whose emergencies were treated onsite. When onsite emergencies were identified, the response generally was timely, but in at least one case discussed elsewhere in this report, the response was not appropriate. The Monitoring Team found problems with the

[104] In the case of access to emergency care, there is no set period of time that will *per se* be reasonable. The period of time that is appropriate will be that period of time which meets the needs of a patient under the circumstances.

appropriateness of the care in four of the seven cases reviewed. In one case, the log reflected that the patient presented after a fight with neck pain, however, there was no medical note in the chart on the day that the incident occurred. In addition, the Monitoring Team found one disturbing case in which a patient presented in the middle of the night with what could have been classic heart attack symptoms and a physician was never contacted. A third case was one in which a patient was on KOP medicine, but because of the severity of her symptoms was taking a number of pills beyond that which were prescribed. She was seen and the physician was contacted, but the patient was never counseled by the physician about following the prescribed regimen. In the fourth case, the patient was seen and treated for a possible urinary tract infection with an antibiotic, but the patient never received the medication because the nurse who noted the order never initiated an MAR.

With regard to the patients whose emergencies were treated offsite, the Monitoring Team reviewed six records and had concerns regarding the appropriateness of the care in four cases. For instance, one of these patients was pregnant and complained of abdominal pain. The patient was sent offsite and treated, but had no follow-up visit with the primary care provider after returning to the facility. A second case involved a patient with seizures and mental illness whose record does not reflect receipt of medications prescribed, and who, despite being in the institution for a month and a half, has not had a chronic care visit. This patient was sent offsite with a seizure. Another case involved a patient who had a seizure and was sent offsite to the ER for a CT scan, but the chart did not contain a CT scan report. In the fourth case, the patient was sent offsite to the ER for evaluation of an abdominal problem, yet there was no hospital report in the chart.

With respect to mental health emergencies, the Monitoring Team was informed that three inmates were referred to and accepted to Delaware Psychiatric Center ("DPC") since the Monitoring Team's last visit in April 2008. This process generally took three to seven weeks per inmate.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found that JTVCC is in substantial compliance with respect to mental health services and in partial compliance with respect to medical services.

2. Findings

In discussing the tracking of emergency patients, the Monitoring Team learned that there is a log book containing the names and presenting complaints of the people who are sent offsite emergently. But for people who present onsite for emergencies to which the staff responds, there is no tracking log. The only possible way to identify some of these patients is to use the nurses daily work log in which a given nurse may document that he or she responded to a patient either by going to the housing unit or having the patient brought over. But utilizing this

daily nurse worksheet makes it almost impossible to track urgent problems handled on site. There is supposed to be an onsite urgent care logbook which documents the time of the call, the presenting complaint, where the patient was seen and what the disposition was. This needs to be developed so that the program can more carefully assist the nurses in improving their performance with regard to emergencies.

In addition, the Monitoring Team reviewed six records of patients sent offsite on an emergent basis. The problems that the Monitoring Team found were, in a few records, no follow-up by a physician at the time or shortly after the return to the institution. The Monitoring Team also found instances in which the documentation returning from the emergency room was inadequate or in conflict with the apparent reason the patient was sent out.

Regarding mental health emergencies, the Monitoring Team noted no significant changes with respect to access to off-site emergency care.

During its December 2008 visit, the Monitoring Team observed a response to a medical emergency at the facility. Access to a gurney with wheels was very problematic and could have had serious consequences. Although everything worked out in this instance, the State should ensure access to gurneys with wheels in order to appropriately respond to medical emergencies.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found that HRYCI is in substantial compliance with respect to mental health services and in partial compliance with respect to medical services.

2. Findings

There was significant improvement in this area since the Monitoring Team's last visit. The Monitoring Team reviewed the records of patients who had been sent to the emergency room. The Monitoring Team made the following findings:

- Problem lists were complete on all patients.
- All patients were sent out in a timely manner and it did not appear that prior intervention would have prevented them from being sent out.
- All patients had a provider order before being sent out, although one of these was written in the progress notes and not transcribed to the order sheet.
- All patients were seen upon return from the hospital and placed in the infirmary for observation.

- There was minimal-to-no information received back from the hospital on all of the patients; however the Regional Medical Director is in the process of getting hospital privileges at all of the hospitals to which the patients are sent so that he will be able to access their records.

Regarding mental health emergencies, the Monitoring Team noted no significant changes with respect to access to off-site emergency care.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

2. Findings

Although the response to the emergencies was appropriate and timely, the Monitoring Team identified a few cases in which, had access to emergency care occurred earlier, the emergency might have been mitigated. In addition, the Monitoring Team identified one patient who was released to the street from the infirmary on critical medications without any documentation of a re-entry plan. This is an issue that has come up once before and should be addressed in DOC.

Regarding mental health emergencies, the Monitoring Team noted no significant changes with respect to access to off-site emergency care.

F. Recommendations

At Baylor, the Monitoring Team makes the following recommendations:

- Patients who present with possible coronary problems must have a physician called to assess the patient and determine the plan.
- For all patients seen and treated as recorded in the onsite log of patients presenting to the medical area, there must be a note in the chart.
- When patients are not appropriately taking their medications they must be counseled directly by the prescriber.
- Patients sent offsite on an emergent basis must have a follow-up visit with the primary care provider.
- Patients sent offsite to an ER or a hospital must have those records retrieved from the offsite service and be seen in follow-up by a primary care provider.

At JTVCC, the Monitoring Team recommends the State do the following:

- Maintain an urgent care log book in the main clinic and anywhere else that after hour calls are received, where urgent nursing responses are required.

- Use that log book as a way of reviewing nursing care and response to urgent conditions and providing constructive feedback for how to improve performance.
- Work with the offsite providers, such as local hospitals, so that they will provide useful information as to what was found at their facility, what diagnosis the patient carries and what their recommended plans are.

At SCI, the State should promulgate a policy that insures that patients who are in the infirmary who become available for release first have their medical needs reviewed and discussed with them so that an appropriate re-entry plan can be implemented.

28. First Responder Assistance

A. Relevant MOA Provision

Paragraph 28 of the MOA provides:

> The State shall train all security staff to provide first responder assistance (including cardiopulmonary resuscitation ("CPR") and addressing serious bleeding) in an emergency situation. The State shall provide all security staff with the necessary protective gear, including masks and gloves, to provide first line emergency response.

This provision of the MOA defines the complete standard for first responder assistance. For further information, see discussions of provisions 9, 32, and 52.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed personnel records for security staff in order to determine the State's compliance with several provisions of this MOA. In reviewing those records, the Monitoring Team found that more than 90% of all staff had received the required first aid, CPR and AED training.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in substantial compliance with this provision of the MOA.

2. Findings

The review of the records for the 35 security staff indicates that, for 32 of the 35 staff members, the CPR and AED training were in fact up to date.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the records of security staff. All of the records reflected that security staff had received the required training.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

2. Findings

All individuals who are required to have their CPR and first aid training did meet that requirement.

MENTAL HEALTH CARE

29. Treatment

A. Relevant MOA Provision

Paragraph 29 of the MOA provides:

> The State shall ensure that qualified mental health professionals provide timely, adequate, and appropriate screening, assessment, evaluation, treatment and structured therapeutic activities to inmates requesting mental health services, inmates who become suicidal, and inmates who enter with serious mental health needs or develop serious mental health needs while incarcerated.

This provision of the MOA is an overall standard governing the timeliness and appropriateness of the following components of mental health care to be provided at the Facilities:

- mental health screening;
- assessment;
- evaluation;
- treatment; and
- structured therapeutic activities.

The NCCHC recommends that there be mental health services[105] available for all inmates who require them. J-G-04; P-G-04. The MOA, on the other hand, requires that mental health services be available to all inmates *requesting* them, inmates who become suicidal, and inmates who enter with serious mental health needs or develop serious mental health needs while incarcerated. The NCCHC standards state that mental health treatment is more than prescribing psychotropic medications; treatment goals include the development of self-understanding, self-improvement, and development of skills to cope with and overcome disabilities associated with various mental disorders. J-G-04; P-G-04. The NCCHC provides that facilities housing significant numbers of patients with mental health problems who have longer sentences are expected to offer more extensive mental health programming. *Id*. Correctional facilities that provide for the needs of patients requiring psychiatric hospitalization levels of care are expected to mirror treatment provided in inpatient settings in the community. *Id*.

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[105] "Mental health services" includes "the use of a variety of psychosocial and pharmacological therapies, either individual or group, including biological, psychological, and social, to alleviate symptoms, attain appropriate functions, and prevent relapse."

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

During its October 2008 visit, the Monitoring Team identified problems which included, but were not limited to the following:

- Inadequate physical plant, with specific reference to office space in the infirmary and problems with other office space due to sound privacy issues;
- Inadequate mental health staffing allocations that have been exacerbated by staffing vacancies;
- Significant medication management issues, including problems with continuity of medications, noncompliance practices, and obtaining necessary laboratory tests; and
- Inadequate CQI system.

Based upon a review of records, and information obtained from staff members, the Monitoring Team found that the treatment scope and options provided to those inmates on the mental health caseload who do not reside in Harbor House was extremely limited and not adequate. The Monitoring Team attributes these issues primarily to the staffing allocation and vacancy issues discussed elsewhere in this report. Also, office space for mental health assessment and treatment purposes has exacerbated the mental health treatment system problems.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

During its December 2008 visit, the Monitoring Team noted the following improvements since its April 2008 site visit:

- The development of the T-1 Special Needs Unit;
- Laboratory testing;
- A more cohesive mental health staff;
- Better overall coverage by psychiatrists in terms of continuity of care; and

- Improvements in the psychiatric coverage for the infirmary. The Monitoring Team also looks forward to impending improvement with regard to office space in the infirmary and expanded health services space in the SHU.

The Monitoring Team also found significant problems, including the following:

- Inadequate office and programming space with specific reference to most of the compound housing units and the SNUs;
- Mental health staffing allocation shortages, including psychiatric coverage;
- Treatment services consisting primarily of medication and welfare checks by mental health counselors, except in the SNUs;
- Limited programming for SNU inmates. Such programming should include reasonable access to education and job opportunities, and access to at least 10 hours per week of structured therapeutic activities. Those therapeutic activities should be treatment plan driven based on individualized needs. Programming is currently limited by both programming space and staffing allocation issues;
- Need for an improved treatment team concept in the SNU with specific reference to more involvement by the psychiatrist and correctional officers (this appears to be a staffing allocation issue);
- Significant medication management issues;
- Access issues to inpatient psychiatric hospitalization for inmates in need of such treatment is also very problematic due both to bed availability and legal logistical issues; and
- Lack of a meaningful CQI process.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

Mental health practices at HRYCI remain largely unchanged, partly due to staffing shortages. However, the staff at HRYCI has done an admirable job trying to cover the needs of the service.

Specific improvements noted since the last site visit include the following:

- Adequate office space in the infirmary will be available soon;
- The use of a stainless steel toilet in the PCO cell appears to have been successful;[106]

[106] As discussed in previous reports, the PCO cell at HRYCI contained a toilet, which essentially was a hole in the ground. The State has used this type of toilet because inmates consistently had removed

- Access issues to inpatient psychiatric hospitalization for inmates in need of such treatment;
- The mental health staff does a good job of responding to sick call requests within 24 hours and new assessments;
- Based on prior recommendations of the Monitoring Team, the DOC has classified sentenced inmates requiring treatment for special mental health needs to the SNU in Smyrna. As a result, only one sentenced inmate is currently being housed in the Transitions Unit; and
- Suicidal inmates are being identified and transferred to the infirmary on PCO status.

However, despite these improvements, significant problems with compliance were identified during this monitoring period and are summarized in relevant sections of this report. These problems include the following:

- Inadequate physical plant, with specific reference to office space in the eastside dormitory housing units;
- Mental health staffing vacancies, psychiatrists' allocation shortages, and use of multiple psychiatrists;
- Unlicensed mental health staff is not being clinically supervised on a regular basis;
- Treatment services consisting primarily of medication and welfare checks by mental health counselors. Compliance with monthly visits with caseload inmates has decreased related to the staff vacancies as has meeting timeframes for treatment plan reviews;
- The quality of treatment planning remains poor even for inmates with special needs;
- There is a paucity of therapeutic activities offered at this site. Currently group therapy has been suspended because of staffing shortages in the general population. Related to the current staffing patterns, there is little access to structured individual counseling throughout the facility. Rather, most caseload inmates are assigned journaling activities and given educational handouts as their counseling treatment. Even on the special needs unit, there is limited group activities with an attendance size that hampers the delivery of quality problem focused treatment. The Transitions Unit lacks a developed program;
- Inadequate discharge planning;
- Continued medication management issues;
- Patterns of inadequate laboratory monitoring, especially with the use of lithium and Depakote, continue;
- Staff training is needed regarding the mental health assessment relevant to the disciplinary process;
- Policies and procedures relevant to suicide prevention (specifically, PCO status) are not being completely implemented; and
- The mental health CQI system remains very rudimentary.

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standard toilets and destroyed them, presenting a safety risk. However, in reaction to the Monitoring Team's criticisms that such a "toilet" was dehumanizing, and its recommendations in the Second Report, the State implemented a pilot program at HRYCI in order to improve the type of toilet being offered to inmates.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team finds that the leadership provided at SCI by the mental health director continues to be excellent.

Additionally, its review of records indicated the presence of mental health notes, including treatment plans that were excellent in content and indicate a good level of professionalism.

The staffing vacancies issues have recently decreased, which has resulted in better compliance with various MOA provisions.

Problems with treatment remain, that are addressed elsewhere in the report, but which are summarized briefly below:

- inadequate office space and inadequate sound privacy for interviews in many areas of the facility, especially in the infirmary;
- inadequate numbers of safety cells for PCO purposes;
- significant medication management issues, including continuity of medication issues;
- mental health staffing allocation issues; and
- The mental health CQI system remains very rudimentary.

F. Recommendations[107]

At all facilities, the Monitoring Team recommends that the staffing allocation issues be addressed. Additionally, the Monitoring Team repeats its recommendations that the State develop protocols and patient selection criteria in connection with its use of telepsychiatry.[108]

Additionally system wide, the State needs to address space issues referenced throughout this report.

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[107] These recommendations do not include ones made elsewhere in this report; other recommendations made in this report apply to some of the issues highlighted in this section of the report.

[108] On July 1, 2008, the State implemented a telepsychiatry policy.

Finally, as discussed in paragraph 54, the State needs to improve its CQI program and the methodology employed in the studies performed.

30. Psychiatrist Staffing

A. Relevant MOA Provision

Paragraph 30 of the MOA provides:

> The State shall retain sufficient psychiatrists to enable the Facilities to address the serious mental health needs of all inmates with timely and appropriate mental health care consistent with generally accepted professional standards. This shall include retaining appropriately licensed and qualified psychiatrists for a sufficient number of hours per week to see patients, prescribe and adequately monitor psychotropic medications, participate in the development of individualized treatment plans for inmates with serious mental health needs, review records in the context of rendering appropriate mental health care, review and respond to the results of diagnostic and laboratory tests, and be familiar with and follow policies, procedures, and protocols. The psychiatrist shall collaborate with the chief psychologist in mental health services management as well as clinical treatment, shall communicate problems and resource needs to the Warden and chief psychologist, and shall have medically appropriate autonomy for clinical decisions at the facility. The psychiatrist shall supervise and oversee the treatment team.

This provision of the MOA does not differ significantly from the standards applicable to provision 6 of the MOA with respect to the requirement for sufficient psychiatrist staffing, and therefore, the Monitoring Team refers to the standards set forth with respect to that provision. *See* J-C-07; P-C-07.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. <u>Findings</u>

In the Third Report the Monitoring Team expressed concern that the psychiatric coverage was provided on two consecutive days. During its October 2008 visit, the Monitoring Team learned that the psychiatrist's 16 hours of coverage now occurs during Mondays and Thursdays. While the Monitoring Team believes scheduling the psychiatric coverage on non-consecutive days is an improvement, it believes that it is unlikely that 16 hours per week is adequate for the population being served.

This belief was shared by one of the psychiatrists at the facility who believed that a 0.5 FTE psychiatrist was needed at Baylor.

Additionally, the Monitoring Team learned that 30 minutes are allotted for new assessments of inmates, and follow-ups appointments are allotted 15 minutes. There is no State policy mandating that new assessments be limited to 30 minutes. Instead, staff members informed the Monitoring Team that this is their general rule and the time allocations are based on the manner of the scheduling of these assessments. The Monitoring Team believes that new assessments should be allotted a minimum of 45 minutes. This belief is based on their professional judgment and their understanding of everything that must be done during a initial assessment. It is unlikely that this can be adequately completed and documented in a 30 minute window.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

During the current monitoring cycle, the major change in psychiatric coverage is that the 58 hours of coverage per week is now provided by two psychiatrists on a five day per week basis in contrast to four psychiatrists providing the same coverage. The psychiatrists' hours are now more predictable as well.

Despite this change in coverage, the Monitoring Team believes that additional staffing of psychiatrists is necessary at JTVCC. The Monitoring Team has previously recommended that the State examine its staffing allocation at the facility to determine its needs. Because that assessment has not been completed, the Monitoring Team has taken it upon itself to calculate the psychiatrists' staffing allocation needs based on its experience. The results of the Monitoring Team's assessment demonstrated that an increase of a 1.0 FTE psychiatrist position is needed in order for the facility to adequately meet the needs of its inmates. The detailed breakdown of this study is attached hereto as Appendix II.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team notes that the psychiatrists' allocation at HRYCI is still 40 hours per week. CMS has not submitted a request to increase the allocation since 2007. As previously stated, the psychiatrist allocation at HRYCI should be increased to 1.5 FTE with onsite coverage at least six days per week at the infirmary level of care. Additionally, onsite coverage hours should be predominantly during regular working hours.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that the psychiatrist allocation for SCI is 24 hours per week, which was being provided onsite three days per week by the psychiatrist for the two months prior to the Monitoring Team's visit. Most of this psychiatrist's time is spent in the infirmary with inmates on PCO status. As a result, most of the general population outpatient mental health caseload is receiving treatment by any one of two psychiatrists via telepsychiatry. A policy and procedure has apparently been in place since July 1, 2008, but the Monitoring Team has never seen the final version of this policy.[109] As stated in the Third Report, while telemedicine is a useful process to mitigate the current psychiatrists allocation shortage, policies and procedures need to be implemented to ensure that telepsychiatry is used in a more effective manner.

Additionally, the Monitoring Team believes that more on-site psychiatric time is needed, which could be decreased if telepsychiatry was performed in a more standardized manner.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State conduct a staffing analysis to determine how much psychiatric coverage is needed.

At JTVCC, the Monitoring Team recommends that the State add a 1.0 FTE psychiatrist position.

At HRYCI, the Monitoring Team recommends the State add a 0.5 FTE psychiatrist position. Additionally, the State should revise the scheduling of psychiatrists so most coverage is provided during regular working hours.

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[109] The Monitoring Team did provide comments to a draft policy in June 2008. However, the Monitoring Team never received an updated version of this policy and therefore did not see the final version.

31. Administration of Mental Health Medications

A. Relevant MOA Provision

Paragraph 31 of the MOA provides:

> The State shall develop and implement policies, procedures, and practices consistent with generally accepted professional standards to ensure that psychotropic medications are prescribed, distributed, and monitored properly and safely and consistent with generally accepted professional standards. The State shall ensure that all psychotropic medications are administered by qualified medical professionals or other health care personnel qualified under Delaware state law to administer medications, who consistently implement adequate policies and procedures to monitor for adverse reactions and potential side effects and to adequately document the administration of such medications in the MARs. Documentation in the MARs shall include a clear and consistent indication of whether the inmate refused or otherwise missed any doses of medication, as well as doses consumed. As part of the CQI program set forth in Section V of this Agreement, a qualified medical professional or RN supervisor shall review MARs on a regular and periodic basis to determine whether policies and procedures are being followed.

The MOA provides that the State shall develop and implement policies, procedures, and practices consistent with generally accepted professional standards to ensure that psychotropic medications are prescribed, distributed, and monitored properly and safely and consistent with generally accepted professional standards. The State has developed policies consistent with generally accepted professional standards and the requirements of the MOA. *See* Policy D-02.

The State shall ensure that all psychotropic medications are administered by qualified medical professionals or other health care personnel qualified under Delaware state law to administer medications, who consistently implement adequate policies and procedures to monitor for adverse reactions and potential side effects and to adequately document the administration of such medications in the MARs. According to the MOA, adequate documentation in the MARs shall include a clear and consistent indication of whether the inmate refused or otherwise missed any doses of medications, as well as doses consumed. These standards have been addressed with respect to provisions 24 and 25 of the MOA.

The MOA also requires that the State have a qualified medical professional or RN supervisor review MARs on a regular and periodic basis to determine whether policies and procedures are being followed. This can take place as a part of the CQI process. *See* discussion of paragraph 54.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team bases the following assessment on the same findings that are discussed with reference to MOA paragraphs 4, 24, 25, and 54.

Additionally, the Monitoring Team found that Lamictal was being prescribed at the facility without a specific consent form. Lamictal is used to treat bipolar disorder. Serious side effects of this drug, are rare, but include a rash indicative of Stevens Johnson syndrome that can be life threatening. Less serious but more common side effects include dizziness, ataxia, somnolence, headaches, double vision, blurred vision, nausea, and vomiting. While consent forms are required for all psychotropic medications, a generic form is not recommended for Lamictal because of the uniqueness of this medication.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team bases the following assessment on the same findings that are discussed with reference to MOA paragraphs 4, 24, 25, and 54.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team bases the following assessment on the same findings that are discussed with reference to MOA paragraphs 4, 24, 25, and 54.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team bases the following assessment on the same findings that are discussed with reference to MOA paragraphs 4, 24, 25, and 54.

F. Recommendation

At Baylor, the Monitoring Team recommends that a specific consent form for Lamictal be developed and implemented because this medication can have serious, life threatening, side effects and appears to be used at the Facility for clinically appropriate reasons more often.

32. Mental Illness Training

A. Relevant MOA Provision

Paragraph 32 of the MOA provides:

> The State shall conduct initial and periodic training for all security staff on how to recognize symptoms of mental illness and respond appropriately. Such training shall be conducted by a qualified mental health professional, registered psychiatric nurse, or other appropriately trained and qualified individual, and shall include instruction on how to recognize and respond to mental health emergencies.

The Monitoring Team interprets this provision of the MOA as being encompassed within provision 9 of the MOA, and therefore, the Monitoring Team refers to the standards set forth with respect to that provision. Also, the Monitoring Team notes that correctional officers should be trained at least every two years with respect to recognizing signs and symptoms of mental illness. J-C-04; P-C-04.

The Monitoring Team conducted a review of this provision of the MOA in connection with its review of provision 9 of the MOA. The Monitoring Team found that greater than 90% of the security staff at each of the Facilities had received training in accordance with this provision of the MOA. Therefore, the Monitoring Team found that the Facilities are in substantial compliance with this provision of the MOA.

33. Mental Health Screening

A. Relevant MOA Provision

Paragraph 33 of the MOA provides:

> The State shall develop and implement adequate policies, procedures, and practices consistent with generally accepted correctional mental health care standards to ensure that all inmates receive an adequate initial mental health screening by appropriately trained staff within twenty-four (24) hours after intake. Such screening shall include an individual private (consistent with security limitations) interview of each incoming inmate, including whether the inmate has a history of mental illness, is currently receiving or has received psychotropic medications, has attempted suicide, or has suicidal propensities. Documentation of the screening shall be maintained in the appropriate medical record. Inmates who have been on psychotropic medications prior to intake will be assessed by a psychiatrist as to the need to continue those medications, in a timely manner, no later than 7-10 days after intake or sooner if clinically appropriate. These inmates shall remain on previously prescribed psychotropic medications pending psychiatrist assessment. Incoming inmates who are in need of emergency mental health services shall receive such care immediately after intake. Incoming inmates who require resumption of psychotropic medications shall be seen by a psychiatrist as soon as clinically appropriate.

The NCCHC recommends that individuals conducting the receiving screening (*see* discussion of provision 10 of the MOA) make adequate efforts to explore the potential for suicide. J-E-02; P-E-02. Both reviewing with an inmate any history of suicidal behavior and visually observing the inmate's behavior (delusions, hallucinations, communication difficulties, speech and posture, impaired level of consciousness, disorganization, memory defects, depression, or evidence of self-mutilation) should be done at the screening. *Id*.

Within 24 hours after the intake screening takes place, the initial mental health screening should take place and include a structured interview with inquiries into:

- a history of:
  - psychiatric hospitalization and outpatient treatment;
  - suicidal behavior;
  - violent behavior;
  - victimization;
  - special education placement;
  - cerebral trauma or seizures, and
  - sex offenses; and

- the current status of:
    - psychotropic medications;
    - suicidal ideation;
    - drug or alcohol use, and
    - orientation to person, place, and time;
- emotional response to incarceration; and
- a screening for intellectual functions (*i.e.*, mental retardation, developmental disability, learning disability).

J-E-05; P-E-05. The NCCHC further recommends that the inmate's health record contains results of the initial screening. *Id*.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed eleven charts and found that in ten charts, appropriate documentation indicated that the requirements of this provision were met. However, as described in the findings section for MOA Paragraphs 25 and 31, significant problems exist with respect to bridging medications. These problems are the basis for the partial compliance rating.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the results of a relevant CMS audit which demonstrated that initial mental health screenings are consistently completed by qualified health professionals within the required 24 hour time period. However, the requirement that inmates who require mental health assessments receive those assessments within 72 hours is not being met consistently. In five of the twenty records examined by the audit, this time period was not met. Additionally, as described in the findings section for paragraphs 25 and 31 of the MOA,

significant problems exist with respect to bridging medications which support the partial compliance assessment.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the records of inmates which demonstrated that initial mental health screenings are completed consistently by qualified health professionals within the required 24 hour time period. However, the requirement that inmates who require mental health assessments receive those assessments within 72 hours is not being met consistently. In three of the fifteen records examined by the audit, this time period was not met. Additionally, as described in the findings section for paragraphs 25 and 31 of the MOA, significant problems exist with respect to bridging medications which support the partial compliance assessment.

The Monitoring Team believes the delays in responses to be a direct result of staffing vacancies that had been substantial until the time preceding the Monitoring Team's visit to the facility in August 2008. It was anticipated that HRYCI would be adding an additional mental health counselor and an additional psychiatrist which will hopefully remedy these problems in the future.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the records of inmates which demonstrated that initial mental health screenings are consistently completed by qualified health professionals within the required 24 hour time period. However, the requirement that inmates who require mental health assessments receive those assessments within 72 hours is not being met consistently. In five of the nine records examined by the audit, this time period was not met. Additionally, as described in the findings section for paragraphs 25 and 31 of the MOA, significant problems exist with respect to bridging medications which support the partial compliance assessment.

Finally, Staff reported compliance problems with the requirement of this provision that "inmates who have been on psychotropic medications prior to intake will be assessed by a psychiatrist as to the need to continue those medications, in a timely manner, no later than 7-10 days after intake or sooner if clinically appropriate." Specifically, these problems occurred during the summer months and were related to various technical difficulties with the telepsychiatry process during which there were difficulties connecting with the telepsychiatrist. Staff members believed there had been improvement during the past two months, but this was not based on audit studies.

34. Mental Health Assessment and Referral

A. Relevant MOA Provision

Paragraph 34 of the MOA provides:

> The State shall develop and implement adequate policies, procedures, and practices consistent with generally accepted professional standards to ensure timely and appropriate mental health assessments by qualified mental health professionals for those inmates whose mental health histories, or whose responses to initial screening questions, indicate a need for such an assessment. Such assessments shall occur within seventy-two (72) hours of the inmate's mental health screening or the identification of the need for such assessment, whichever is later. The State shall also ensure that inmates have access to a confidential self-referral system by which they may request mental health care without revealing the substance of their request to security staff. Written requests for mental health services shall be forwarded to a qualified mental health professional and timely evaluated by him or her. The State shall ensure adequate and timely treatment for inmates whose assessments reveal serious mental illness, including timely and appropriate referrals for specialty care and regularly scheduled visits with qualified mental health professionals.

Any inmates with positive screenings for mental health problems should be referred to qualified mental health professionals for further evaluation. J-G-04; P-G-04. The health record should contain the results of the evaluations with documentation of referral or initiation of treatment when indicated. *Id*. Patients with needs that require acute mental health services beyond those available at the facility are transferred to an appropriate facility. *Id*.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team bases the assessment on the same findings that are discussed with reference to MOA paragraphs 12 and 19.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team bases the assessment on the same findings that are discussed with reference to MOA paragraphs 12 and 19.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team bases the assessment on the same findings that are discussed with reference to MOA paragraphs 12 and 19. The Monitoring Team also notes one specific improvement with respect to the handling of mental health referrals. In the Third Report, the Monitoring Team criticized HRYCI due to the frequency in which the referral log failed to indicate what action was taken in response to a mental health referral. During its visit in August 2008, the Monitoring Team noted that staff at HRYCI had recently begun noting the response taken to a mental health referral and hopes that this practice continues.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team bases the assessment on the same findings that are discussed with reference to paragraphs 12 and 19 of the MOA.

35. Mental Health Treatment Plans

A. Relevant MOA Provision

Paragraph 35 of the MOA provides:

> The State shall ensure that a qualified mental health professional prepares in a timely manner and regularly updates an individual mental health treatment plan for each inmate who requires mental health services. The State shall also ensure that the plan is timely and consistently implemented. Implementation of and any changes to the plan shall be documented in the inmate's medical/mental health record.

A mental health treatment plan should include, at a minimum, a description of: (i) the frequency of follow-up for medical evaluation and adjustment of treatment modality; (ii) the type and frequency of diagnostic testing and therapeutic regimens; and (iii) when appropriate, instructions about diet, exercise, adaptation to the correctional environment, and medication. J-G-01; P-G-01. Further, the plans should include ways to address the patients' problems and enhance their strengths, involve patients in their development, and include relapse prevention risk management strategies, which should describe signs and symptoms associated with relapse or recurring difficulties, how the patient thinks that a relapse can be averted, and how best to help him or her manage crises that occur. *Id*.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. <u>Findings</u>

In reviewing this provision, the Monitoring Team examined 18 charts of inmates located both in Harbor House and the general population. Within the Harbor House, 12 charts were examined and the Monitoring Team considers the treatments plans in five of those charts to be completed and updated with an adequate plan. With regard to the six charts of inmates located in the general population, the Monitoring Team considers the treatment plans in four of those charts to be completed and updated with an adequate plan. In making a determination of whether a treatment plan was complete and adequate, the Monitoring Team bases this decision on its clinical judgment, paying careful attention to whether the treatment plan was generic or individualized. Additionally, the Monitoring Team examined whether the treatment plan contained interventions specified to address the inmate's needs, whether the treatment plan was completed and updated in a timely manner, and most importantly, whether there was even a treatment plan in the chart. During its visit to Baylor in October 2008, the Monitoring Team

found numerous examples where the charts did not contain the required treatment plans or those plans had not been updated since February or March 2008.

Additionally, the Monitoring Team found that the State has modified the treatment form used at the facilities so that it now includes an "intervention" section within the treatment plan. However, there had not been any training regarding this form at the time of the Monitoring Team's October 2008 visit.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the charts of 23 inmates and found that treatment plans generally were present in the records where required. However, the Monitoring Team notes that although the treatment plans were present, they were often very generic in nature or not followed.

As an example of the inadequacies of treatment plans, one plan reviewed indicated the inmate was seen once every three months which the Monitoring Team believes is too infrequent to engage this individual in treatment. Moreover, most of this inmate's contacts are with an activity aide and his plan focuses on hygiene month after month. Finally, although it appears this inmate has made complaints about fatigue due to the medication he is taking, these complaints are not addressed in his treatment plan.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is not in compliance with this provision of the MOA.

2. Findings

The Monitoring Team found no changes related to the quality of the treatment plans at HRYCI and notes the quality remains poor. Additionally, timeliness associated with preparing these plans has been problematic related to the recent staff vacancies.

The Monitoring Team reviewed the records of 21 inmates and examined the quality of the treatment plans contained within those records. The Monitoring Team found that there were appropriate treatment plans in seven of the 21 records reviewed. Many of the records reviewed did not contain treatment plans even though one should have been included.

One case reviewed by the Monitoring Team is particularly illustrative and highlights the Monitoring Team's concern about the adequacy of treatment planning. This particular inmate was initially seen by mental health after his intake screening indicated the inmate was taking medication and had a recent psychiatric hospitalization. His assessment revealed a mental illness. The inmate refused to be interviewed by psychiatry and was subsequently released from regular psychiatry care after signing a release of responsibility and being informed how to access care via sick call requests. There is no treatment plan in the record. The Monitoring Team confirmed with the mental health clerk that there is no scheduled date for any follow-up. Given this inmate's history, psychiatry should have rescheduled him and obtained prior records to try and engage him in treatment and observe him for signs of decompensation following incarceration.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the records of 15 inmates who were on medications requiring laboratory monitoring. The Monitoring Team found that treatment plans were completed and updated with an adequate plan in 13 of the 15 records. The remaining two records did not contain the required treatment plan. The Monitoring Team found that where treatment plans were present, the quality of these plans was adequate.

Since the Monitoring Team's last visit, SCI had implemented a new treatment plan form. The main difference with this new form is a prompt for the nature of the actual intervention that will be implemented to reach the inmate's treatment goal. The Monitoring Team believes that additional training should be provided to mental health staff with respect to this new form.

F. Recommendations

At all of the Facilities, the Monitoring Team reiterates its recommendations from the Third Report that the State should implement training so that treatment plans include more patient-specific components. For instance, more complex treatment plans may be necessary for inmates with serious mental illnesses, while simpler forms may be all that is required for inmates who are not routinely involved in programming. Additionally, with regard to outpatient mental health caseload inmates, the frequency of treatment plans should be changed to every six months

or as clinically indicated.[110] Furthermore, the State should involve psychiatrists at the facility more in the treatment planning process.

36. Crisis Services

A. Relevant MOA Provision

Paragraph 36 of the MOA provides:

> The State shall ensure an adequate array of crisis services to appropriately manage psychiatric emergencies. Crisis services shall not be limited to administrative/disciplinary isolation or observation status. Inmates shall have access to appropriate in-patient psychiatric care when clinically appropriate.

An adequate array of crisis services should include not only observation beds, but also some form of a crisis intervention specialist or team.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

During its October 2008 visit, the Monitoring Team found that the misperceptions between mental health and custody staffs which were discussed in the Third Report had been fully resolved.

However, in the Third Report, the Monitoring Team recommended that the State reposition the fixed bed in the cell used for PCO purposes so that two beds could be placed in the cell, instead of forcing one inmate to sleep in a mattress on the floor. This recommendation still has not been followed, and currently one inmate is still required to sleep in a mattress on the floor.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

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[110] This recommendation only applies to outpatient mental health caseload inmates. For special needs inmates and infirmary level inmates, treatment plans should be changed every thirty days or whenever clinically appropriate.

2. Findings

Psychiatric coverage is provided on a four day per week basis during the morning hours by the same psychiatrist and during the uncovered weekday on an as needed basis by the other psychiatrist at JTVCC. Discussion with the new regional director of psychiatry indicated that he was attempting to eventually arrange psychiatrist coverage for the infirmary on a five to six days per week basis.

As reported in the previously summarized program statement, PCO status for SHU inmates generally occurs in the SHU except for inmates assessed to be psychotic or suicidal as a result of a mental illness. Staff reported that they noticed a lot of problems with inmates wanting a break from the SHU, which often resulted in a SHU inmate attempting to go to the infirmary. The mental health staff received approval to house a specific inmate elsewhere[111] for attention seeking behavior from the warden, which was described as a successful intervention for this particular inmate. A general discussion with DOC followed regarding other similar inmates, which eventually resulted in a significant expansion of this intervention.

Inmates in the SHU on PCO status have various property restrictions and are reportedly observed by correctional staff on an every 15 minutes basis.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team was informed that access to DPC for inmates in need of treatment had improved since its last visit. However, there have been no new referrals from HRYCI since March 2008. Currently, there are approximately 37 inmates at DPC for treatment. On-site coverage by a psychiatrist remains inadequate as there is only three days per week of on-site planned coverage.

[111] The unit in which the inmate was housed is a two tiered housing unit, one of four units in building 18 with about 16-20 cells. Currently the State is using the single cells on the bottom tier to house inmates who have been placed in administrative segregation and inmates on watch who are not suicidal. All the cells on these units are hardened and equally secure.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team observed during its October 2008 visit that there continues to be three safety cells in the infirmary used for PCO status. There are also three administrative segregation detention area (ASDA) cells used for overflow purposes, which at times may house up to seven inmates in an area designed for three inmates. The ASDA cells are not retrofitted to be "safety cells." Due to the limited number of safety cells, inmates are periodically double celled in cells designed only for single occupancy. The infirmary safety cell is not designed for double occupancy. This MOA provision requires the State to "appropriately manage psychiatric emergencies." Because inmates on PCO status often are not being housed in appropriate housing, this serves as evidence the State is not appropriately managing psychiatric emergencies.

F. Recommendations

At Baylor, the Monitoring Team repeats its recommendation that the State reposition the fixed bed in the PCO cell so that two beds can be placed in the cell.

At SCI, the State needs to address the need for more safety cells for PCI purposes.

37. Treatment for Seriously Mentally Ill Inmates

A. Relevant MOA Provision

Paragraph 37 of the MOA provides:

> The State shall ensure timely and appropriate therapy, counseling, and other mental health programs for all inmates with serious mental illness. This includes adequate space for treatment, adequate staff to provide treatment, and an adequate array of therapeutic programming. The State shall ensure that inmates who are being treated with psychotropic medications are seen regularly by a physician to monitor responses and potential reactions to those medications, in accordance with generally accepted correctional mental health care standards.

This provision of the MOA will assist the State with providing continuity of mental health care, and provides a complete general standard against which to assess the State's compliance with this provision of the MOA, or the standards are discussed with regard to other provisions of the MOA (*see, e.g.*, discussions of provisions 6, 18, 24, 25, 31 and 33 of the

MOA). To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team notes that referrals to Harbor House are frequently driven by DOC Treatment Services and women court ordered to receive treatment on the unit. Oftentimes, women with severe mental illness will be perceived as disruptive on this unit and management of these combined populations is difficult. Staff reports that it is difficult for them to encourage security to override placements on the segregation unit in order to move these individuals onto the treatment unit. Recently, two women were able to join Harbor House with success and work on their behavioral dyscontrol in that environment.

During its visit to the facility, the Monitoring Team met with inmates in Harbor House. The inmates described being very satisfied with the current program. The current program was reported to be very helpful in contrast to the program during the summer months, which had been problematic due to both a staffing vacancy issue and a change in the clinician assigned to this program.

The clinician assigned to Harbor House spends approximately 95% of her time providing all the services (individual and group therapies) in Harbor House. All women in Harbor House are seen individually at least monthly. She will sit in on visits with the psychiatrist for her caseload and meets with the psychiatrist weekly to do treatment planning.

This unit has therapy groups each week and two community meetings. The Monitoring Team was informed during its August 2008 visit that there was an instance where the counselor did not have access to the private group room because that space was being used as a dormitory for new admissions to the facility (even though other areas in the facility were not at full capacity). Housing unassigned women on Harbor House disrupts the therapeutic milieu and forces groups to be run in the common area of the pod.

The Monitoring Team found that whenever one therapist is on vacation, programming on Harbor House ceases in order to provide coverage to high priority services such as new referrals and sick call requests. For example, groups were essentially not conducted during August 2008 related to staffing vacancy issues. Reasonable access to the psychiatrist was described by inmates and staff to exist.

There is not a multidisciplinary treatment team concept in this Harbor House unit, with particular reference to treatment plan development and implementation.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

During its December 2008 visit, the Monitoring Team observed a major change in the SNU at JTVCC. In the Third Report, the Monitoring Team observed that inmates in the SNU were being treated and classified as MHU inmates from a security perspective. This resulted in them enjoying less privileges and access to certain things. Since the Third Report, the State has moved one tier of the SNU program onto the Compound (Unit T1) from the Maximum Security Housing Unit, which has resulted in these inmates enjoying improved access to facility jobs, educational programming, increased visits, and commissary privileges. The less restrictive setting also provides greater ability to offer group programming. Programming continues to be limited due to staffing allocation issues. However, increased programming has been available to the SNU inmates in the compound related to better access to such programs.

The Monitoring Team had an opportunity to meet with these SNU inmates in a group setting. These inmates described the moved SNU to be significantly better than the maximum security SNU due to increased freedom of movement and better opportunity for programming.

There were two hours per weekday of activity therapies offered to inmates as well as a substance abuse and an anger management group per week. These latter groups, which lasted about one hour per group, were repeated each week which meant that about half of the inmates on this unit were offered participation in each group at any given time. The group programming was scheduled to expand to four groups per week in the very near future.

Staffing for the T1 SNU included a psychiatrist one full day every other week, 1.0 FTE mental health counselor and 1.0 FTE activities therapist, which was the same staffing allocation for the maximum security SNU.

The MHU SNU had been offering three groups per week until this past week when the group rooms used were then allotted to the educational department. The space problems subsequently were resolved during the site visit so that the SNU was again allotted space for three one-hour groups per week in the educational classrooms. When not in groups, inmates in the maximum security SNU are locked down except for activity time two hours each afternoon.

Inmates in the MHU SNU described good access to the mental health staff and found the groups to be useful. They complained about the limited number of groups offered to them and the amount of time that they are locked in their cells as well as very limited access to jobs. About four inmates reported being involved in school every week day.

Overall, the major problem keeping the State from achieving a substantial compliance rating is the limited programming available to inmates. Additionally, the State is not meeting the requirement that inmates on psychotropic medications be seen and monitored on a regular basis. The Monitoring Team believes this is not happening due to staffing allocation issues.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

There remains a paucity of programming and access to meaningful activities at HRYCI, which results in inmate idleness most of the time. Although this is not called a Special Needs Unit, it in essence functions like one and houses the most mentally ill inmates and detainees at HRYCI. The assigned counselor to this unit now has other non-transitional unit responsibilities, in contrast to his sole assignment to this unit as was once the case.

This unit clearly does not provide adequate treatment for many of the inmates on this unit who are experiencing symptoms. This is due both to staffing allocation issues and physical plant limitations. Discussions with inmates revealed that group therapy is limited to five structured activities per week that were held in a dayroom. These activities were frequently interrupted by the intercom system. Additionally, inmates reported access to the outside yard on a once per week basis.

The Monitoring Team was informed that staff at New York prisons had been consulted about programming in these units. Reportedly, useful information was gained that will hopefully aide HRYCI in coming into compliance with this provision.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that due to staffing vacancies during the summer months, inmates with serious mental health problems were not being routinely seen every 30 days. Staff had been prioritizing the available resources to focus on mental health screening and the sick call process. It was reported to the Monitoring Team that in the month preceding its

visit to the facility, staffing vacancies had decreased and these inmates were being more regularly seen.

The Monitoring Team also found that there is not adequate space for the treatment of these mental health patients. There continues to be a need for a more confidential space to provide therapeutic services by clinicians. The Monitoring Team observed that there is no area in which the psychiatrist is able to meet with inmates in an adequate environment. As mentioned above, most of the psychiatrists' time is spent in the infirmary, which has inadequate office space. Infirmary patients continue to be seen at a desk in the common area. The doctor's "office" outside the infirmary is essentially a storage closet in a main corridor. Aside from the Monitoring Team's belief that this room is potentially unsafe for a doctor to be evaluating certain inmates, the room is still being used to store filing cabinets and a gurney. The open floor space is approximately 3 x 6 feet. Finally, there continues to be an overcrowding in the infirmary for both medical and mental health inmates.

Programming for mental health inmates is also very limited due to the staffing vacancies that had existed until recently.

F. Recommendations

At Baylor, the Monitoring Team incorporates its recommendations from paragraph six of this MOA.

At JTVCC, the Monitoring Team recommends that the state increase staffing in the SNU so as to allow for more adequate programming.

38. Review of Disciplinary Charges for Mental Illness Symptoms

A. Relevant MOA Provision

Paragraph 38 of the MOA provides:

> The State shall ensure that disciplinary charges against inmates with serious mental illness who are placed in Isolation are reviewed by a qualified mental health professional to determine the extent to which the charge may have been related to serious mental illness, and to determine whether an inmate's serious mental illness should be considered by the State as a mitigating factor when punishment is imposed on inmates with a serious mental illness.

This provision of the MOA will assist the State with providing continuity of mental health care, and provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found that Baylor is not in compliance with this provision of the MOA.

2. <u>Findings</u>

In the Third Report, the Monitoring Team noted that the State had not yet implemented a policy to involve mental health staff in the disciplinary process. At the time, the Monitoring Team had provided feedback on a proposed policy and the State had made appropriate revisions. At the time of the Third Report, the policy was awaiting final approval and implementation.

During the Monitoring Team's October 2008 visit, it learned that the policy had been approved. However, it still has not been implemented. The Monitoring Team believes that it should take some time to implement this policy due to the training and supervision that is required of both mental health staff and hearing officers. However, as stated in the last report, once the policy is implemented, the Monitoring Team believes that it will not take Baylor very long to come into compliance with this provision, due to the unique disciplinary system employed at the facility, in which isolation is not used for extended periods of time.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is not in compliance with this provision of the MOA.

2. Findings

As is the case at Baylor, the policy regarding mental health input into the disciplinary process has not yet been implemented. As a result, at least one individual in the administrative segregation unit was removed from a special needs unit this past summer because in the course of his psychosis he received a disciplinary report for throwing a bucket. His observed behavior on segregation rounds during this audit may indicate that he remains actively psychotic. In the Monitoring Team's opinion, this policy may have prevented his placement in administrative segregation and allowed staff to consider moving him to a higher level of mental health care.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is not in compliance with this provision of the MOA.

2. Findings

As is the case with the other facilities, the policy that would require mental health staff's involvement in the disciplinary process has been approved but has not yet been implemented.

E. SCI

1. Assessment

The Monitoring Team found that HRYCI is not in compliance with this provision of the MOA.

2. Findings

As is the case with the other facilities, the policy which would require mental health staff's involvement in the disciplinary process has been approved but has not yet been implemented.

F. Recommendations

At all facilities, the Monitoring Team recommends that the State implement the approved policy and conduct appropriate training to ensure the policy is in place and operating effectively.

39. Procedures for Mentally Ill Inmates in Isolation or Observation Status

A. Relevant MOA Provision

Paragraph 39 of the MOA provides:

> The State shall implement policies, procedures, and practices consistent with generally accepted professional standards to ensure that all mentally ill inmates on the facility's mental health caseload and who are housed in Isolation receive timely and appropriate treatment, including completion and documentation of regular rounds in the Isolation units at least once per week by qualified mental health professionals in order to assess the serious mental health needs of those inmates. Inmates with serious mental illness who are placed in Isolation shall be evaluated by a qualified mental health professional within twenty-four [sic] hours and regularly thereafter to determine the inmate's mental health status, which shall include an assessment of the potential effect of the Isolation on the inmate's mental health. During these regular evaluations, the State shall evaluate whether continued Isolation is appropriate for that inmate, considering the assessment of the qualified mental health professional, or whether the inmate would be appropriate for graduated alternatives. The State shall adequately document all admissions to, and discharges from, Isolation, including a review of treatment by a psychiatrist. The State shall provide adequate facilities for observation, with no more than two inmates per room.

This provision of the MOA makes clear that those inmates already on the mental health caseload must receive appropriate and timely treatment, regardless of their status as being in isolation. This means that these inmates must have adequate access to mental health care. *See* J-E-07; P-E-07. According to this MOA language, this treatment includes, but is not limited to, weekly rounds in the isolation units. *See* discussion of MOA provision 20 above.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found no changes at Baylor since its last visit. As discussed elsewhere, segregation status is infrequently used at Baylor.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team notes that the policy regarding segregated inmates has not yet been implemented at JTVCC. Rounds by mental health staff in the SHU are being performed three times per week for all mental health caseload inmates and on a weekly basis for all SHU inmates. This provision requires that all inmates on the mental health caseload who are admitted to isolation status receive a mental health assessment within 24 hours of such placement to ensure there are no contraindications with respect to such placement. The Monitoring Team observed that these assessments are not routinely being performed at JTVCC.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team notes that the policy regarding segregated inmates has not yet been implemented at HRYCI. Rounds by mental health staff are being performed three times per week for all mental health caseload inmates in isolation. However, the Monitoring Team believes that rounds could be conducted more efficiently by having an assigned clinician conduct rounds instead of having multiple clinicians doing so. By using one clinician to conduct rounds, it gives that clinician an opportunity to better know the inmates and their problems and also eliminates the possibility of inmates asking multiple clinicians the same questions because they do not like the answer given by one.

This provision additionally requires that all inmates on the mental health caseload who are admitted to isolation status receive a mental health assessment within 24 hours of such placement to ensure there are no contraindications with respect to such placement. The Monitoring Team notes that the mental health clerk highlights a list of new transfers into segregation who are on the mental health caseload. As a result, the clinician conducting rounds knows to see these inmates and to conduct an assessment. However, there is no log or other method to verify this is actually taking place.

Inmates on the mental health caseload no longer have access to the "journaling" process. Previously, inmates on the mental health caseload could be provided a paper notebook and pencil so that they could keep a diary-like document for anger management or other mental health purposes. However, the staff at HRYCI was getting overwhelmed with requests from inmates to be put on the mental health caseload so that they could have access to the journaling materials for writing purposes. Inmates were attempting to get on the mental health caseload so they could avoid commissary expenses they would otherwise incur in order to get these materials.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that isolation rounds required by this provision are still occurring in a manner consistent with this paragraph.

At the time of the Monitoring Team's October 2008 visit, a contract psychologist had been handling discharge decisions from PCO status during days that a psychiatrist was not on-site. However, this psychologist was only working at SCI temporarily and it was expected that he would no longer be at SCI a few weeks after the Monitoring Team's visit. As such, it is very likely that problems will once again exist with a timely process relevant to assessment and discharge procedures regarding PCO status.

40. Mental Health Services Logs and Documentation

A. Relevant MOA Provision

Paragraph 40 of the MOA provides:

> The State shall ensure that the State maintains an updated log of inmates receiving mental health services, which shall include both those inmates who receive counseling and those who receive medication. The log shall include each inmate's name, diagnosis or complaint, and next scheduled appointment. Each clinician shall have ready access to a current log listing any prescribed medication(s) and dosages for inmates on psychotropic medications. In addition, inmate's files shall contain current and accurate information regarding any medication changes ordered in at least the past year.

This provision of the MOA will assist the State with providing continuity of mental health care, and provides a complete general standard against which to assess the State's

compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

In the Third Report, the Monitoring Team commented that a log of inmates receiving mental health services was maintained at Baylor, but that it was missing two key components required by this provision: any prescribed medications received by an inmate, and the dosages for those medications. During its October 2008 visit, the Monitoring Team observed that the log now contains a list of medications received by inmates, but still does not indicated the prescribed dosages.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found no changes at JTVCC with respect to this provision.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

In the Third Report the Monitoring Team noted that the mental health services log did not include the date of the next scheduled appointments for inmates. During its review for this report, the Monitoring Team observed that this required component is still missing from the mental health services log.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found no changes at SCI with respect to this provision.

F. Recommendations

At Baylor, the State should modify the log to include the prescribed dosages of medications.

SUICIDE PREVENTION

41. Suicide Prevention Policy

A. Relevant MOA Provision

Paragraph 41 of the MOA provides:

> The State shall review and, to the extent necessary, revise its suicide prevention policy to ensure that it includes the following provisions: 1) training; 2) intake screening/assessment; 3) communication; 4) housing; 5) observation; 6) intervention; and 7) mortality and morbidity review.

The MOA provides the complete standard against which the State is to be assessed for this provision of the MOA. The required substance of the required policy is, in large part, set forth in the MOA provisions and standards applying to each of the categories enumerated in this provision of the MOA.

The Monitoring Team found that the State is in substantial compliance with this provision of the MOA, because it has an adequate suicide prevention policy in place. The Monitoring Team notes that this provision of the MOA does not relate to the implementation of the suicide prevention policy; this provision requires only that the State review and revise its policy. Therefore, this rating of substantial compliance should not be construed as assessing the State in substantial compliance with the implementation of its suicide prevention policy.

42. Suicide Prevention Training Curriculum

A. Relevant MOA Provision

Paragraph 42 of the MOA provides:

> The State shall review and, to the extent necessary, revise its suicide prevention training curriculum, which shall include the following topics: 1) the suicide prevention policy as revised consistent with this Agreement; 2) why facility environments may contribute to suicidal behavior; 3) potential predisposing factors to suicide; 4) high risk suicide periods; 5) warning signs and symptoms of suicidal behavior; 6) case studies of recent suicides and serious suicide attempts; 7) mock demonstrations regarding the proper response to a suicide attempt; and 8) the proper use of emergency equipment.

The MOA provides the complete standard against which the State is to be assessed for this provision of the MOA. The required substance of the training curriculum is, in large part, set forth in the MOA provisions and standards applying to each of the categories enumerated in this provision of the MOA.

The Monitoring Team found that the State is in substantial compliance with this provision of the MOA, because it has an adequate suicide prevention training curriculum. The Monitoring Team notes that this provision of the MOA requires the State to review and revise its suicide prevention training curriculum, and does not relate to conducting the training. Thus, the Monitoring Team's assessment of substantial compliance is limited only to an assessment that the State has reviewed and revised its suicide prevention training curriculum. (*See also* discussion of provision 8 of the MOA, which discusses a recent revision to the suicide training curriculum for psychiatrists.)

43. Staff Training

A. Relevant MOA Provision

Paragraph 43 of the MOA provides:

> Within twelve months of the effective date of this Agreement, the State shall ensure that all existing and newly hired correctional, medical, and mental health staff members receive an initial eight-hour training on suicide prevention curriculum described above. Following completion of the initial training, the State shall ensure that a minimum of two hours of refresher training on the curriculum are completed by all correctional care, medical, and mental health staff each year.

The Monitoring Team refers to its findings and assessments relating to MOA provision 8 and 9 because the Monitoring Team interprets those provisions as requiring all correctional, medical, and mental health staff to complete the required suicide prevention training. In addition, as noted above, psychiatrists are required to take a suicide training curriculum that differs from the course that other staff takes. The DOJ recently approved the curriculum, and the DOC is in the process of implementing that training. As a result, each of the Facilities is in partial compliance with this provision of the MOA.

44. Intake Screening/Assessment

A. Relevant MOA Provision

Paragraph 44 of the MOA provides:

> The State shall develop and implement policies and procedures pertaining to intake screening in order to identify newly arrived inmates who may be at risk for suicide. The screening process shall include inquiry regarding: 1) past suicidal ideation and/or attempts; 2) current ideation, threat, plan; 3) prior mental health treatment/hospitalization; 4) recent significant loss (job, relationship, death of family member/close friend, etc.); 5) history of suicidal behavior by family member/close friend; 6) suicide risk during prior confinement in a state facility; and 7) arresting/transporting officer(s) belief that the inmate is currently at risk.

The requirement for intake screening and assessment to include these factors is discussed above, with regard to provision 33 of the MOA. The Monitoring Team found that the State has developed policies consistent with the requirements of this provision of the MOA. In addition, the Monitoring Team found that the State has implemented this policy in a manner generally consistent with this provision of the MOA. In order to make this determination, the Monitoring Team reviewed intake screening records (*see* discussion of provision 33 of the MOA), and State internal audits, if any.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team found no changes at Baylor since its last visit.

C. JTVCC

1. <u>Assessment</u>

The Monitoring Team found that JTVCC is in substantial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team found no changes at JTVCC since its last visit.

D. HRYCI

1. <u>Assessment</u>

The Monitoring Team found that HRYCI is in substantial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team reviewed the results of an audit of this provision conducted by the State. This audit showed that while initial screenings are consistently taking place as required by this provision, the assessments required by this provision are only occurring in a timely basis 84% of the time. While the State is conducting screenings as required by this

paragraph, which forms the basis for the substantial compliance rating, the Monitoring Team is concerned by the responsive rate to these initial screening and will monitor this closely during the next reporting cycle.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found no changes at SCI with respect to this provision.

45. Mental Health Records

A. Relevant MOA Provision

Paragraph 45 of the MOA provides:

> Upon admission, the State shall immediately request all pertinent mental health records regarding the inmate's prior hospitalization, court-ordered evaluations, medication, and other treatment. DOJ acknowledges that the State's ability to obtain such records depends on the inmate's consent to the release of such records.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is not in compliance with this provision of the MOA.

2. Findings

The Monitoring Team notes that the situation is unchanged since the last monitoring period. According to staff, the State is not requesting community mental health

records as required by this provision. Additionally, the State is not tracking data with respect to this provision. As a result, it is impossible to know the overall frequency of how often this is not happening.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team was informed by staff at JTVCC that records are now being routinely requested as part of the intake process. Although staff has indicated requests are being made, there is no evidence of this. Additionally, the State has not performed a CQI study to assess why response rates are so low, as previously recommended. In making its finding of partial compliance, the Monitoring Team is relying upon the representations of staff at JTVCC that these requests are actually being made. The Monitoring Team expects to see evidence of these requests during its next visit to the facility and may downgrade the finding during the next report if such evidence is not presented.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is not in compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that the State is not routinely requesting mental health records as required by this provision.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team was informed that past mental health records are requested by the nursing staff during the screening process, but significant difficulties were reported in obtaining these records in a timely manner. It is unclear what exactly the State is doing to

request these outside records and how they are doing it. Also unclear is the exact response they are getting from these outside records holders. In making its finding of partial compliance, the Monitoring Team is relying upon the representations of staff at SCI that these requests are actually being made. The Monitoring Team expects to see evidence of these requests during its next visit to the facility and may downgrade the finding during the next report if such evidence is not presented.

F. Recommendations

At Baylor and HRYCI, the Monitoring Team repeats it recommendation from the Third Report that the facility implement policies and procedures to ensure timely requests and tracking of community records.

46. Identification of Inmates at Risk of Suicide

A. Relevant MOA Provision

Paragraph 46 of the MOA provides:

> Inmates at risk for suicide shall be placed on suicide precautions until they can be assessed by qualified mental health personnel. Inmates at risk of suicide include those who are actively suicidal, either threatening or engaging in self-injurious behavior; inmates who are not actively suicidal, but express suicidal ideation (*e.g.*, expressing a wish to die without a specific threat or plan) and/or have a recent prior history of self-destructive behavior; and inmates who deny suicidal ideation or do not threaten suicide, but demonstrate other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury.

The MOA requires that the State place any inmate at risk for suicide[112] on suicide precautions until they can be assessed by qualified mental health personnel. Suicide precautions refer to the housing and observation requirements set forth in paragraphs 49 through 51 below. The State has developed a policy that suicide precautions will consist of placing the inmate under constant observation by correctional staff in a safe cell while an order for placement on psychiatric observation is obtained from the appropriate medical or mental health personnel. G-05. The Monitoring Team finds that this policy conforms to generally accepted professional standards. *See* J-G-05; P-G-05. As set forth in paragraph 47 below, the assessment by qualified mental health personnel should be performed within 24 hours of the initiation of suicide precautions.

[112] The MOA defines an "inmate at risk for suicide" as one who is (i) actively suicidal by threatening or engaging in self-injurious behavior; (ii) not actively suicidal, but expresses suicidal ideation; and/or has a recent prior history of self-destructive behavior; and (iii) who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior indicating the potential for self-injury.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found no changes at Baylor since its last visit.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

In examining this provision, the Monitoring Team reviewed the records of five inmates who had been placed on PCO status since April 2008. The Monitoring Team found that these inmates were seen on a daily basis as documented on the PCO progress form. However, these forms frequently were filled out incompletely. Inmates on PCO status while housed in the SHU continued to be monitored closely although their treatment plans were often very vague in content, which is the basis for this partial compliance rating. While it is clear that inmates on PCO status are being seen on a daily basis, documentation issues exist within five charts reviewed.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team's review of records was consistent with their findings in the previous reports that inmates are placed on watch if HRYCI staff determines they are at risk of suicide, and that the determinations regarding which inmates are at risk of suicide are appropriate.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team was informed by the mental health supervisor that inmates identified as being suicidal are placed on suicide precautions in a timely manner as required by this provision. However, as noted in the findings for paragraph 36, there is a shortage of PCO cells, which means that many inmates are placed on suicide precautions in cells that are not safety cells. As these inmates are not being placed on appropriate suicide precautions, the State is not fully compliant with this provision at this point. This MOA paragraph requires that inmates at risk for suicide be placed on suicide precautions. The fact that inmates are placed on suicide precautions in cells that are not safety cells is a treatment issue because it affects the clinical safety needs of the inmate.

47. Suicide Risk Assessment

A. Relevant MOA Provision

Paragraph 47 of the MOA provides:

> The State shall ensure that a formalized suicide risk assessment by a qualified mental health professional is performed within an appropriate time not to exceed 24 hours of the initiation of suicide precautions. The assessment of suicide risk by qualified mental health professionals shall include, but not be limited to, the following: description of the antecedent events and precipitating factors; suicidal indicators; mental status examination; previous psychiatric and suicide risk history, level of lethality; current medication and diagnosis; and recommendations/ treatment plan. Findings from the assessment shall be documented on both the assessment form and health care record.

This provision of the MOA requires a formalized suicide risk assessment to be performed by a qualified mental health professional[113] within an appropriate period of time, which, in any event, is not to exceed 24 hours of the initiation of suicide precautions as described above in relation to paragraph 46 of the MOA. The formalized suicide risk assessment should designate the individual's level of suicide risk, level of supervision needed, and the need for

[113] The State has developed a policy that a mental health staff (*i.e.*, an employee with a master's degree or greater level of certification) is qualified for the purposes of initiating an order for psychiatric observation, but that only a psychologist with a Ph.D., or a psychiatrist may discharge or downgrade an inmate's level of risk while on psychiatric observation. *See* State Policy G-05. The Monitoring Team found that policy to be adequate.

transfer to an inpatient mental health facility or program. J-G-05; P-G-05. In addition, the MOA provides that the assessment of the individual's level of suicide risk should include at least: (i) a description of the antecedent events and precipitating factors; (ii) suicidal indicators; (iii) mental status examination; (iv) previous psychiatric and suicide risk history, (v) level of lethality; (vi) current medication and diagnosis; and (vii) recommendations/treatment plan.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the charts of 11 inmates who had been placed on PCO. The Monitoring Team looked for the initial assessment required by this provision and examined the contents of that assessment. The Monitoring Team found initial assessments recorded in nine of the 11 charts. However, even in those charts where initial assessments were present, most of these lacked any extensive narrative.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the charts of inmates on PCO status. This review demonstrated that formalized suicide risk assessments by qualified mental health professionals were performed within an appropriate time frame that did not exceed 24 hours from the initiation of suicide precautions. This initial assessment was documented in the inmate's record and included all elements required by this provision.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the charts of 14 inmates who had been placed on PCO status and found that nine of these inmates had completed suicide risk assessments as required by this provision. The inconsistencies with completing these assessments may be due to the staffing shortages at the facility. In most of the cases where adequate assessments were not present in the record it was due to an incomplete assessment. Most commonly, the section for lethality risk on the assessment form was not completed as required by this provision.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that suicide risk assessments are being performed by the mental health staff. Additionally, during its October 2008 visit, the Monitoring Team observed that there is more meaningful input to the PCO status from the psychiatrist. This has also been supplemented by a psychologist who was working at the facility on a temporary basis. In several of the records examined by the Monitoring Team, there was no risk assessment.

48. Communication

A. Relevant MOA Provision

Paragraph 48 of the MOA provides:

> The State shall ensure that any staff member who places an inmate on suicide precautions shall document the initiation of the precautions, level of observation, housing location, and conditions of the precautions. The State shall develop and implement policies and procedures to ensure that the documentation described above is provided to mental health staff and that in-person contact is made with mental health staff to alert them of the placement of an inmate on suicide precautions. The State shall ensure that mental health staff thoroughly review an inmate's health care record for documentation of any prior suicidal behavior. The State shall promulgate a policy requiring mental health to utilize progress notes to document each interaction and/or assessment of a suicidal inmate. The decision to upgrade, downgrade, discharge, or maintain an inmate on suicide precautions shall be fully justified in each progress note. An inmate shall not be downgraded or discharged from suicide precautions until the responsible mental health staff has thoroughly reviewed the inmate's health care record, as well as conferred with correctional personnel regarding the inmate's stability. Multidisciplinary case management team meetings (to include facility officials and available medical and

mental health personnel) shall occur on a weekly basis to discuss the status of inmates on suicide precautions.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that there are no weekly multi-disciplinary meetings occurring that include staff other than the counselor and psychiatrist monitoring a patient's progress. The Monitoring Team notes that inmates continue to be appropriately assessed for risk of imminent self-harm and are placed on a clinically determined level of observation.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found no changes at JTVCC since its last visit.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found no changes since its last visit with respect to this provision. While multidisciplinary case management team meetings are occurring on a weekly basis, they still do not include facility level custody staff as required by this provision.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found no changes at SCI since its last visit.

F. Recommendations

At Baylor, the Monitoring Team repeats its recommendation from the Third Report that multidisciplinary case management team meetings be established relevant to the requirements of this provision.

49. Housing

A. Relevant MOA Provision

Paragraph 49 of the MOA provides:

> The State shall ensure that all inmates placed on suicide precautions are housed in suicide-resistant cells (*i.e.,* cells without protrusions that would enable inmates to hang themselves). The location of the cells shall provide full visibility to staff. At the time of placement on suicide precautions, medical or mental health staff shall write orders setting forth the conditions of the observation, including but not limited to allowable clothing, property, and utensils, and orders addressing continuation of privileges, such as showers, telephone, visiting, recreation, etc., commensurate with the inmate's security level. Removal of an inmate's prison jumpsuit (excluding belts and shoelaces) and the use of any restraints shall be avoided whenever possible, and used only as a last resort when the inmate is engaging in self-destructive behavior. The Parties recognize that security and mental health staff are working towards the common goal of protecting inmates from self-injury and from harm inflicted by other inmates. Such orders must therefore take into account all relevant security concerns, which can include issues relating to the commingling of certain prison populations and the smuggling of contraband. Mental health staff shall give due consideration to such factors when setting forth the conditions of the observation, and any disputes over the privileges that are appropriate shall be resolved by the Warden or his or her designee. Scheduled court hearings shall not be cancelled because an inmate is on suicide precautions.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings. The State has developed a policy that addresses these issues with more specificity. *See* State Policy G-05. The State's policy classifies differing levels of suicide risk as Levels I through III.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team found that inmates on suicide watch are placed in another area of the facility on occasion for overflow purposes when the safety cells are filled or occasionally as a result of staffing issues. Inmates in those cells are not always under constant observation by an officer. Rather, the single officer assigned to the unit covers PCO for these cells as well as all the other residents in the segregation area. The cells used in the alternative areas for PCO purposes are not "safety cells" and such cells should not be used unless the inmate is on constant watch.

The above concerns were discussed with the Warden at Baylor, who explained that the process for converting these four cells in the alternative areas to safety cells has been initiated.

C. JTVCC

1. <u>Assessment</u>

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team found no changes from its previous two visits to the facility. Of continued significance is JTVCC's continued use of a toilet in one of the cells used for suicide watch which is essentially a hole in the ground. As discussed elsewhere in this report, a pilot project was recently completed at HRYCI to improve the type of toilet used in these types of cells. The Monitoring Team hopes that with the success of this pilot program, JTVCC can also begin using a stainless steel toilet instead of the current option.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

As noted elsewhere in this Report, the State has successfully completed a pilot program at HRYCI to improve the type of toilet used in the suicide-resistant cells. This program was used in one of the two cells at HRYCI, and the Monitoring Team hopes that its successful implementation will result in a similar change to the other cell.

E. SCI

1. Assessment

The Monitoring Team found that SCI is not in compliance with this provision of the MOA.

2. Findings

The Monitoring Team bases its assessment on the same findings as discussed in paragraph 36.

50. Observation

A. Relevant MOA Provision

Paragraph 50 of the MOA provides:

> The State shall develop and implement policies and procedures pertaining to observation of suicidal inmates, whereby an inmate who is not actively suicidal, but expresses suicidal ideation (*e.g.*, expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior, or an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, shall be placed under close observation status and observed by staff at staggered intervals not to exceed every 15 minutes (*e.g.*, 5, 10, 7 minutes). An inmate who is actively suicidal, either threatening or engaging in self-injurious behavior, shall be placed on constant observation status and observed by staff on a continuous, uninterrupted basis. Mental health staff shall assess and interact with (not just observe) inmates on suicide precautions on a daily basis.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found no changes at Baylor since its last visit.

C. JTVCC

1. Assessment

The Monitoring Team found JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that problems noted in previous reports concerning a lack of sound privacy from correctional officers and other inmates continues to exist and significantly hampers the quality of assessments required by this provision. However, the State is in the final stages of completing renovations which should remedy this problem.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

In the Third Report, the Monitoring Team was critical about a lack of sound privacy from correctional officers and other inmates which hampers the quality of assessments required by this provision. The Monitoring Team was informed during its more recent visit that renovations to remedy this issue are nearly complete. These renovations will provide private interview space for the mental health staff and their patients.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in substantial compliance with this provision of the MOA.

2. Findings

In the Third Report, the Monitoring Team noted that although 15 minute checks were ordered in appropriate circumstances, it was unable to determine whether the checks were actually occurring as the records did not indicate this. During its October 2008 visit, the Monitoring Team observed that check off sheets were marked indicating that the required 15 minute checks were occurring.

51. "Step-Down Observation"

A. Relevant MOA Provision

Paragraph 51 of the MOA provides:

> The State shall develop and implement a "step-down" level of observation whereby inmates on suicide precaution are released gradually from more restrictive levels of supervision to less restrictive levels for an appropriate period of time prior to their discharge from suicide precautions. The State shall ensure that all inmates discharged from suicide precautions continue to receive follow-up assessment in accordance with a treatment plan developed by a qualified mental health professional.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the records of 11 inmates who had been placed on PCO status. In those records it appears that eight of the 11 followed the policy requirements

for step down and post-PCO review. In the three cases where the requirements were not met, there did not appear to be any notes evidencing step down observations.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the records of five inmates who had been placed on PCO status since April 2008. While this small sample indicated that step down observation was occurring as required by this provision, there is little documentation in the records indicating why inmates were released to less restrictive levels of supervision. Additionally, the partial compliance assessment is due to space issues which have not yet been remedied. These space issues pertain to the infirmary, where inmates are still not seen in private areas because there is no furniture.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that inmates are being seen daily by mental health staff once they are on PCO status. Step downs and release from observation occurs by order of the psychiatrist. In its review of relevant records, the Monitoring Team observed an absence of notes indicating that the required post-observations had occurred. It is the absence of these notes which is keeping the State from achieving substantial compliance with this provision.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the results of an audit completed by the State which examined whether inmates released from suicide watch were seen within 24 hours by

mental health staff. The audits produced highly inconsistent results between June and September 2008, suggesting that the methodology needs improvement. As a result of the audit, a post-level documentation form was created. When an inmate is removed from a level of supervision, notice is given by a clinician to their supervisor. The Clinician is required to follow-up within 24 hours.

52. Intervention

A. Relevant MOA Provision

Paragraph 52 of the MOA provides:

> The State shall develop and implement an intervention policy to ensure that all staff who come into contact with inmates are trained in standard first aid and cardiopulmonary resuscitation; all staff who come into contact with inmates participate in annual "mock drill" training to ensure a prompt emergency response to all suicide attempts; and shall ensure that an emergency response bag that includes appropriate equipment, including a first aid kit and emergency rescue tool, shall be in close proximity to all housing units. All staff members who come into regular contact with inmates shall know the location of this emergency response bag and be trained in its use.

As provided by the MOA, all staff coming into contact with the inmate should be trained in standard first aid procedures and CPR. Further, the "mock drill" training should include training for staff coming into contact with inmates regarding what to do when coming into contact with an inmate engaging in self-harm, or who has engaged in self-harm. Lindsay M. Hayes, *Guide to Developing and Revising Suicide Prevention Protocols*, included as Appendix C to the NCCHC Standards cited above. The staff member coming upon an inmate engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and to start first aid and/or CPR as necessary, even if the inmate appears to have died until relieved by arriving medical personnel. *Id*. The emergency response equipment available to staff should be checked on a daily basis to determine that it is in working order. Finally, all suicide attempts, regardless of their severity should result in an immediate intervention and assessment by mental health staff. *Id*.

B. <u>Assessment</u>

The Monitoring Team found that each of the Facilities is in partial compliance with this provision of the MOA.

C. <u>Findings</u>

The Monitoring Team incorporates its findings and assessments regarding provisions 8, 9, 27, 28, and 32, as the training and equipment-related requirements overlap with the requirements contained in this provision of the MOA. Although some of the Facilities are in substantial compliance with some of the overlapping provisions, this provision of the MOA

requires emergency preparedness, which is a component of the MOA with which the State has not come into substantial compliance.

53. Mortality and Morbidity Review

A. Relevant MOA Provision

Paragraph 53 of the MOA provides:

> The State shall develop and implement policies, procedures, and practices to ensure that a multidisciplinary review is established to review all suicides and serious suicide attempts (*e.g.*, those incidents requiring hospitalization for medical treatment). At a minimum, the review shall comprise an inquiry of: a) circumstances surrounding the incident; b) facility procedures relevant to the incident; c) all relevant training received by involved staff; d) pertinent medical and mental health services/reports involving the victim; e) possible precipitating factors leading to the suicide; and, f) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. When appropriate, the review team shall develop a written plan (and timetable) to address areas that require corrective action.

An appropriate procedure in the event of an inmate death from suicide or a serious suicide attempt is one in which the State determines the appropriateness of clinical care that was provided to the inmate, ascertains whether corrective action in the State's policies, procedures, or practices is warranted; and identifies trends that require further study. J-A-10; P-A-10. If the inmate has committed suicide, the State should immediately notify the State of Delaware medical examiner, and, within 30 days of the suicide, conduct a clinical mortality review[114] and a psychological autopsy[115] in a manner consistent with this MOA provision, which provides the minimum inquiries necessary for these studies. J-A-10; P-A-10.

The Monitoring Team found that the Mortality and Morbidity review ("M&M") process designed by the State is adequate, and applies to all inmate deaths, not just those due to suicide. The M&M process consists of a review of inmate's record by a physician on site within 24 hours of the inmate's death. In addition, the State refers the inmate's death to the Medical Society, which performs a review of the circumstances of the inmate's death within 30 days.

[114] A "clinical mortality review" is "an assessment of the clinical care provided and the circumstances leading up to the death" in order to "identify any areas of patient care or the system's policies and procedures that can be improved." J-A-10; P-A-10.

[115] A "psychological autopsy" is "usually conducted by a psychologist or other qualified mental health professional" and consists of "a written reconstruction of an individual's life with an emphasis on factors that may have contributed to the individual's death." J-A-10; P-A-10.

The inmate is sent to the State Medical Examiner for a review of the inmate's body.[116] The next step in the process is that each Facility's M&M Committee, which consists of a physician and nursing staff, and local and regional committee members, convenes a meeting to review the Medical Society report, 24-hour report, and, if available, the Medical Examiner's report and death certificate of the inmate.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team was not able to assess this provision of the MOA because there had been no serious suicide attempts since the Monitoring Team's last visit.[117] The Monitoring Team notes, however, that the State has adopted and implemented a policy relating to this provision of the MOA.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is not in compliance with this provision of the MOA.

2. Findings

During its December 2008 visit, the Monitoring Team reviewed two mortality and morbidity reviews conducted since August 2008. The Monitoring Team found several problem areas within these reports. Currently, the HSA writes up the initial and final mortality reviews. In the Monitoring Team's opinion, the site medical director should be responsible to complete and sign these critical clinical reports. In the event of a suicide, input from the psychiatric director or mental health director on site should be included as well with a co-signature by that clinician.

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[116] The State Medical Examiner conducts a visual examination of the body, but does not conduct an autopsy. Recently, the Monitoring Team has learned that the State has asked the Medical Examiner to conduct autopsies on inmates who die in custody, and the Medical Examiner has agreed to do so.

[117] There was a suicide attempt prior to the publication of this report, but subsequent to the Monitoring Team's visit to Baylor. That attempt will be reviewed for the next report.

In addition, neither the HSA nor the other staff members in attendance were able to locate the M&M committee report from one case. Therefore, a change in recording and tracking of this type of document is recommended.

The quality of the clinical detail in the reports, especially references to every known timeframe, is underdeveloped. There is no reference to a review of prior medical records or a listing of all sources of data used to draw conclusions. In addition, neither report included the medical examiner's report.

Finally, any problems identified during the M&M review process should be referenced to a corrective action plan with a timeline for implementation and the responsible party to carry out the element of the plan. Problems identified that are broad in scope because they relate to prior adverse events should be identified so that the scope of the corrective action plan can be judged appropriate to the magnitude of the identified problem.

D. HRYCI

1. Assessment

The Monitoring Team defers providing an assessment rating due to the fact that there have been no recent deaths from suicide at HRYCI.

2. Findings

There have been no deaths since the Monitoring Team's last visit so there has been no documentation to review.[118]

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that policies and procedures have been developed for M&M reviews. The Monitoring Team reviewed past reports, and found that they lacked a summary of findings and planned actions. The Monitoring Team was informed that this information did exist in written form and would be available to CMS staff in the future. The Monitoring Team believes that this information should be a part of the report.

[118] There was a serious suicide attempt at HRYCI prior to the publication of this report, but subsequent to the Monitoring Team's visit to HRYCI. The Monitoring Team will review that suicide attempt during the next visit.

QUALITY ASSURANCE

54. Policies and Procedures

A. Relevant MOA Provision

Paragraph 54 of the MOA provides:

> The State shall develop and implement written quality assurance policies and procedures to regularly assess and ensure compliance with the terms of this Agreement. These policies and procedures should include, at a minimum: provisions requiring an annual quality management plan and annual evaluation; quantitative performance measurement with tools to be approved in advance by DOJ; tracking and trending of data; creation of a multidisciplinary team; morbidity and mortality reviews with self-critical analysis, and periodic review of emergency room visits and hospitalizations for ambulatory-sensitive conditions.

The Facilities should create a comprehensive CQI program[119] that performs the following functions in a fashion that complements the requirements contained in this provision of the MOA:

- establishes a multidisciplinary quality improvement committee[120] that meets at least quarterly and designs quality improvement monitoring activities, discusses the results, and implements corrective action;

- reviews, at least annually, access to care, receiving screening, health assessment, continuity of care (sick call, chronic disease management, discharge planning), infirmary care, nursing care, pharmacy services, diagnostic services, mental health care, dental care, emergency care, and hospitalizations, adverse patient occurrences including all deaths, critiques of disaster drills, environmental inspection reports, inmate grievances, and infection control;

- completes an annual review of the effectiveness of the CQI program by reviewing minutes of its committee meetings;

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[119] A "comprehensive CQI program" is defined as including, "a multidisciplinary quality improvement committee, monitoring of the areas specified in the compliance indicators, and an annual review of the effectiveness of the CQI program itself." J-A-06; P-A-06. "CQI" means "continuous quality improvement."

[120] A "multidisciplinary quality improvement committee" is defined as "a group of health staff from various disciplines that designs quality improvement monitoring activities, discusses the results, and implements corrective action. J-A-06; P-A-06.

- performs at least one process quality improvement study[121] a year; and
- performs at least one outcome quality improvement study[122] a year.

J-A-06; P-A-06.

As reported in the Third Report, the Monitoring Team found that there is a Regional CQI Committee, and was able to participate at that committee's first meeting. The Monitoring Team also has been informed that the Regional Medical Director has begun to conduct peer review. The Monitoring Team is encouraged by this process, but encourages greater focus on detailed clinician assessment, and diagnostic and therapeutic plans. The policy that has been enacted requires an annual peer review. The Monitoring Team recommends that for every new clinician, a peer review be conducted within the first three months of his or her start date in order to determine the adequacy of the clinician's performance and provide the clinician with helpful feedback. Once that peer review process demonstrates satisfactory performance by the clinician, then annual peer review would be appropriate.

A new quality assurance person has been hired by the State and, in addition, the Monitoring Team met with the new regional manager from CMS as well as the DON who has been assigned the quality assurance responsibility.

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that there continues to be regular meetings of the CQI Committee, and documentation of the CQI studies performed as required by the OHS quality assurance program. However, the Monitoring Team's findings of systemic problems such as (1) an increase in refusals of physical assessments, (2) a lack of detailing to "yes" answers on the screen, (3) delays in the screen being performed, (4) problems with the timeliness of the health assessments, as well as problems with medication administration and chronic disease management suggest that the local program needs to do a better job of suggesting areas for study based on people's experiences with the program. The Monitoring Team would expect that the CQI program would utilize the discussions that the Monitoring Team had with facility leadership during the Monitoring Team's visit and at the exit interview to augment the quality

[121] "Process quality improvement studies" are studies that "examine the effectiveness of the health care delivery process." J-A-06; P-A-06.

[122] "Outcome quality improvement studies" are studies that "examine whether expected outcomes of patient care were achieved." J-A-06; P-A-06.

assurance program, looking at the areas that the Monitoring Team identified as problematic during their visit. While the CQI committee does meet on a monthly basis, the minutes of its meetings were sparse in nature.

The State conducted an audit at Baylor in September 2008. The Monitoring Team reviewed the results of this audit and the methodology used in completing it. The Monitoring Team found several problems with the methodology used. Specifically, the Monitoring Team believes the audit should be written in a report form that includes the purposes of the audit, the specific methodology used, the results of the audit, an assessment of the results, and finally, planned actions that will be taken based upon that assessment. Additionally, the Monitoring Team believes the sample size used for some of the items reviewed was too small. This negatively impacts the statistical significance of the results.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team had a lengthy discussion with the leadership at JTVCC. Since January 2008, there were only three monthly meetings with minutes documenting quality assurance data and discussion. The most recent minutes were from May 2008.

There is activity by the program performing the studies required by the OHS, including studies of chronic care, nurse sick call, medication administration, specialty care and receiving screening, as well as controlled substance usage and Warfarin follow-up. There are plans for studies on discharge planning and substance withdrawal. However, if one looks at the studies, one finds over time varying performance, such that it appears that the processes are not stable. In a stable process, one might see incremental improvement or deterioration but one should not find wildly fluctuating percentages of compliance, which was found with several of the processes. Very few (if any) of the areas studied demonstrated consistent improvement over time. Thus, it is not at all clear that whatever is being done to improve performance is having any significant impact.

At the end of this discussion, the leadership team indicated they were going to substantially re-vamp the program. The Monitoring Team strongly encouraged the leadership group to utilize information they learned from the Monitoring Team's monitoring process to set up their own monitoring of many of the same things the Monitoring Team looks at so that they can begin to potentially be a step ahead of us and use their Quality Assurance Program for improving things before the Monitoring Team arrives. Their Quality Assurance Program has been completely driven by CMS corporate quality assurance program. That program alone will not facilitate their achieving substantial compliance with the MOA. They must incorporate the kind of studies that the Monitoring Team is doing in order to facilitate improvement in the areas

which the Monitoring Team reviews. They were in agreement and indicated they were going to incorporate this aspect in the very near future.

The Monitoring Team found that CQI studies performed regarding mental health-related issues, since its last visit were few in number and inadequate in scope. As discussed elsewhere in this report, the Monitoring Team found serious problems with the methodology employed by the State in the CQI studies that were completed. These problems related both to the sample sizes used for these studies and the basis for compliance in these studies being unclear.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.

2. Findings

There is a statewide policy which has not yet been fully implemented at HRYCI. In fact, there had been no Quality Assurance Committee meetings since the Monitoring Team's previous visit to HRYCI in May 2008. There have been isolated studies performed, but the data from those studies has not been reviewed, analyzed or discussed, nor have there been any implemented improvement strategies.

The Monitoring Team found little change in the CQI process since the Third Report. As is the case at the other Facilities, studies conducted at the facility were problematic from the perspective of understanding the methodology used and the assessment of the results.

Additionally, the Monitoring Team noted that while monthly CQI committee meetings had occurred without interruption, monthly mental health CQI subcommittee meetings had not occurred for a period of time due to staffing issues. The Monitoring Team was informed that these subcommittee meetings had restarted in July 2008.

E. SCI

1. Assessment

The Monitoring Team found SCI to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed some of the documented studies performed during this monitoring period, and, although some of the studies contained useful information for tracking, many of the studies were not using a methodology which resulted in adequate data. For

many of the studies, medical records were selected randomly. As a result, the majority of the records were not applicable to the subject matter being reviewed causing the denominator of usable records to be insufficient to produce meaningful data.

The Monitoring Team offered technical assistance regarding how to efficiently perform studies using targeted record selection. The Monitoring Team also discussed the appropriateness of utilizing the Monitoring Team's reports and the action plans generated from the reports as material to be monitored in the quality assurance program. Things such as timeliness of nurse sick call as well as specialty follow-up visits should be monitored.

It appears that many items may be monitored using the DACS system by running reports. The Monitoring Team offered technical assistance regarding how to effectively use DACS to perform such studies. An example would be to pull records of people for whom a sick call slip was submitted and received and to determine whether the assessment visit occurred within the required timeframe. Equally important to the number of outliers in a given timeframe is a list of the names of the outliers so that DACS and the medical record can be reviewed to determine the cause for the outliers (and whether the DACS data is correct). This additional review will facilitate the design of the improvement strategies that are likely to be effective. The Monitoring Team and staff went over this process with regard to medical screening, health assessments, sick call access, specialty consultations, offsite emergency care and hospitalizations and other major service areas. The critical need is for all of the health care staff to assiduously utilize the DACS system so that supervisory staff can utilize DACS reports and be confident that these reports accurately reflect performance. The Monitoring Team looks forward to a return visit, and hopes that not just SCI but all of the Facilities will use the DACS reports as a tool for monitoring the program and understanding reasons for outliers. The Monitoring Team also would hope that all institutions utilize their corrective action plans as part of what is to be monitored through their quality assurance program.

In connection with this provision, an audit was conducted at SCI in August 2008. The Monitoring Team reviewed the results of this audit and the methodology used in completing it. The Monitoring Team found several problems with the methodology used. Specifically, the Monitoring Team believes the audit should be written in a report form that includes the purposes of the audit, the specific methodology used, the results of the audit, an assessment of the results, and finally, planned actions that will be taken based upon that assessment. Additionally, the Monitoring Team believes the sample size used for some of the items reviewed was too small. This negatively impacts the statistical significance of the results.

F. Recommendations

At all of the Facilities, the Monitoring Team recommends that the State implement a more robust CQI system. Audits conducted as part of this system should be reported in a written format that includes the various components discussed in above in the findings section.

55. Corrective Action Plans

A. Relevant MOA Provision

Paragraph 55 of the MOA provides:

> The State shall develop and implement policies and procedures to address problems that are uncovered during the course of CQI activities. The State shall develop and implement corrective action plans to address these problems in such a manner as to prevent them from occurring again in the future.

This provision of the MOA requires that the State develop and implement policies and procedures in response to the uncovering of problems during the CQI activities that are discussed in paragraph 54 of the MOA. In addition, the State is required to develop and implement corrective action plans to address these problems in such a manner as to prevent them from occurring again in the future. The Monitoring Team suggests that an adequate corrective action plan will include a description of the problem that has, the specific steps that the State plans to take to remedy the problem, and a deadline for correction of the problem. Finally, the State should make provisions for a responsible party to follow-up after the deadline to ensure that the corrective action plan was followed appropriately.

The Monitoring Team reports that the State has not created or implemented any corrective action plans pursuant to this provision of the MOA during the past reporting period about which the Monitoring Team has been made aware. The Monitoring Team believes that to be the case because the CQI programs at the Facilities are in the early stages of implementation. The Monitoring Team expects that as the Facilities implement and strengthen their respective CQI programs, the State will have corrective action plans for the Monitoring Team to evaluate. Thus, at present, there is nothing for the Monitoring Team to assess. Without an effective CQI process to general the corrective action plans, the State will not be able to come into compliance with this provision of the MOA.

CONCLUSION

As discussed in the Third Report, the State is making progress toward substantial compliance with the provisions of the MOA. The State, however, continues to have a great deal more to do to achieve substantial compliance with the MOA. As noted in the Executive Summary, 164 of the 217 compliance assessments contained in this report are partial compliance.[123] As noted earlier in this report, a partial compliance rating can signify that the State has made some progress toward substantial compliance, or it can signify that the State is nearly in substantial compliance with respect to a given provision of the MOA. As shown in the findings and recommendations in this report, the Monitoring Team has attempted to assist the State with determining how to change partial compliance assessments to substantial compliance assessments.

The Fifth Report will be issued in September 2009. The Monitoring Team will continue to provide technical assistance to the State during the next monitoring period. The Monitoring Team also anticipates that the State might implement some of the Monitoring Team's recommendations and, as a result, see additional improvement in its performance. Additionally, it is anticipated that the State will begin some form of self-monitoring during the next monitoring cycle. The Monitoring Team anticipates reviewing and evaluating this initiative in addition to its own monitoring of the State's performance under the MOA provisions. The Monitoring Team expects to report on the State's initiatives in the next report.

[123] There are 217 compliance assessments in this report because for JTVCC, HRYCI, and SCI, there are 54 provisions being rated, and, for Baylor, there are 55 provisions being rated. Further, the Monitoring Team found that 38 of the 217 compliance assessments were substantial compliance, and 15 of the compliance assessments were non-compliance.

APPENDIX I

The Monitoring Team

The following is a collection of brief biographies for each of the experts, including the two new members:

Ronald Shansky, M.D.

Dr. Shansky has over three decades of experience auditing or investigating health care facilities in correctional facilities. He has experience in jails and prisons and in both the federal system, state systems, local jails and in the District of Columbia system.

Dr. Shansky has worked with the DOJ in reviewing programs in such states as Alabama, Mississippi, and Georgia. He has also monitored programs for the courts in other jurisdictions such as New Jersey, Wisconsin, and Ohio

Dr. Shansky graduated from the University of Wisconsin with a Bachelor of Science and received his Doctor of Medicine from the Medical College of Wisconsin. Additionally, Dr. Shansky received a Master of Public Health from the University of Illinois School of Public Health. He has a special focus on improving the quality of correctional health services and is an expert on chronic care diseases.

Dr. Shansky currently resides in Illinois.

Lynn Sander, M.D., FACP, FSCP, CCHP

Dr. Sander, a board certified internist, joined the Monitoring Team in the third reporting cycle. Dr. Sander has over two decades of experience with health care in correctional facilities. Her experience includes nineteen years caring for inmates of the Denver Sherriff Department first as Director of Medical Services and then as Departmental Medical Director. She spent three years working as the Corporate Medical Director for Correctional Healthcare Management. Dr. Sander is also a member of several professional organizations and is a Fellow of both the Society of Correctional Physicians and the American College of Physicians. She served as the President of the Society of Correctional Physicians from 2005-2007 and is currently serving as Immediate Past-President and Editor of Corrdocs.

Dr. Sander graduated from the University of Vermont with a Bachelor of Arts, and received her Doctor of Medicine from Boston University School of Medicine. She currently resides in Colorado.

Madeleine LaMarre, MN, FPN-BC

Ms. LaMarre is a board certified family nurse practitioner, and has over twenty years of experience working in the Georgia Department of Corrections. She was the Nursing Director of the Georgia Department of Corrections for over a decade, and was the Statewide Clinical Services Manager for an additional nine years. Ms. LaMarre also has been appointed a medical expert in the states of California and Ohio.

Ms. LaMarre has authored numerous publications on health care related issues in correctional facilities. She received her Master of Nursing from Emory University, and her Bachelor of Science in Nursing from Russell Sage College. Ms. LaMarre currently resides in Georgia.

Mary Ellen Lane, BSN, MBA

Ms. Lane, along with Dr. Sander, joined the team during this third reporting cycle. She is a registered nurse, and has over twenty years of experience in the health care industry. She was employed as a Clinical Services Consultant in the Georgia Department of Corrections, and also was the Health Service Administrator at Walpole State Prison in Massachusetts.

Ms. Lane received a Master of Business Administration from Bryant College, and her Bachelor of Science in Nursing from Boston College. She currently resides in Georgia.

Jeffrey Metzner, M.D.

Dr. Metzner is a board certified forensic psychiatrist with extensive experience over the last twenty five years, much of which has included working for the courts monitoring mental health programs in prisons and jails. Specifically, he has served as a monitor in some capacity in facilities in New York, Puerto Rico, Kansas, Ohio, California, Illinois, Georgia, Montana, Washington, Florida, and New Mexico.

Dr. Metzner has written numerous articles and portions of books covering mental health services in the correctional facility setting. He received his Bachelor of Science from the University of Maryland, and received his Doctor of Medicine from the University of Maryland Medical School. Dr. Metzner currently resides in Colorado.

Roberta Stellman, M.D., DABPN, CCHP, DFAPA

Dr. Stellman is also a board certified psychiatrist with previous experience in the correctional facility setting. Dr. Stellman also serves as Compliance Monitor for Behavioral Health Services for a facility in Albuquerque, New Mexico. She has also spent over 17 years working in facilities in New Mexico as a Clinical Psychiatrist. She has also monitored and reviewed correctional systems in Arizona, Florida, Texas, and Massachusetts.

Dr. Stellman received her Doctor of Medicine from the State University of New York. She completed her residency at the University of New Mexico and currently resides in New Mexico.

APPENDIX II

JTVCC Staffing Analysis

Currently there are 58 hours per week at this site for an estimated 49 weeks per year which equals 2,842 hours per year.

ACTIVITY[124]	TOTAL TIME EXPENDED
New mental health DACS referrals: 945 x .75 hours = 708.75	709
The SNU caseload is approximately 70 inmates; A minimum of two treatment team meetings per week at 1 hours each = 104 hours/year; A minimum of two treatment planning meetings per month at 2 hours each =104 hours/year; Attendance at weekly facility wide treatment meeting 1.5 hrs x 1 psychiatrists (each attends ½ of the meetings) x 52 = 78 hours/year; A minimum of monthly MD visits at .5 hours per month x 70= 420 hours/year	706
PCO (Infirmary) 256 contacts with an ALOS 11 days = 2816 patient days per year; 256 psychiatric assessments of PCO patients at 1 hour = 256 hours/year; Daily PCO visits at .5 hour per out of cell contact x 2816 x 5/7 days/week =1006 hour/year; Documentation and crisis petitions, contacts, etc. 3 hrs/week = 156 hours per year.	1417
SHU contacts Average MD follow-up visits monthly, since contacts with isolated inmates should be more frequent than with those in general population and some are seen more often than that due to PCO status. Contact time	840

[124] Assumptions include time to obtain and examine the inmate. Information available was for 11.5 months in 2008.

includes movement to and from cell. 82 inmates at .5 hour per contact for a maximum of 8 per day (due to custody movement and counts), which means it will take about 10 days/month to see the whole SHU caseload. 10 days x 12 months= 120 days per year working 4 hrs/day to see the SHU caseload=480 hrs. Add 240 hrs /year for walking back and forth from the SHU and various unexpected delays=720 hrs. Add another 120 hrs/year for not being able to see inmates due to custody issues=840 hrs/year.	
MHU contacts 67 inmates x .5 x 5 visits per year	168
Attendance at weekly mental health meeting 1.5 hours x 52 x 2 psychiatrists	156
General Population 140 inmates x.5 hr x 5 (this accounts for those who will need more than the 90 day minimum) visits per year =	350
Misc. time walking, documenting, reviewing, etc. per week = 1.5 hours per day per 8 hour shift	390
TOTAL Assume a 1 FTE = 40 hours x 48 wks. = 1920	4736 4736/ 1920 = 2.46 FTE
Current staffing is 1.45	**Essential increase is 1.0 FTE**