Potter Anderson & Corroon LLP

FIFTH 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 Fifth Report submitted pursuant to the MOA[1] and the Monitoring Agreement,[2] covering the period from January 1, 2009 through July 31, 2009. During this monitoring period, the Monitoring Team[3] has visited each of the Facilities[4] 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.

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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.

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, at times, prior to the 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

On December 29, 2009, the MOA expires by its terms. The State has made progress toward reaching substantial compliance with the terms of the MOA, but the State still has a great deal more to accomplish and it does not appear that the State will have reached substantial compliance with all of the provisions of the MOA by the time of the expiration of the MOA. The State is continuing to work to achieve substantial compliance with the terms of the MOA, and Monitoring Team is hopeful that it will be able to report additional progress in the Sixth Report.

One concern that the Monitoring Team has expressed in prior reports relates to the lack of stable and effective leadership at the vendor-level. The State has developed a strong central office, now known as the Bureau of Correctional Healthcare Services ("BCHS"). According to the DOC, the elevation of the Office of Health Services to a Bureau status conferred substantially increased authority to this team, as well as the allocation of substantial additional human and financial resources. The presence and effectiveness of the BCHS is promising, and can ameliorate the problem of shifting leadership at the facility level to some degree. As previously stated, however, without stable and effective leadership at the facility level, the State's efforts to achieve substantial compliance with the terms of the MOA will be hampered. Stable leadership at the facility level can keep institutional knowledge intact, and ensure that line staff members are receiving appropriate supervision (and re-direction if necessary) and performing their tasks appropriately.

The State has continued to implement its Continuous Quality Improvement ("CQI") process, but a great deal of work remains to be done to bring this area into substantial compliance. An effective CQI process will enable the State to identify problems, analyze the causes of those problems, implement effective corrective action plans to remedy those problems, follow-up on those corrective action plans to ensure that they are effective, and ensure that improvements are maintained. The State's CQI process is mostly in place, but it has not yet reached a level of consistency and effectiveness at all of the necessary stages. An effective CQI process is key to the State's ability to provide the level of healthcare required by the MOA without the need for outside monitoring.

Another issue that the State continues to grapple with is the tension between providing adequate health care, and the need to promote a secure and safe environment within the Facilities. The Monitoring Team has found several instances in which custodial policies have interfered with the healthcare staff's ability to provide care, affecting issues such as privacy, access to care, timeliness of care, and inappropriate amounts of "down time" for

healthcare staff. There are well-established lines of communication between custodial leadership and healthcare leadership to discuss such issues, but the Monitoring Team encourages leadership to continue to focus on finding strategies that can allow for goals of both security and adequate healthcare to be reached.

As the reader will note, this Fifth Report demonstrates that the State has continued to make improvements, and the Monitoring Team is especially pleased with the gains it found at Baylor and SCI. Many of the areas in which the State is beginning to see more improvement relate to getting a process in place, and many of the areas in which the State needs to improve relate to the substantive adequacy of the care being provided through those processes. Some of the areas of improvement are that the State continues to attempt to re-configure spaces to allow for better privacy, clinic spaces, and work spaces for staff. This also affects medication administration, storage, and continuity. The State also continues to demonstrate an ability to implement timely screening processes. In addition, as mentioned above, the State has allocated more significant authority and resources to its central office to assist with the improvement in inmate health care and sustaining that improvement.

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 21 of the provisions and in partial compliance with 34 of the provisions.

- The Monitoring Team found that JTVCC is in substantial compliance with 12 of the provisions; in partial compliance with 36 of the provisions; and in non-compliance with 6 provisions.

- The Monitoring Team found that HRYCI is in substantial compliance with 10 of the provisions and in partial compliance with 44 of the provisions.

- The Monitoring Team found that SCI is in substantial compliance with 21 of provisions and in partial compliance with 33 of the provisions.

As compared to the Fourth Report, overall, the number of provisions which the State is in substantial compliance with has increased from 39 to 64. More importantly, the number of provisions with which the State is not in compliance has decreased from 15 to six, all of which are at JTVCC. 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 from close to non-compliance to close to substantial. It should be noted therefore 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.[8] 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"), and the Fourth Semi-Annual Report (the "Fourth Report"), were published on July 29, 2008 and January 30, 2009, respectively. Both of these reports continued to describe the progress made by the State and the problems that still existed.

In this Fifth Semi-Annual Report (the "Fifth Report"), the Monitoring Team continues to report on its monitoring of the Facilities. As was the case in previous reports, 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 Fifth Report are the same as those in the Fourth 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 April through July 2009. 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

[8] 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.

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.

Additionally, it is important to note that under the terms of the MOA, the Monitoring Team is only given the power to review and report on the State's implementation of the MOA, and to assist the State by providing technical assistance regarding compliance with the MOA. The Monitoring Team has no independent authority to enforce the terms of the MOA or to force the State to make certain changes. Ultimately the implementation of changes and the enforcement of the MOA are the responsibility of the State and the U.S. Department of Justice.

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 Fifth 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 Fifth Report

The Fifth 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.[9] The Fifth Report mirrors that format, and 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;[10]
- key findings made by the Monitoring Team;
- an assessment of the State's compliance with the relevant provision; and
- recommendations, if any, to assist the State in achieving substantial compliance with the provision.[11]

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

[10] 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.

[11] 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.[12]

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[13] and as prisons.[14] 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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[12] 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.

[13] 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.*

[14] 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.[15]

B. Assessment

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

C. Findings

This provision of the MOA is very broad, and encompasses many different aspects of care. 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.

In the Fourth Report, the Monitoring Team presented some information about its observations regarding some of the infirmary-type areas within the Facilities as an example of general medical care provided at the Facilities. The following is an updated summary of findings relating specifically to the infirmary units of each Facility. The summaries include standards described in relation to provisions 3, 10, 12, 13, 15, 16, 22, 24, 25, and 27.

1. Baylor

During this audit period, there were few patients who had been placed in the infirmary for over 24 hours. The Monitoring Team reviewed the records of four such patients. One patient had been placed in the infirmary for housing after an accident resulting in multiple fractures, and three other patients had been placed in the infirmary for observation of some kind.

- All records reviewed had a nursing and provider intake note, frequent nursing notes, provider notes as appropriate, intake and discharge orders and a discharge note. On one record, there was no diagnosis on the nursing intake note.
- All documentation was written on the green infirmary forms.

2. JTVCC

The facility Medical Director is responsible for infirmary care. 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. Ideally, she should also have time to do audits

[15] 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).

of the care provided by all providers. There has been no analysis of the time needed to perform these duties as the Monitoring Team has recommended in the two prior reporting periods. The Medical Director's office and exam room have been completed and are in use. Although she still is frequently interrupted from performing her essential tasks, she is better able to complete her work.

The Monitoring Team reviewed six infirmary patients' medical records: four of the six patients had been admitted for acute problems (two of these patients had been admitted the previous day), and two of the six patients were chronically ill patients who 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. The majority of patients in the infirmary are housing patients.

- All of the patient's health records contained nursing intake notes. The nursing intake notes were made on the form specifically created for this purpose, which contained complete documentation. Some records contained additional admission-related information in the progress notes.
- There were nursing notes in all of the patients' records at more frequent intervals; however, nursing assessments of the patients with acute problems were not always documented during every shift.
- The records of the patients who had been admitted to the infirmary for acute problems contained admitting orders. The records of the housing patients had been thinned and the admitting orders were not maintained in the current volume of the health record.
- Intake notes were written on the next business day in the health records of all of the patients admitted for an acute problem.
- Providers documented their rounds as required by generally accepted professional standards.
- The Monitoring Team did not assess the discharge orders and notes because all of the patients in the infirmary at the time were active infirmary patients. It appeared to the Monitoring Team, however, that the previously documented problem of patients having discharge orders in their record but not actually leaving the infirmary has been resolved.
- It also appeared that there was a group of security officers regularly scheduled in the infirmary who were familiar with and empathetic to the infirmary patients.

3. HRYCI

The Monitoring Team reviewed five infirmary patients' records: two of the patients had been admitted to the infirmary with acute problems, and three of them were housing patients. One patient had both medical and psychiatric needs. The Monitoring Team reviewed this area in a manner that sought to avoid removing active charts that might be needed from the area, as well as to observe the activity in the infirmary. The Monitoring Team spoke with officers assigned to the infirmary as well.

The Facility Medical Director no longer works at HRYCI. At the time of the Monitoring Team's review, the physician responsible for chronic disease care was covering the infirmary in addition to his other duties; however, he recently had been on a three-week vacation and many physician notes were written by a physician covering from another facility.

The majority of patients' charts had a provider intake note in them; however, one patient who was admitted for acute withdrawal had not been seen by a provider for over 48 hours from intake. Generally accepted professional standards require such an examination within 24 hours. Also, the patient was sent to court without a provider assessing if this was appropriate given his medical diagnosis. In addition, although most charts had notes written with the frequency expected for the acuity of the patient, the quality of the notes varied greatly among the physicians. The Regional Medical Director from CMS had performed training sessions for all providers; however, compliance with the expectations of this training was variable.

A third correctional officer has been assigned to the infirmary to assist during times of peak need. The permanent infirmary officers noted that this has had a dramatic impact on their ability to get patients seen in a timely manner and in compliance with security regulations.

Specific findings of the chart review follow.

- The Monitoring Team would have expected to find seven nursing intake notes for these five patients, since two of the patients had been in the infirmary, but were then sent out for an admission or procedure elsewhere. Their re-admission to the infirmary caused the need for an additional nursing intake note. The Monitoring Team found six out of the seven expected nursing intake notes in the patients' records.
- Of the two patients admitted to the infirmary with acute problems, one patient's record contained a provider intake note on the day of admission to the infirmary. The other patient's record did not contain a provider intake note although orders had been written for the patient. All of the housing patients' records contained a provider intake note within 24 hours of arrival.
- Intake orders were written the day of arrival for four of the five patients. For one patient, the Monitoring Team was unable to find any intake orders for his initial entry into the infirmary.
- Both of the acute patients were admitted for observation of withdrawal. One patient remained only 24 hours because he did not go into withdrawal and was discharged. The other patient was attending a court appointment when the provider made rounds, and the Monitoring Team did not find any documentation reflecting that the provider attempted to see this patient either before or after his court date.
- The health records of any patients housed in the infirmary should contain weekly notes. All of these patients' records contained notes at a greater frequency than required: two to three times a week.
- The health records of the two patients who had been discharged from the infirmary contained discharge notes and orders.
- There was marked improvement in the state of the medical records. Additionally, it was noted that the designated infirmary forms were being used more consistently and were more completely filled out.

4. SCI

The Monitoring Team reviewed the health records of five patients in the infirmary. One of the patients was in the infirmary at the time of the Monitoring Team's visit, and the other four patients had been in the infirmary shortly before the Monitoring Team's visit. All had been in the infirmary for medical reasons.[16] The Monitoring Team notes that the infirmary at SCI is used primarily for patients in need of skilled nursing care (*e.g.*, extensive wound care), immediate post-hospitalization care, or for monitoring purposes.

- All patients' records contained a nursing intake note.
  - Of the nursing intake notes, three patients' intake notes were written on the infirmary form specifically created for this purpose. Two were completely filled out and one omitted an admission diagnosis.
  - Two nursing intake notes were written in the progress notes section of the health record. One patient was brought to the infirmary directly at intake, by-passing the admission screening. The screening was completed the following day with a more extensive progress note which explained the reason for the admission.
- All patients' records contained appropriate and complete nursing progress notes. The progress notes were written three times a day or more frequently as needed.
- All patients' records contained intake orders written or given verbally on the day of admission.
- The provider intake notes in the patients' records were not as expected.
  - Two of the five patients' records contained a note written within 24 hours of admission, but only one of these was on the Provider Admission Form. The other note was written in the progress notes, but was not adequate because it did not include a working diagnosis.
  - One patient's record reflected that the Provider Admission Form had been completed two days after admission, and another patient's record had a Provider Admission Form that had been completed three days after the patient's admission to the infirmary. One patient's record did not contain provider admission note either on the form or in the progress notes. The Monitoring Team did find progress notes written on the second and third day after the patient's admission to the infirmary, however.
- Once the patients were seen by a provider, notes occurred as required.
- The health records of three of the four patients discharged from the infirmary contained required Nursing Discharge Summaries.
- Provider discharge notes and orders were significantly problematic.
  - Of the four patients who had been discharged from the infirmary, only two of their health records contained discharge orders.
  - Two of the patients' records contained a completed Provider Discharge Summary, although neither of these was on the form created for this purpose. One record contained a note in the progress notes section, and the other record contained a note written on the day of discharge on the Provider Admission Form.

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[16] The Monitoring Team does not address patients sent to the infirmary at SCI for observation pursuant to withdrawal protocols in this section, as that issue is addressed in connection with provision 15 of the MOA.

- Two patients' records contained neither Discharge Orders nor Discharge Summaries. This lack of documentation is troubling because it is unclear whether patients are given instructions or supplies needed for ongoing care after discharge. For instance, one of these patients' Discharge Form stated, "Released to Street." This patient had a condition that required ongoing care, and there was no documentation that the patient was given self-care instructions, medical supplies and information necessary for follow-up of his condition.

C. Recommendation

- At Baylor, the Monitoring Team recommends that the State continue to use the infirmary forms for documentation and ensure that the forms are completely filled out.

- At JTVCC, the Monitoring Team makes the following comments and recommendations:

    - The Monitoring Team discussed the problem of documenting nursing rounds on the patients with acute problems every shift with the infirmary charge nurse and the Medical Director. The Monitoring Team offered technical assistance in the form of suggested methods for accomplishing this goal, and sample forms.
    - The Monitoring Team recommends that the State or CMS conduct an analysis of the responsibilities of the Medical Director, and the time needed to perform each of her administrative duties, with redistribution of tasks and/or hiring of addition providers to assist her.
    - The Monitoring Team notes that housing patients had chronic care forms completed in addition to infirmary rounding notes. This is a duplication of effort and does not give a sense of the overall status of the patient. This might be better achieved by discussing the status of each of the chronic diseases of the housing patients in a summary progress note every one to three months, depending on the acuity of the patients' underlying diseases.

- At HRYCI, the Monitoring Team notes that the primary problem with the infirmary records appears to lie with one staff person. The CMS Regional Medical Director is aware of and addressing this issue.

- At SCI, the Monitoring Team recommends that:

    - Additional training should be given to both providers and nursing staff on the proper use of the infirmary forms.
    - A procedure should be developed for patients who are brought to the infirmary prior to the intake screening process being completed to ensure that it is completed in a timely manner.
    - Patients should not be released from the infirmary to the street without provider notification. There should be provider notification if a patient will be going to court where there is a likelihood of release, bond is posted or if a patient is near his or her release date.

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[17] and procedures[18] 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, which represent generally accepted professional standards, policies and procedures should be facility-specific. J-A-05; P-A-05.

The State previously had a substantially complete set of policies which had been approved by the DOJ as of November 6, 2007. With respect to mental health-related policies and procedures at the Facilities, the State has implemented three policies which affect mental health standards. The first, Policy 11.G-02.1 concerns mental health treatment plans. This policy sets forth the minimum standards expected in a treatment plan for inmates with mental health needs, and also sets forth requirements for updating these plans.[19] Second, the State has finalized Policy 11.C-02.1, which addresses supervision requirements for unlicensed mental health clinicians. Finally, the State has implemented Policy E-09 which addresses procedures that should be followed when inmates on the mental health caseload are placed on isolation status.[20]

The facility-specific review of the local operating procedures by Facility is set forth below.

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[17] 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.

[18] 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.

[19] Mental health treatment plans will be discussed further in the findings for MOA paragraph 35.

[20] This policy and the State's treatment of mental health inmates who are placed on isolation status will be discussed in further in the findings for MOA paragraph 38.

B. Baylor

1. Assessment

The Monitoring Team found Baylor to be in substantial compliance with this provision of the MOA.

2. Findings

During the course of the Monitoring Team's visit, they reviewed a comprehensive set of local operating procedures, and found that the State has implemented the changes that the Monitoring Team had previously recommended. The Monitoring Team did identify the need for some additional minor revisions, but overall, the local operating procedures are in substantial compliance.

C. JTVCC

1. Assessment

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

2. Findings

The Monitoring Team reviewed a draft set of operational procedures. During the Monitoring Team's review, they identified elements in the procedures that either were unclear or inconsistent with DOC's policies. The Monitoring Team then learned that these drafts had not yet been reviewed by the Bureau of Correctional Healthcare Services ("BCHS").[21] The Monitoring Team previously had agreed with the State and CMS that it would not review the local operating procedures before the BCHS had the opportunity to review and approve the procedures, but, since there appears to have been a lapse in that process, the Monitoring Team reports that it found approximately 10 of the procedures needed some revision. The most serious deficiency was with regard to policy I-01.1, which related to therapeutic restraints. In the DOC policy, there is a clearly defined limit with regard to the duration of an order for the therapeutic restraints. This limitation on the duration of a physician's order did not appear in the procedure. The BCHS agreed that CMS needs to make this change, and the other changes that the Monitoring Team recommended. The Monitoring Team expects that by the time of the next visit, CMS will have submitted a revised set of local operating procedures to the BCHS for review and approval.

[21] The BCHS was formerly the Office of Health Services, or "OHS". For additional discussion of this change, see the Executive Summary and the DOC's Compliance Report dated July 31, 2009.

D. HRYCI

1. Assessment

The Monitoring Team found HRYCI to be in partial compliance with this provision of the MOA.

2. Findings

During this visit, the Monitoring Team reviewed approximately ten major policies and procedures, most of which required at least some minor revision in order to come into compliance with current actual practice or DOC policy. In particular, the Monitoring Team reviewed the medical policies covering screening, assessments, TB control, chronic disease, special needs and treatment accommodations, continuity of care, medications, infirmary and alcohol and drug withdrawal. The current draft is an improvement over previous drafts, but is not yet completely in sync with DOC policy or the actual practice at HRYCI. This is true with regard to the procedures for screening, assessments, special needs and accommodations, medications and alcohol and drug withdrawal.

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 approximately 20 local operational procedures drafted for SCI. Among those, approximately 12 required some revisions or additions to bring them into compliance with DOC policy or with actual practice at SCI. The procedures the Monitoring Team reviewed included intake screening, sick call, chronic disease management, infirmary care, and infection control. Local operating procedures are critical for the line staff's understanding of the expectations with regard to particular job assignments. The medical director for the DOC participated in the Monitoring Team's review. The BCHS, CMS and the Monitoring Team agreed as to the necessary changes to the procedures

F. Recommendations

- At Baylor, the Monitoring Team recommends that the State (through CMS, if applicable) continue to review and revise the local operating procedures as agreed.

- At JTVCC, the Monitoring Team recommends that the State proceed with its plan to have CMS revise the draft procedures, and insure that the BCHS has reviewed and approved the procedures prior to the Monitoring Team's next visit.

- At HRYCI, the Monitoring Team recommends that the State insure that local operating procedures are not only consistent with DOC policy, but also actually reflect the practice as intended by the policy.

- At SCI, the Monitoring Team recommends that the State (through CMS, if applicable) make the revisions to the local operating procedures, and then provide relevant staff with the appropriate training.

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, which are either explicitly stated in the MOA, or are generally accepted professional standards that are implicated by the terms of the MOA. 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, according to generally accepted professional standards, 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 at each of the Facilities 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.

In prior reports, the Monitoring Team reported that the State needed a credentialed statewide medical records director to supervise and oversee medical records services at the Facilities. The Monitoring Team believed that the lack of a person in this capacity 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.[22] The State now has filled this position. The Monitoring team believes that the hiring of this person has improved the State's compliance with this provision of the MOA.

B. Baylor

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that recommendations made in the previous report have been implemented: filling the statewide Medical Records Director position; establishing systems to ensure tracking, clinical review and filing of all health records occur in a timely manner; and that tracking systems should include the date the report is received by the facility.

Appropriateness of Format and Organization of Health Records

With respect to the formatting of the health record, the Monitoring Team found that both in policy and practice there is a unified health care record that contains medical, dental, and mental health information. The facility still maintains "temporary files" but for a much shorter period of time (approximately two weeks or until the admission physical is completed) before a permanent record is established. During prior audits, the Monitoring Team found that

[22] 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.

"temporary files" were maintained for one to two months before a permanent file was established. Temporary files contain only loose information, which is not organized using appropriate dividers. These are appropriate to use only 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 for a longer period of time makes health information difficult for healthcare providers to locate and review.

With respect to health record accountability and retrieval, the Monitoring Team found that the facility has implemented a health record accountability system that is actively used by staff. Health records are now stored on shelves in a room that can be locked. Medical records are now located in a larger space in the new Medical Administration area across the main hall from what is now the clinic area.

With respect to the condition and organization of the health record, the Monitoring Team found that the records were in good condition and in general, it was easy to locate specific papers within the records behind appropriate section tabs. In the records room there were two files for "papers and reports to be filed"- one for inmates released and one for current inmates; the one medical records clerk works days and indicated she has no problem keeping current with filing. Review of the filing bins revealed: for the released files - current; a handful of papers dated late May-June to be filed; for the current inmates – there were 15 papers to file, accumulated since the day before. None of the monitors reported a pattern of late review of labs, consultant or other test reports which might indicate late filing.

Timeliness of Health Record Filing

Of nine lab/diagnostic orders reviewed (five lab tests and four x-rays/ ultrasound), 100% were done timely, with results received, reviewed and placed in the records timely. Three different staff members are responsible for the Consult, Laboratory and X-ray Tracking logs and monitor for timeliness of the test as well as receipt of the report. The logs have columns to track the dates for tests ordered, completion of the test/appointment, and receipt of the reports.

Record-Keeping Issues Relating to the Mental Health Caseload

With respect to the records of inmates on the mental health caseload, at the time of the Monitoring Team's visit in June 2009, the State had not yet implemented the uniform chart organization system as it had at other facilities. Under this system Psychiatric Close Observation ("PCO") charting is color coded, meaning that all PCO records are supposed to be documented on green forms. At Baylor, staff was not using the green forms consistently.

At Baylor, the Monitoring Team found that the mental health department had no filing backlog beyond five business days. Additionally, it was anticipated that the mental health clerk position at Baylor would increase to a full time position from half time at the end of June 2009.

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 staff has made improvements in record keeping. These improvements include improved organization of the health records room, and up-to-date filing of health documents. However, additional improvements are required to establish an adequate health record management system.

Appropriateness of Format and Organization of Health Records

With respect to the formatting of the health record, the Monitoring Team found that both in policy and practice there is a unified health care record that contains medical, dental, and mental health information. Health record staffing appears to be sufficient.

With respect to the condition and organization of the health record, as noted in the previous report, the Monitoring Team again found contents that have relevance to one another (*e.g.*, nursing and physician progress notes, chronic disease notes) were not filed chronologically, making it difficult to locate information that provide health care staff a complete picture of the patient's medical condition. This problem can, in part, be attributed to health record procedures regarding where documents are to be filed.

Timeliness of Health Record Filing

Although there was no back log of documents to be filed, the Monitoring Team found continued delays in clinician review of laboratory and radiology reports. This delay relates also to provision 4 of the MOA, which is discussed below; however, the Monitoring Team reviewed this issue in connection with provision 3 of the MOA and reports its findings here. The delay in review and the delay in filing of laboratory reports while connected, are different issues. The Monitoring Team also found that recent changes have been made to improve tracking of laboratory and radiology reports; however, the impact of the changes was not fully realized at the time of the Monitoring Team's visit.

To evaluate the timeliness of clinician review of radiology reports, the Monitoring Team randomly selected 12 records from the radiology tracking log. The Monitoring Team's review of these reports showed that the average time from when the report was available until it was reviewed was 6.0 days (range =0-14 days, median = 5 days).

The Monitoring Team also reviewed the timeliness of clinician review of laboratory reports from 10 records randomly selected for review of chronic disease and nursing

sick call. Of 10 laboratory reports reviewed, the average time from when the report was available until it was reviewed was 4.5 days (range =0-18 days, median = 3 days).

Adequacy of Tracking Systems

With respect to health record accountability and retrieval, the Monitoring Team found that the facility has implemented a health record accountability (*i.e.*, "out guide") system, but it is not reliably used by staff. Improvements are also needed in thinning and putting the health records into volumes.

Record-Keeping Issues Relating to the Mental Health Caseload

With respect to records of inmates on the mental health caseload, staff informed the Monitoring Team that there were major problems with respect to access to healthcare records. This problem apparently is compounded by staffing issues with respect to mental health records personnel. In the past, these staffing shortages were not a major problem because mental health staff had a key to the medical records room and could obtain the records themselves. However, the Monitoring Team learned that, due to a change in security regulations, mental health staff members no longer have access to the key to the records room.

Additionally, the Monitoring Team's observed many records missing various forms and progress notes during its review of other provisions of the MOA. Those notes that were present were often not filed in chronological order. Moreover, handwritten notes are often filed without being dated and signed.

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 improvements are still required to establish an adequate health record management system. On a positive note, as stated above, since the Monitoring Team's last round of site visits, CMS has hired a Regional Medical Records Supervisor for the State of Delaware. At the time of the Monitoring Team's visit to HRYCI, this individual was relatively new, and had not yet had the opportunity to fully assess and implement improvement strategies.

Appropriateness of Format and Organization of Health Records

With respect to the formatting of the health records, the Monitoring Team found that both in policy and practice there is a unified health care record that contains medical, dental and mental health information.

With respect to organization of the health records, the Monitoring Team found that although many records are neatly organized, the contents that have relevance to one another (*e.g.*, nursing and physician progress notes, chronic disease notes) are not filed chronologically, making it difficult to locate information that will provide health care staff a complete picture of the patient's medical condition. This problem is in part, a procedural issue regarding where documents are to be filed. In addition, Problem Lists were not consistently visible upon opening the health record, nor were they consistently complete. It is a generally accepted professional standard for these lists to be in the front of a health record.

Adequacy of Tracking Systems

With respect to health record accountability and retrieval, the Monitoring Team found that a record accountability system is not consistently in use at HRYCI. This has resulted in the inability to locate health records and cancellation of scheduled appointments which delays patient access to care.

Timeliness of Health Record Filing

There are issues related to health record management that result in delayed clinician review and/or filing of laboratory reports. The Monitoring Team reviewed 10 records of patients who were listed on the laboratory tracking log on the West side of the Facility in order to evaluate the amount of time taken between when the lab test was ordered and when it actually was performed and when it was reviewed. Of the eight records available for review, the average length of time from when the report was available until it was reviewed was eight days (range 0-27 days). In one record, there was no report for the ordered lab test.

Upon further exploration, the Monitoring Team learned that on the West side, the laboratory printer located in the phlebotomist's office does not consistently work (reportedly due to a problem with the telephone lines). Consequently, the lab both faxes and mails lab reports to the facility. Staff reported that clinicians typically review and sign the faxed copy first, but this copy is later discarded when the mailed copy arrives. Thus, it is the mailed laboratory report reviewed at a later date that is usually filed in the record.

However, this may not explain delays in review and filing of lab reports entirely, as the Monitoring Team also found a stack of lab reports including HIV test results sitting on a table by the phlebotomist's desk. This group of lab reports was several weeks old and had not been reviewed by a clinician. A related issue is that the Monitoring Team observed that officers who used the phlebotomist's computer were in a position to easily see this confidential medical information.

With respect to the backlog of health record documents to be filed, there were approximately six inches of health record documents to be filed on both the East and West sides, which is not excessive. Most record documents in this stack were from March and April 2009, however the Monitoring Team also found record documents that dated back to August and November of 2008. Most laboratory and diagnostic reports the Monitoring Team reviewed had

been signed off by a clinician. However, the Monitoring Team did find a March 2009 pathology report with abnormal findings that had not yet been reviewed. This delayed evaluation of the patient's condition could have a negative outcome for the patient's care.

Record-Keeping Issues Relating to the Mental Health Caseload

With respect to the health records of inmates on the mental health caseload, the Monitoring Team notes significant progress relevant to the medical records department, which includes the hiring of a statewide medical records director. This person has been providing direct services at HRYCI, which has resulted in significant improvements in the medical records filing system. At the time of the Monitoring Team's visit, the medical records department had recently taken over the responsibility from the mental health staff regarding the filing of mental health progress notes. The use of the "outguide" sleeves, discussed in previous reports, has been discontinued and it was reported there was no backlog of medical records filings. If the State can maintain this level of improvement, it should come into compliance with this provision by the time of the Monitoring Team's next visit to the facility.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that improvements are still required to establish an adequate health record management system. At the time of the Monitoring Team's site visit to SCI that is being reported here, CMS had hired a Regional Medical Records Supervisor for the State of Delaware but that individual was relatively new and had not yet had the opportunity to fully assess and implement local or system-wide improvement strategies. The Monitoring Team also wishes to note that the SCI medical record clerks appear to be very conscientious.

Appropriateness of Format and Organization of Health Record

With respect to the formatting of the health record, the Monitoring Team found that both in policy and practice there is a unified health care record that contains medical, dental, and mental health information.

With respect to the condition and organization of the health record, the Monitoring Team found that the records were bulky and in need of thinning.[23] As noted at other

[23] Bulky health records make medical information more difficult to locate, which can negatively impact medical care. The Monitoring Team recommends that the DOC implement a standardized procedure for all of the Facilities regarding the thinning of health records. The standardized procedure will have to take into consideration the balance between including

facilities, the contents that have relevance to one another (*e.g.*, nursing and physician progress notes, chronic disease notes) are not filed chronologically, making it difficult to locate information that will provide health care staff a complete picture of the patient's medical condition. This problem can be attributed to health record policies regarding where documents are to be filed. The Monitoring Team also found documents that were misfiled in the record (*i.e.* in the wrong section). There is only one medical records clerk on the day shift to perform and monitor filing of health record documents.

Adequacy of Tracking Systems

With respect to health record accountability and retrieval, the Monitoring Team found that the facility has implemented a health record accountability system that is used actively by staff. Health records remain stored in unlocked file cabinets in the Maximum Security Building ("MSB") clinic area, which does not ensure adequate privacy; however, the State is moving forward with renovation of the medical clinic, which will create a secure health records storage area. In the pre-trial area, health records are stored in file cabinets in a room that can be secured.

As noted in the Monitoring Team's last SCI report, in the MSB clinic, there are significant issues related to management of laboratory and diagnostic reports, which routinely result in the filing of laboratory and diagnostic reports prior to clinician review and in the delaying of clinician review of laboratory reports.

The Monitoring Team learned from staff members that there is a high volume of laboratory reports arriving on a daily basis. Normal practice would be to place the report in the record for timely clinician review of the report, and to document clinical actions if necessary. Because of space limitations in the clinic, however, medical records staff members do not place these reports in the health record for expedient review by clinicians. Instead, nurses triage the daily laboratory reports for abnormal test results, which are given to the clinician with the record. The normal laboratory reports are flagged with a yellow sticker and filed in the health record, which is then placed in the health record cabinet. Each Thursday and Friday, the clerk searches and retrieves records with a flagged laboratory report for clinician review. The clinician who reviews the report is often not the ordering clinician.

Therefore, there continues to be a built-in delay in reviewing laboratory and diagnostic reports. The Monitoring Team's review of 14 orders for laboratory/diagnostic tests showed that the average length of time from when the report was available until it was reviewed was 11 days (range = 0-30, median = 8 days). In some cases, laboratory reports had not been reviewed at all. This highlights the problem of filing laboratory reports in the record before a clinician has reviewed them. Moreover, despite the intention of the system to ensure timely review of abnormal reports, the Monitoring Team found delayed review of both abnormal and normal reports.

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necessary health record contents as listed in the discussion of generally accepted professional standards above, and the need to have a file that is not too bulky if at all possible.

The Monitoring Team also found that the laboratory tracking log is not consistently used. Specifically, the Monitoring Team found that there were no entries on the log for the week prior to the Monitoring Team's visit.

The Monitoring Team did not find excessive quantities of health records to be filed. However, staff members reported that there were two boxes of archived records that contained health record documents of inmates who are still at the facility, which means that those inmates' health records are not as accessible as they should be. This practice is inconsistent with generally accepted professional standards, and should not occur. On the pre-trial side of the facility, staff members showed the Monitoring Team three to four inches of medication administration records (MARs) that had been retrieved earlier that day from these archived records.[24]

Adequacy of Staffing

With respect to medical records staffing, the MSB and pretrial clinic has one day shift health record clerk to manage health records. Given the significant issues the Monitoring Team found with laboratory filing at the MSB clinic, the Monitoring Team question whether this staffing allocation is sufficient.

Record-Keeping Issues Related to the Mental Health Caseload

With respect to the health records of inmates on the mental health caseload, the Monitoring Team notes that there was no backlog of mental health record filing. There is a problem related to lab test results not being placed in an inmate's chart in a timely manner, although it is not clear whether this is a filing issue or another related issue such as untimely clinician review.

The Monitoring Team noted some minor problems related to the legibility of records. For instance, documentation on initial assessment forms are often written in the margins of the form, because there is inadequate space for narrative entries on the form itself. Also, forms are frequently Xeroxed with inadequate toner so that the printed forms are faint and are often difficult or impossible to read.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State continue to maintain and monitor the current medical records system, the tracking logs, and the timely status of filing papers and reports.

At JTVCC, the Monitoring Team recommends that:

[24] At SCI, there are two areas in which health records can be mainatained: the MSB or the pre-trial area.

- Health care leadership should develop and implement systems to ensure that laboratory and diagnostic reports are reviewed and filed in a timely manner.
- Staff should consistently use the health record out guide system.
- Ensure that health records are appropriately thinned and put into volumes.
- The DOC should amend health record policies and procedures to require that health record documents of similar content are filed chronologically (*e.g.* physician and nurse progress notes, chronic disease notes, nursing protocol forms, etc.).

At HRYCI, the Monitoring Team recommends that the State:

- Ensure that a health record accountability system is accurately and consistently used at all times.
- Ensure that clinically related documents are filed in chronological order. This may require policy revisions.
- Ensure that staff consistently uses the laboratory tracking log to record all clinician-ordered laboratory tests and that staff compares lab results against what was ordered to ensure that all tests were completed.
- Ensure that lab and other diagnostic tests are maintained in a manner that preserves confidentiality of health information and that tests are reviewed by a clinician and filed in the health record in a timely manner.
- Ensure that all health record documents are filed in the record in a timely manner.

At SCI, the Monitoring Team recommended in the last report, and continues to recommend, that health care leadership (HSA, Medical, and Nursing Directors) develops and implements a system to ensure that laboratory and diagnostic tracking logs are consistently used and that the process results in timelier review by the clinician who ordered the tests. The clinicians should document appropriate action in the health record including scheduling patient encounters as clinically indicated. The Monitoring Team recommends that CMS reevaluate its health record staffing in the MSB.

With respect to mental health records, the Monitoring Team recommends that the State use professionally printed forms rather than rely on copying forms. Additionally, the State should consider revising its forms so that there is adequate space to enter narrative responses where appropriate.

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* the discussion of provision 2 of the MOA). 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).

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 a sample of 10 records containing medication and/or laboratory orders for the period of March 2009 to early June 2009. For each order, the Monitoring Team evaluated the completeness of the order, timeliness of transcription, and implementation of the medication or laboratory order.

With regard to medication orders, in general, the Monitoring Team found problems with the timeliness, completeness, and clinician notification for missed doses. In seven of 10 records (70%), clinician orders were complete, which means they contained medication name, dosage, frequency, route of administration, duration and number of refills. The route of administration was missing in three. In eight of 10 records, the clinician orders were dated, timed and signed. In one record, the order was not timed. In another record, the telephone order was not dated and never signed by the clinician. Generally accepted professional standards dictate that telephone orders should be signed within 72 hours of the order being written.

The Monitoring Team found problems with the timeliness of nursing transcription of orders in four of 10 records (40%). Generally accepted professional standards require that nursing transcription occur on the same day that the order was written. In two records, transcription was not done timely. In one record, the time of transcription was not noted so timeliness could not be determined; in one record, the date of transcription was inaccurate, based on the date recorded on the Medication Administration Record (MAR) and the date the medication was received by the inmate. Transcription was accurate in seven of 10 records (70%).

Five of 10 (50%) health records demonstrated untimely medication receipt. The range of the delay was two to eight days. In two records, the Monitoring Team determined that the delays were caused by inaccurate transcription and in two other records by late transcription; one delay was caused by a non-formulary medication and not using a local pharmacy to obtain it timely. In two of four applicable records (50%), clinicians were not notified of missed doses, per policy.

With regard to laboratory orders, the Monitoring Team did not find any issues concerning orders, timeliness and filing. This area is compliant.

C. JTVCC

1. Assessment

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

2. Findings

The Monitoring Team evaluated compliance with this provision by reviewing a sample of records containing laboratory and medication orders from late January 2009 to July 2009. For each order, the Monitoring Team evaluated the completeness of the order, timeliness of transcription, and implementation of the medication or laboratory order.

In general, since the Monitoring Team's last visit, the Monitoring Team found slight improvements in the timeliness of nurse transcription of clinician orders. The Monitoring Team's review showed that in only eight of 15 records did a nurse transcribe the order on the day it was written, but if a nurse did not transcribe the order on the day it was written, the order was usually transcribed the following day.

With respect to the accuracy of medication order transcription, only six (46%) of 13 medication orders were transcribed accurately. For medication orders that were renewals of previous orders, the widespread transcription practice was for the nurse to retrieve the existing medication administration record (MAR), cross out the dates of the previous order, and write in new dates. This is not consistent with generally accepted professional standards for transcribing orders and can lead to medication errors. The Monitoring Team noted medication errors as a result of this practice at the Monitoring Team's last site visit as well as the current visit. With respect to the timeliness of receipt of medications, one record showed a delay of two and five days respectively.

Although the Monitoring Team's review showed that the timeliness of nurse transcription of clinician orders had improved, the Monitoring Team did not find that there was a corresponding increase in the timeliness of implementation of clinician orders. The Monitoring Team reviewed 23 physician orders that involved completion of laboratory tests, x-rays, or electrocardiograms (ECGs). The Monitoring Team found that eight (35%) orders were implemented in a timely manner; four (17%) were not implemented timely, and nine (39%) were not implemented at all.

To explore what factors may be contributing to the lack of timely implementation of physician orders, the Monitoring Team spoke with staff who reported that when nurses document in the record that physician orders have been "noted," the nurses do not consistently carry out all the steps to ensure the order will be implemented. For example, if the nurse signs off on an order for an x-ray, the nurse should complete a requisition form and schedule the patient for a radiology appointment in DACS. If the nurse signs the order off without completing this step, it will not be carried out. The same is true for laboratory tests. This was not occurring consistently, resulting in clinician orders not being implemented.

In summary, there was not a reliable system in place to ensure that clinician orders are completely transcribed and implemented in a timely manner at the time of the Monitoring Team's 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 evaluated compliance with this provision by reviewing a sample of 21 physician order records containing laboratory and medication orders for the period of December 2008 to April 2009. For each order, the Monitoring Team evaluated the completeness of the order, the timeliness of transcription, and implementation of the order.

In general, the Monitoring Team found improvements in the timeliness of physician order transcription from the Monitoring Team's last visit. However, problems with delayed and accurate order transcription persist, and there is not a reliable system in place to ensure that physician orders are implemented completely and in a timely manner.

With respect to tracking the implementation of laboratory tests, the Monitoring Team note that the method of tracking laboratory tests differs between the East and West sides. On the East side, staff exclusively uses DACS to track the completion of laboratory tests, and on the West side, staff uses DACS and a laboratory tracking log.

On the West side, when a nurse transcribes a laboratory order, the nurse enters it into DACS and is supposed to enter it onto a laboratory tracking log, which the phlebotomist uses as an accountability tool for completion of labs . Healthcare leadership reported that nurses transcribing lab orders enter the information into DACS but do not consistently document the order onto the laboratory tracking log. Thus, the phlebotomist does not have access to a complete and reliable system for tracking laboratory tests from the time the physician orders the labs until the report is received and reviewed.

From the laboratory tracking log on the West side, the Monitoring Team requested 10 records to evaluate the timeliness from when the lab test was ordered until it was performed and reviewed. Of the eight records available for review, the average length of time from when the test was ordered until it was performed was 15 days (range = 5-38 days). However, in three of eight records, the Monitoring Team found that some, but not all of the tests ordered had actually been performed; however, these tests were all marked as completed on the laboratory tracking log.

With regard to medication orders, the Monitoring Team noted delays and errors in transcription that resulted in medication errors such as missed medication doses, or patients continuing to receive medications following the expiration of the order (see discussion of provision 24 of the MOA).

Issues Related to Inmates on the Mental Health Caseload

With respect to mental health, the Monitoring Team was aware of one audit relevant to obtaining laboratory tests for inmates receiving certain types of psychotropic medications since the Monitoring Team's previous visit in August 2008. A review of this audit demonstrated that in four of ten charts, noncompliance with respect to obtaining needed laboratory testing was found. The audit did not document the reasons for this noncompliance nor did it address a corrective action plan. The Monitoring Team recommends that, whenever an audit uncovers a problem, the State analyze the cause of the problem and create a targeted plan to correction such problem. Otherwise, the audit will not result in improvement.

In addition to the DOC's audit results, the Monitoring Team's independent review of medical records demonstrated problems with obtaining laboratory tests in a timely manner. In many cases, appropriate tests were not ordered, and in other cases, tests that were ordered were not obtained in a timely manner.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated compliance with this provision by reviewing a sample of 20 records containing laboratory and medication orders for the period of late December 2008 to early May 2009. For each order, the Monitoring Team evaluated the completeness of the order, timeliness of transcription, and implementation of the medication or laboratory order.

In general, the Monitoring Team found persistent problems with the timeliness, completeness, and accuracy of clinician order transcription since the Monitoring Team's last

visit. The Monitoring Team's review showed that in only seven of 18 applicable records did a nurse transcribe the order on the day it was written. The average transcription time for this sample of records was three days (range 1-7 days).

With respect to medication order transcriptions that involved renewal of medication, it is a typical practice of nurses transcribing orders to not transcribe the complete order onto the MAR, but instead cross out the dates of the previous order and write in dates of the new order. This practice has been addressed in prior reports. This defaces the record, and enhances the potential for medication errors.

With respect to the transcription and implementation of laboratory tests, the Monitoring Team notes that in the MSB medical clinic, staff did not use the laboratory tracking log consistently. Thus, staff has no mechanism to compare laboratory tests that were ordered to laboratory test that were actually performed.

The Monitoring Team's review of the 20 records showed that ordered laboratories were performed between seven to 14 days after being ordered on average, with some laboratories being obtained one month after ordering. Routine laboratory tests should be obtained within one week unless otherwise specified in the order (*e.g.*, obtain two weeks prior to next chronic disease clinic). Although the average length of time to obtain the tests found in the Monitoring Team's sample was not in and of itself excessive, when combined with delayed clinician review of reports, it becomes problematic. The Monitoring Team found examples in which the delayed review of laboratories posed clinical issues. (See discussion of provision 22 of the MOA.)

On the pre-trial side, as opposed to the MSB, there appeared to be a more reliable system for tracking, obtaining, and reviewing laboratory reports.

In summary, at the time of the Monitoring Team's visit, there was not a reliable system in place to ensure that clinician orders are completely transcribed and implemented in a timely manner.

Issues Related to Inmates on the Mental Health Caseload

With respect to inmates on the mental health caseload, the State completed a study of 14 records of mental health charts. Six of these 14 charts showed a delay in the taking of any orders which was greater than two days. While doctors appear to be ordering labs as required, nurses are not performing the test within the timeframe requested. Two of these 14 charts showed a delay that was over four weeks. The remainder of the charts showed labs completed in less than two days. The State does not appear to have yet assessed the cause of this problem.

The Monitoring Team conducted its own review of records with a sample size of 15 records reviewed for laboratory studies and found that nine of those records met applicable criteria. Those records that did not meet the applicable criteria either were not performed in a timely manner, a physician's order was not actually written, or, in one case, because the orders were insufficient.

The Monitoring Team also spoke with a psychiatrist who reported that there had been improvement in obtaining ordered laboratory results in a timely manner. This statement was in conflict with both the State's own audit and the Monitoring Team's independent review. The Monitoring Team believes that it is significant that this psychiatrist is not perceiving what the Monitoring Team believes to be a significant problem in his practice.

F. Recommendations

At Baylor, the Monitoring Team recommends that:

- The HSA or DON should implement a system to insure timely and accurate transcription of medication orders and a system to track implementation of these orders.
- Nurses who transcribe orders should be educated on appropriate methods and the need to ensure accuracy of transcription.
- The State/CMS should monitor and document medication transcription errors through the CQI process and target strategies to lower the incidence.

At JTVCC, the Monitoring Team recommends that:

- Health care leadership should conduct root cause analysis of failures to accurately and completely transcribe clinician orders, develop and implement strategies for improvement, and perform CQI studies to evaluate their effectiveness.
- Nurses should completely transcribe all medication orders, regardless of whether the order is a renewal of medication.

At HRYCI, the Monitoring Team recommends that:

- The State/CMS should conduct CQI studies to monitor and evaluate the timely and accurate transcription of physician orders.
- The State/CMS should develop, implement and monitor a uniform system for tracking of laboratory/diagnostic tests.
- The State/CMS should monitor and document medication errors through the CQI process and target strategies to lower the incidence of medication errors.
- With respect to mental healthcare, CMS should initiate a more robust QI process to address this provision. This audit should review a larger sample of records and should address such categories as when the blood was ordered, when it was drawn, whether the results were returned in a timely manner, whether these results were in fact viewed by a psychiatrist, and whether abnormal test results were acted upon.

At SCI, the Monitoring Team recommends that:

- The State/CMS should assess and implement strategies to improve the timeliness and accuracy of order transcription, followed by CQI studies to monitor improvement.
- The State/CMS should monitor and document medication transcription errors through the

CQI process and target strategies to lower the incidence.

- The State/CMS should develop, implement, and monitor a uniform system for tracking of laboratory/diagnostic tests and ensuring timely review of all laboratory reports.

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. Delaware law on this topic provides the appropriate standard of review. In particular, the Monitoring Team has been concerned in the past 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.[25] The State further revised the job descriptions to the Monitoring Team's satisfaction. The Monitoring Team notes that the State has improved its allocation of responsibilities between RNs and LPNs to become more consistent with Delaware law (the applicable generally accepted professional standard under this circumstance), and the job descriptions.

As discussed in the Third and Fourth Reports, 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, generally accepted professional standards require some supervision 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. The State has implemented this supervision.

Consistent with its practice during other monitoring periods, 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. In addition, the State has filled the State Medical Director position. Facility-specific findings are listed below.

B. Baylor

1. Assessment

The Monitoring Team found Baylor to be in substantial compliance with this provision of the MOA.

2. Findings

The job descriptions had been revised several months ago. However, at the time of the Monitoring Team's last visit, LPNs were performing sick call assessments. During this visit, the Monitoring Team found that only RNs were performing sick call assessments. This is an improvement. Thus, the job description, and performance within the scope of licensure are in substantial compliance. The Monitoring Team also reviewed the files of the staff for which licenses are required and found all of the licenses were up to date.

With respect to mental health staff, the Monitoring Team found that a licensed psychologist is providing individual and group supervision of all unlicensed mental health professionals at Baylor, as required by generally accepted professional standards and State Policy 11.C-02.1.

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[25] 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 JTVCC to be in substantial compliance with this provision of the MOA.

2. Findings

The job descriptions have all been approved and are being utilized. Also, the Monitoring Team reviewed the licensure status of all those requiring a license and the documents demonstrated that all individuals had up-to-date licensure.

With respect to mental health staff, the Monitoring Team found that a licensed psychologist is providing individual and group supervision of all unlicensed mental health professionals at JTVCC, as required by generally accepted professional standards and State Policy 11.C-02.1.

D. HRYCI

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

Since the Monitoring Team's previous visit, LPNs are no longer conducting sick call and in fact, this is now being performed by RNs. The personnel records reviewed also reflect that all staff who were working were maintaining current licenses in good standing.

With respect to mental health staff, the Monitoring Team found that a licensed psychologist is providing individual and group supervision of all unlicensed mental health professionals at HRYCI, as required by generally accepted professional standards and State Policy 11.C-02.1. However, at the time of the Monitoring Team's visit in April 2009, this supervision had just started. The Monitoring Team wants to see the State sustain this supervision for some period of time, before it is willing to assess the State as being in substantial compliance with this provision at HRYCI.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in substantial 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, and found the required documentation verified that all licensed staff was licensed. All of the job descriptions had been completed previously, so this area remains in substantial compliance.

With respect to mental health, the Monitoring Team found that a licensed psychologist is providing individual and group supervision of all unlicensed mental health professionals at SCI, as required by Policy 11.C-02.1.

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[26] is available for a sufficient amount of time so as to avoid any unreasonable delay in patients receiving necessary care, and if physician time[27] is sufficient to meet both clinical[28] and administrative responsibilities.[29] *Id*.

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[26] 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.

[27] Typically, 3.5 hours of physician time per week 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.

[28] 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.

The Monitoring Team strongly recommends that the State conduct a detailed staffing analysis at all of the Facilities to make the determination as to whether their staffing needs are met. In addition, such a staffing analysis should occur on an annual basis. Otherwise, the State will be unable to identify its staffing needs as populations change, and to accommodate security constraints (or lack thereof).

B. Baylor

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this provision of the MOA.

2. Findings

Nurse Staffing

With respect to nurse staffing, there were 6.0 Full Time Equivalent ("FTE") RNs, excluding the DON, to cover 24 hours per day, seven days per week. There are two RNs on the day shift, one RN to cover evenings and one RN to cover nights. The remaining 2.0 RNs are assigned to cover weekends. The facility is using "as needed" (PRN) staffing for relief coverage. In 12 of 12 records reviewed for nurse sick call, RNs conducted 12 of 12 encounters (100%), which is very encouraging. The recommendation for RNs to perform sick call was made in previous reports and documentation in the records selected from March 2009 to May 2009, revealed that the State has implemented this recommendation.

There are 8.0 FTE LPN positions to cover 24 hours per day, seven days per week. This is a 0.2 increase since the last visit. There are 3.6 LPNs assigned to the day shift, three assigned to the evening shift and 1.4 assigned to the night shift. Some week days (three) there are two LPNs assigned to medication administration and one LPN the rest of the week. (See discussion of provision 24 of the MOA.)

Other Staffing

With respect to clerical staffing, there are two FTE Medical Assistant staff positions as in the prior visit. This staffing appears sufficient. There are two Medical Record clerk positions. Since there was no backlog of filing found, this level appears adequate to meet the needs of the facility.

Mental Health Staffing

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[29] 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.

With respect to mental health staffing, the Monitoring Team believes that although there are adequate numbers of staff, there is a need for team building and a clear job description, organizational structure, and caseload clarification at this site for it to function as efficiently as possible. At the time of the Monitoring Team's visit, services outside of the SNU remained limited to routing mental health visits and sick call responses. Programming on the SNU was not individualized. There were no therapeutic mental health groups or activities offered to the general population. Therefore, while the amount of personnel devoted to mental health might be otherwise sufficient, in order for personnel to be effectively used, the State should redefine job descriptions so that staff functions in a more efficient manner.

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 this area by reviewing budgeted staff allocations assigned to the facility, vacancy rates, and compliance with the requirements of the MOA and the State's policies and procedures. The Monitoring Team assessed this area as being in partial compliance because the Monitoring Team found significant operational issues that may be related to staffing, but the State has not conducted a staffing assessment to determine the adequacy of staffing as required by their own policies.

The Monitoring Team note that from a physical plant perspective, JTVCC is two distinct facilities: the main unit (that also contains a pre-trial unit), and the Maximum Security Complex, which is comprised of the Supermax Housing Unit (SHU) and the Maximum Housing Unit (MHU). The main unit and Maximum Security Complex each have dedicated nurse and clinician staffing.

Advanced-Level Provider Staffing

With respect to medical staffing, the facility was budgeted 5.6 clinical FTEs: a 1.0 Medical Director, 1.8 physicians, and 2.6 nurse practitioners ("NP"). Of these positions, 3.6 are allocated to the Main unit and 1.8 are shared by the Supermax Complex (SHU and MHU). All of the positions were filled at the time of the Monitoring Team's visit. SHU staff advised us that during the month of June 2009, a clinician was only available three days per week.

Nurse Staffing

With respect to nurse staffing, the main unit is staffed using eight hour shifts, seven days per week. Currently there are 13.2 RN and 9.8 LPN budgeted positions for the unit. In addition, there are 11.6 ancillary positions (*e.g.* medical assistant, phlebotomist, pharmacy,

and activity technician). At the time of the Monitoring Team's visit, all positions (except one LPN) were noted as being filled. Also, the Assistant Director of Nursing ("DON") had resigned approximately 10 days prior to the Monitoring Team's review, but the Staffing Control Document (SCD) was not yet updated to note the position as being vacant.

In the Maximum Security Complex, nurses work 12-hour shifts, seven days per week. At the time of the Monitoring Team's visit, there were 6.2 budgeted RN positions and 8.4 LPN positions. All of the positions were noted as being filled. CMS reported to the Monitoring team that it plans to convert all nursing positions to RN positions in the near future.

RNs are now assigned to conduct sick call and other responsibilities that require an independent nursing assessment. This is an improvement from the Monitoring Team's last visit.

Mental Health Staffing

With respect to mental health staffing, the Monitoring Team reviewed records, and spoke with staff members and inmates. The Monitoring Team observed that the psychiatrists' allocations have been increased by 0.5 FTE at JTVCC, which is an improvement. All other staffing levels remain unchanged from previous reports. As noted in the Fourth Report, and despite the change in the psychiatrists' allocations, the Monitoring Team continues to believe that the current mental health staffing levels are inadequate.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team evaluated this area by reviewing budgeted staff allocations assigned to the facility, vacancy rates, compliance with the requirements of MOA, and the state's policies and procedures.

This area is unchanged since the Monitoring Team's last visit. The Monitoring Team found that the facility most likely has adequate clinical staffing but likely has insufficient numbers of RNs to conduct sick call and LPNs to administer medications in a timely manner.

Advanced-Level Provider Staffing

With respect to clinical staffing, the facility had allocated 4.6 clinical FTEs: a 1.0 Medical Director, 1.6 physician and 2.0 NPs. As the Monitoring Team found during the last monitoring cycle, the Medical Director position is vacant, and, at the time of this visit, the

facility had 3.6 filled FTEs. The Monitoring Team learned that recently both the physicians and the NP went on vacation at the same time, which created problems with access to care.

Nurse Staffing

With respect to nurse staffing, CMS has recently converted 2.0 Nursing Supervisor positions to working Charge Nurse positions who have been assigned sick call duties in addition to other responsibilities.[30] In addition, there is an RN Infection Control Nurse ("ICN"), QA/Case Manager positions, and another RN position that have been filled. All part-time weekend positions were vacant at the time of the Monitoring Team's visit. Also, there was a medical records position that was vacant.

The hiring of more RNs is a positive development. However, during the Monitoring Team's visit, the RN assigned to perform sick call was ill, and East side sick call was cancelled. Nursing sick call is a critical access to care process that should not be subject to cancellation based upon the illness of a single staff member.

With respect to LPN staffing, the Monitoring Team noted that each medication administration continues to take three to four hours, primarily due to it being a decentralized process in which nurses transport medications to the housing units. Standard nursing practice is for the nurse to administer medications within a one hour window of a designated time. To accomplish medication administration in a timely process may require additional LPNs.

Mental Health Staffing

The Monitoring Team observed that mental health clinician vacancies had decreased from 3.5 FTE vacant positions to only 0.5 FTE vacancies. All other staffing levels remain unchanged from previous reports. As noted in the Fourth Report, and despite the change in the psychiatrists' allocations, the Monitoring Team continues to believe that the current mental health staffing levels are inadequate. This opinion is based upon its review of health care records and information obtained from staff and inmates. This is further evident due to the general lack of treatment services being offered to mental health patients, other than medications and limited group therapy.

E. SCI

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

[30] The difference between a nurse supervisor and a charge nurse is that a charge nurse has assigned duties in addition to her supervisory responsibilities.

The Monitoring Team evaluated this area by reviewing budgeted staff allocations assigned to the facility, vacancy rates, and compliance with the requirements of the MOA and the State's policies and procedures.

Advanced-Level Provider Staffing

With respect to clinical staffing, the facility was allocated 3.0 clinical FTEs: a 1.0 Medical Director, 0.4 physician, and 1.6 NPs. However, the site Medical Director also works a 0.2 FTE at a nearby facility and continues to function as the infectious disease physician for other facilities. Given the clinical issues the Monitoring Team found at SCI, the Monitoring Team believes that the facility requires a dedicated, full-time Medical Director (see discussion of provision 7 of the MOA).

Nurse Staffing

With respect to nurse staffing, there were 9.2 RN and 10.4 LPN positions at the time of the Monitoring Team's visit. Of those allocated positions, all RN positions were filled and all LPN positions except for a 0.4 LPN position were filled. The Monitoring Team was advised that RNs have now been assigned to perform nursing sick call; however, the Monitoring Team's review showed that even recently, LPNs still perform this function. This may be a staffing issue.

Other Staffing

With respect to clerical staffing, at the time of the Monitoring Team's visit, there were two clerks assigned to health record management and filing, one in the MSB and one in the pre-trial area on the day shift. In the MSB clinic area, this staffing pattern does not appear to be sufficient given the volume of health documents to be filed daily.

Mental Health Staffing

With respect to mental health, the Monitoring Team believes that at the time of its May 2009 visit to SCI, the State had adequate staffing levels at the facility to meet the needs of its mental health population.

F. Recommendations

At Baylor, the Monitoring Team recommends that:

- The State/CMS should continue to adjust staffing to insure RNs conduct sick call, intake screening, urgent/emergent evaluations and any other responsibility that requires nursing assessment skills.
- The State/CMS should insure there is sufficient LPN staff to provide two nurses for medication administration on day and evening shifts, seven days per week.

At JTVCC, the Monitoring Team recommends that:

- As previously recommended, the State/CMS should conduct a detailed staffing analysis based upon workload data and consideration of the increased requirements of the MOA. The Monitoring Team would request to review this analysis at the Monitoring Team's next site visit.

At HRYCI, the Monitoring Team recommends that:

- The State/CMS should conduct a detailed staffing analysis based upon workload data and consideration of the increased requirements of the MOA. The Monitoring Team would request to review this analysis at the Monitoring Team's next site visit.

At SCI, the Monitoring Team recommends that:

- The State/CMS should conduct a detailed staffing analysis based upon workload data and consideration of the increased requirements of the MOA. The Monitoring Team would request to review this analysis at the Monitoring Team's next site visit.

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

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 (which dictate the generally accepted professional standard in this case), 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 made 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.

With respect to statewide mental health staff management, the Monitoring Team finds the State to be in substantial compliance. The statewide Mental Health Director has been in place since March 2009. The Monitoring Team also notes that during this monitoring period, two key individuals left the BCHS, but both have been replaced already. On a positive note, the state has hired Dr. Spencer Epps as Statewide Medical Director to provide medical oversight of the system.

B. Baylor

1. Assessment

The Monitoring Team found Baylor to be in partial compliance with this provision of the MOA.

2. Findings

At the time of the Monitoring Team's latest visit, the HSA position was vacant again. The person who had most recently held that position left a week or two before the Monitoring Team's visit. The HAS's predecessor also left after a very short period of time. Thus, there continues to be a significant degree of instability in this critical leadership position. The Monitoring Team understand that a replacement has been identified already, however. It remains to be seen whether this person will be able to provide sustained good quality work in that position.

The DON has been in place approximately six months and appears to be taking over those responsibilities with assistance from CMS regional office staff. The site Medical Director has been in place for about ten months and appears to be developing the requisite skills for this position.

C. JTVCC

1. Assessment

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

2. Findings

The site Medical Director has been in place for 3 ½ years, and the DON has been in place for about eight months at JTVCC. There continues to be turnover in the leadership team at this facility, however. The HSA position is about to be vacated by an individual who had been

in place for only a few months. The Assistant DON position has been vacant for a few months. Thus, there are and will be vacancies in these key positions.

The DON is responsible for a whole series of tasks which otherwise should be shared with other leadership people. In addition, the Monitoring Team found that the site Medical Director is not able to commit the necessary time to perform the administrative and supervisory functions of this position, including substantial involvement in the Quality Improvement Program. The BCHS Statewide Medical Director is aware of this problem. The Monitoring Team discussed with CMS the need to provide set aside time for the Medical Director to perform these non-clinical functions. Whatever amount of time this takes from her clinical duties must be replaced by primary care clinician hours from someone else. The Monitoring Team believe it is appropriate for the Medical Director for the BCHS to ultimately be responsible for determining both the nature of these activities in discussions with the CMS Regional Medical Director, as well as the appropriate time allotments for these duties.

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 medical and mental health staff management by assessing whether leadership positions are vacant or filled, and the duration of occupancy if filled. The Monitoring Team also noted whether health care leadership is effective in implementing the health care program.

Since the Monitoring Team's last visit to HRYCI, there has been continued turnover in leadership positions. The Medical Director, DON, and Assistant HSA positions are vacant. The Regional Nursing Director has been filling in on site. There is also a vacancy in the Associate Health Service Administrator position. The HSA position has been filled since December 2008.

The instability in the leadership positions continues to plague this facility and makes progress towards substantial compliance much more difficult. The Monitoring Team had discussions with both BCHS leadership as well as the CMS leadership team regarding the importance of filling these leadership positions with good people and then maintaining them in order to stabilize the program.

E. SCI

1. Assessment

The Monitoring Team found SCI to be in partial compliance with this provision of the MOA.

2. Findings

At SCI, all of the leadership positions have been filled by appropriately credentialed individuals for more than one year. Thus, with regard to stability of leadership, this facility has provided more stability than have any of the other facilities. However, with regard to clinical oversight by both the medical director and the DON, the Monitoring Team has found that there is a need for improvement. Neither the medical director nor the DON is providing sufficient clinical oversight, review of performance and feedback to the clinical staff, and the staff's performance that the Monitoring Team observed has not improved. Specifically, with regard to the intake health assessments, there were quality issues with more than 50% of the 20 medical records that the Monitoring Team reviewed. With regard to nursing practice, there were quality issues with regard to both the performance of nursing sick call and the performance of medication administration.

F. Recommendations

At Baylor, the Monitoring Team recommends that:

- As before, insure a stable, competent leadership team to provide the kind of stability necessary to implement, monitor and improve all service areas.

At JTVCC, the Monitoring recommends that the State:

- Fill the vacant leadership positions and sustain their employment in the program. In addition, it is necessary to facilitate dedicated administrative and supervisory time by the site Medical Director by providing alternate primary care clinical hours from another clinician.

At SCI, the Monitoring Team recommends that:

- The DON should insure that there is review and feedback to the nursing staff with regard to their clinical performance on sick call, intake screening, medication administration, response to urgent problems, and all other clinical activities.

At all of the Facilities, the Monitoring Team recommends the following:

- The State should work to maintain a stable, competent leadership team which is necessary to implement policies, and monitor and improve all service areas.

- The site medical director, in cooperation with the DOC medical director, as well as the CMS regional medical director, should institute a program of review and feedback to the advanced level clinicians so that over time the performance, with regard to health assessments and any other clinical services, is improved.

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.

Generally accepted professional standards dictate that adequate training for medical and mental health staff includes an immediate basic orientation[31] and all full-time staff must complete a formal in-depth orientation[32] 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

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[31] 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.*

[32] 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.*

whether medical and mental health staff have received suicide prevention training, as required by provision 43 of the MOA.[33]

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. During the previous monitoring period, 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, during the prior monitoring period, 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 was that psychiatrists already have the qualifications necessary to deal with suicidal inmates. Thus, this module comprises the required suicide training for psychiatrists.

B. Baylor

1. Assessment

The Monitoring Team found Baylor to be in substantial compliance with this provision of the MOA.

2. Findings

At the time of this visit, greater than 90% of staff had completed all of the required training. This includes medical as well as mental health staff.

C. JTVCC

1. Assessment

The Monitoring Team found JTVCC to be in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed records of health care staff and mental health staff employed at JTVCC. Greater than 90% of these individuals had training records that

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

supported their having completed the required training. In fact, for most of the items, the figures were greater than 95%.

D. HRYCI

1. Assessment

The Monitoring Team found HRYCI to be in partial compliance with this provision of the MOA.

2. Findings

The major deficiency at the time of the Monitoring Team's visit continues to be documentation of staff having received the annual suicide training. The Monitoring Team have been informed that the State has, since February 2009, arranged for staff to be able to take the suicide training refresher course online and some staff have completed this course already. However, at the time of the Monitoring Team's visit, there is not a system in place to insure documentation of completion of the course.

E. SCI

1. Assessment

The Monitoring Team found SCI to be in partial compliance with this provision of the MOA.

2. Findings

This area is near substantial compliance; however, 11 of 54 healthcare staff records did not contain documentation of the initial suicide training. On the other hand, the annual training had been completed by virtually all of the staff whose records the Monitoring Team reviewed. All other training is also up to date. Insuring that those missing the initial suicide training receive it as well as keeping all others up to date should result in a finding of substantial compliance at the next review.

F. Recommendations

- At Baylor, the Monitoring Team recommends that the State continue to insure that staff has received the requisite training.

- At JTVCC, the Monitoring Team recommends that the State continue to monitor and sustain this high level of compliance with the training requirements.

- At HRYCI, the Monitoring Team recommends that the State complete the infrastructure of the suicide training refresher course so that the State is able to document that all relevant medical and mental health staff have attended and completed the training.

- At SCI, the Monitoring Team recommends that the State provide the initial suicide training for those who are missing that requirement.

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.

According to generally accepted professional standards, 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. Generally accepted professional standards require that, 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. <u>Assessment</u>

The Monitoring Team found Baylor to be in substantial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team reviewed the records of approximately 10% of the security staff at Baylor. Focusing on individuals whose positions require training based on their contact

with inmates, the Monitoring Team found that 100% of those individuals who require training received it.

C. JTVCC

1. Assessment

The Monitoring Team found JTVCC to be in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed a sample of employee records of about 5% of the custody officers, or approximately 35 records. Of those records, greater than 90% had received the required training. Thus, the assessment of substantial compliance is sustained.

D. HRYCI

1. Assessment

The Monitoring Team found HRYCI to be in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the records of 36 officers and again found greater than 90% compliance with the required training. The Monitoring Team also reviewed the training logs on officers assigned to the mental health inpatient unit. The State was able to document that, with the exception of two days, all shifts contained at least one officer who had completed the required mental health training. However, on most days, only one officer in the unit had completed this training.

E. SCI

1. Assessment

The Monitoring Team found SCI to be in substantial compliance with this provision of the MOA.

2. Findings

Of the 404 staff members at SCI, 379 of those staff members required training pursuant to this provision. The Monitoring Team reviewed 45 of the 379 records, or a little more than 10%. Of the records the Monitoring Team reviewed, 93% had completed the CPR and First Aid training and 97.8% had completed the initial suicide training and refresher training, thus the finding of substantial compliance.

F. Recommendations

- At Baylor, continue maintaining the required training for all staff.

- At HRYCI, although many officers have completed the special mental health training, the assignment roster the Monitoring Team reviewed reflected, on most shifts, only one of the officers assigned to the unit had completed the training. It would be helpful to have as many officers as possible who are assigned to the mental health unit complete the special mental health training.

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 generally accepted professional standards, timely receiving screening[34] means that the screening is performed on inmates immediately 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. If a receiving screening is completed within three to four hours of arrival to a Facility, the Monitoring Team believes that is reasonable and consistent with generally accepted professional standards. Thus, the State's policy of completing the screening within two hours exceeds generally accepted professional standards.

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

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[34] 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*.

State should ensure that receiving personnel are making consistent and complete inquiries and observations. Generally accepted professional standards required that 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);[35]

[35] 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 generally accepted professional 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 Monitoring Team previously found that the screening form supplied by the State was adequate, but needed 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 finds the State to be in substantial compliance with this provision of the MOA.

2 <u>Findings</u>

The Monitoring Team reviewed 10 records of individuals who had entered the facility between March and June 2009 for whom a chronic disease had been identified. Thus, by design, the Monitoring Team selected records of individuals who were known to have health problems at the time of intake.

<u>Timeliness of Intake Screening</u>

The Monitoring Team found that virtually all of the records included a medical screen that had been performed by an RN, and completed in less than two hours. This is excellent performance, as the requirement for the screen is to be completed in less than four hours.

Adequacy of Intake Screening

The Monitoring Team found that the quality of the intake screens generally was good. The Monitoring Team also identified that all of the individuals included in the sample had been screened for Tuberculosis ("TB").

Mental Health Screens

With respect to mental health screens, the Monitoring Team notes that in all charts it reviewed as part of its audit, appropriate and timely screens were completed.

C. JTVCC

1. Assessment

The Monitoring Team found JTVCC to be in substantial compliance with this provision of the MOA.

2 Findings

The Monitoring Team reviewed two samples of records with regard to intakes. The Monitoring Team initially reviewed a selected sample of individuals who did not have a screen completed within 24 hours. All of these outliers entered the facility before mid-June 2009. Of the 10 outliers the Monitoring Team reviewed, eight actually had been screened at the time of entry, but the information was written on paper and not entered into the computer system until anywhere from one week to four weeks after the date of entry.

The Monitoring Team learned that the BCHS, in its own audit, had discovered this in mid-June 2009 and had worked with the DON to run a daily report of outlier screens. As a result, for several weeks prior to the Monitoring Team's review, there were anywhere from zero to one or two outliers on a given day, and those were always immediately processed. Thus, the serious problem which had existed appears to have been identified by the BCHS and a correction has been implemented during this monitoring period.

The Monitoring Team also selected 20 other records of individuals who entered the system between April and July 2009, who the Monitoring Team knew had chronic medical problems.

Timeliness of Intake Screening

In the Monitoring Team's review of these individuals' records, the Monitoring Team found that the screening generally occurred less than two hours after the individuals were processed into the offender tracking system.

Adequacy of Intake Screening

All but one of the intake screens was performed by an RN and the one performed by an LPN was countersigned by an RN. The quality of these screens was quite good. In addition, all individuals had a TB skin test planted and read, so that both the timeliness and quality of the screening is consistent with a finding of substantial compliance.

Mental Health Screens

With respect to mental health screens, the Monitoring Team notes that in all charts it reviewed as part of its audit, appropriate and timely screens were completed.

D. HRYCI

1. Assessment

The Monitoring Team found this provision of the MOA to be in partial compliance.

2 Findings

The Monitoring Team reviewed 20 records of individuals who entered the facility between January 2009 and the time of the Monitoring Team's site visit. The Monitoring Team also reviewed six records of individuals who had transferred into HRYCI in the same time frame. The records of people who newly entered the system in this time frame were selected on the basis of having identified that these individuals had some medical problem, usually a chronic disease. The five intrasystem transfer records were selected randomly.

Timeliness of Intake Screening

With regard to the timeliness of intake screening, although the program was in compliance during the Monitoring Team's last visit, and the Monitoring Team is pleased to report that the timeliness has improved and the majority of patients who enter the facility have their medical screening performed in less than one hour from the time they are booked.

Adequacy of Intake Screening

With regard to the appropriateness of the intake screenings, the Monitoring Team identified a deterioration during this monitoring cycle relating to timely RN review of LPN intake screenings. RN review is evidenced by a signature, and the Monitoring Team used the time of the signature to determine the timeliness of the RN review. More than 50% of the records reviewed had no RN signature, and, of those that did have a signature, at least three or four were signed two or more days after the fact. The purpose of the RN signature is to review both the screen and the LPN summary note in the interdisciplinary progress notes to insure that all of the relevant data is summarized and an appropriate disposition is made. When this review occurs well after the fact, there is a potential for serious medical issues to be overlooked.

The Monitoring Team spent a significant amount of time with the HSA reflecting on patterns of errors that the Monitoring Team was able to identify in reviewing the LPN intake process. The Monitoring Team strongly encourages that the HSA utilize this list of patterns of errors in order to train the RNs on what to emphasize when they are reviewing the performance of the LPNs for two reasons. First, so that they can correct any errors, in terms of bringing patients back for appropriate services, and second, to provide feedback to the LPNs so that these types of errors are reduced.[36]

Findings on intrasystem transfers

With regard to the six records of patients who were transferred into HRYCI, the Monitoring Team found that four of the records lacked the LPN summary note and one of the records lacked the RN signature. The Monitoring Team also found that one of the patients who entered with medications did not have the medications documented as having been given to him until six days after his arrival.

Mental Health Screens

With respect to mental health screens, the Monitoring Team notes that in all charts it reviewed as part of its audit, appropriate and timely screens were completed.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this provision of the MOA.

2 Findings

The Monitoring Team reviewed 20 records of patients who were new to the system who arrived at SCI between January 2009 and mid-April 2009. The Monitoring Team also reviewed five records of individuals who were transferred into SCI during the same time period from another facility.

Timeliness of Intake Screenings

Of the records the Monitoring Team reviewed, all of the screenings were performed in less than four hours and the average was within less than one hour. This is a

[36] The patterns of errors included: lack of summary progress note written in the interdisciplinary progress note section, lack of appreciation of abnormal vital signs, lack of detail on specific abnormal findings, lack of appropriate disposition with regard to housing assignment or contacting the physician, as well as lack of comprehensiveness in the summary note, in that the note contained all of the problems which were stated by the patient.

dramatic improvement from when the Monitoring Team first started monitoring and the institution is to be commended for its accomplishment.

Adequacy of Intake Screenings

In addition, the Monitoring Team reviewed the quality of the screens, including the elaboration of detail on positive findings and the review by an RN with countersignature when an LPN performed the screen. The Monitoring Team also reviewed the nursing note summarizing the findings. The performance in all areas was good.[37]

Mental Health Screens

With respect to mental health screens, the Monitoring Team notes that in all charts it reviewed as part of its audit, appropriate and timely screens were completed.

F. **Recommendations**

At JTVCC, the Monitoring Team recommends that the State:

- Continue to monitor this process carefully, utilizing the outlier report and insure that any outliers are investigated and completed.

- Continue to monitor the quality of the screening process.

At HRYCI, the Monitoring Team recommends that the State train the RNs, utilizing some of the information the Monitoring Team discussed and insure that their review, intervention and signature occur timely with the department's goal being within one shift of the timing of the intake screen.

At SCI, the Monitoring Team recommends that the State retrain the nurses so that when they write their interdisciplinary progress note summarizing the findings of the patient's screen, they are instructed to write out the vital sign specifics, including blood pressure, pulse, temperature, etc.

[37] An opportunity for improvement, however, was identified with regard to the documentation in the progress note. Instead of writing the actual vital signs recorded, nurses were writing "VSS", which stands for "vital signs stable." This is inappropriate when only one set of vital signs has been taken; stability describes findings over time. In addition, one can have stable vital signs which are nonetheless abnormal. The important assessment issue is whether the vital signs are normal or not.

11. Privacy

A. Relevant MOA Provision[38]

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[39] 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.[40] 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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[38] Additional, related observations regarding clinic space and equipment can be found in the discussion of provision 18 of the MOA below.

[39] "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.

[40] 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 the State to be 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. Major physical changes have been made to the facility since the time of the Fourth Report, and are noted in this provision because they impact privacy positively, but are discussed in relation to provision 18 with regard the assessment of the clinic space and equipment. The administrative functions and offices have been moved across the hall from the clinic space. All the offices in the clinic space now are used for clinical purposes such as infection control, treatment, nurse sick call, chronic care, lab, infirmary, PCO, and storage. Equipment in the exam rooms was complete and was in working order; the space was clean with a regular inmate worker assigned. Medication administration has been moved to a larger space opposite its old location; this facilitates simultaneous medication lines for inside and outside inmates. Medical records, HSA and DON offices are also opposite the clinic space in the new administration area.

The Monitoring Team also met with a group of four inmates. None had complaints about a lack of privacy. The Monitoring Team observed that inmates waiting for appointments were held in a waiting room separated from the clinic space by a door. Inmates were observed behind doors for chronic disease care clinic, as well as medical emergency and nurse sick call. A security officer was in the clinic area during sick call, but this is not problematic. Medical records are in the offices for the providers and neither charts nor loose papers were observed lying around in public spaces.

Privacy in the Context of Mental Health Services

The Monitoring Team notes that the State has completed extensive renovations to create additional clinical space for medical and psychiatric services. This current space should be adequate to ensure privacy for all clinical encounters. While adequate space to ensure privacy is no longer an issue, it came to the Monitoring Team's attention that inmates being placed in disciplinary segregation are not interviewed in a private setting for their initial mental health assessment. When at all possible under the standard set forth under the MOA, the State needs to make reasonable efforts to conduct these contacts in a private setting.

C. JTVCC

1. Assessment

The Monitoring Team found that the State 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 the State does not make reasonable attempts to provide auditory or visual privacy to patients for medical or mental health patients.

In the main unit, there were four examination rooms in the back of the clinic. One examination room had a door and three rooms did not have a door. As inmates move to and from examination rooms, they are able to view other inmates in various stages of being examined. Although privacy curtains were available in this area, the Monitoring Team did not observe staff using privacy curtains at any time. In addition, a physician who works in the Maximum Security Complex advised the Monitoring Team that she requested a privacy screen to conduct patient examinations that included rectal and/or genital examinations, but was denied the request.

It is unreasonable to expect patients to submit to rectal and genital examinations when inmates and non-medical staff are able to observe the encounter. This likely leads to inmates refusing examinations and serious medical conditions (*e.g.* rectal or prostate cancer, etc.) and/or sexually transmitted diseases not being diagnosed and treated in a timely manner.

Privacy in the Context of Mental Health Services

The Monitoring Team is very concerned with the lack of space that allows for adequate sound privacy. The issues observed by the mental healthcare experts over privacy seemed to be the result of a lack of unity between mental health staff and custody staff over the need for sound privacy in the correctional setting. Specifically, the lack of unity seems to relate to whether mental health contacts need to be held in private in a correctional setting. The MOA requires the State to use reasonable efforts to ensure inmate privacy when conducting mental health treatment, subject to *legitimate* security concerns, and *emergency* situations.

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 were also noted in relation to the Monitoring Team's discussion of provision 18 of the MOA.

During this site visit, the Monitoring Team noted persistent challenges to providing adequate patient privacy, which appear to be related primarily to the availability and

use of medical clinic space.

As noted during the Monitoring Team's last visit, in the East side medical clinic only has one designated examination room and both the clinician and phlebotomist share this room when seeing patients. This has a negative impact on patients' privacy. There is a former medication room that could potentially be converted into space for use by the phlebotomist and/or for other purposes. On a positive note, rooms in the housing units have been designated to be used by medical staff to conduct nursing sick call. The use of these rooms could potentially be expanded for other clinical activities, thereby providing greater privacy.

In the West side clinic, there is a small room behind the officer's desk which is simultaneously used by the NP to perform physical examinations and by the phlebotomist to draw blood. Although there is a curtain to partition the room, because the room is so small, this arrangement does not permit adequate auditory and visual privacy. The Monitoring Team interviewed the NP, who reported that at times she has to write down questions for the patient so the information is not overheard by the inmate having his blood drawn. Thus, the arrangement does not provide for the free flow of information between provider and patient. Inmates in the waiting room can look into the examination room and observe patient examinations.

Privacy in the Context of Mental Health Services

With respect to mental health, since the time of the Monitoring Team's last site visit in the fall of 2008, the old pharmacy room has been converted to a multi-use interview treatment room for medical and mental health purposes. Prior to the Monitoring Team's most recent visit, most of the interviews with mentally ill inmates in the infirmary had been conducted at the cell-front due to custody escort allocation issues, and lack of access to the interview room because it was being used by medical staff. However, at the time of the Monitoring Team's visit, approximately 60% of the interviews with mentally ill inmates in the infirmary were conducted in the multi-use interview room. This is an improvement, but a correctional officer had been present in the room during these interviews due to a perception that it was a custody requirement. Upon review, the warden issued notification that correctional officers will stand back (outside the room) while private encounters are conducted.

Two multipurpose rooms on the East side have been renovated for use for mental health purposes, which should allow for adequate office space for assessing and treating inmates in the Key program and providing group therapy. Additionally, the office space for the mental health clinicians has been improved significantly by their move to the area formerly occupied by correctional counselors.

The Monitoring Team believes that, with respect to mental healthcare, the changes described above, if sustained, will enable the State to achieve an assessment of substantial compliance during the next visit.

E. SCI

1. Assessment

The Monitoring Team finds the State to be 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 also reviewed building plans to renovate the MSB medical clinic and toured the new building which will house mental health and dental services.

In the pre-trial area, the Monitoring Team observed no issues with the provision of medical privacy.

In the MSB medical clinic, as described in previous reports, some improvements have been made to enhance privacy. However, the current size and layout of the clinic does not permit adequate patient auditory and visual privacy. During this visit, the Monitoring Team observed a physician-patient encounter where there were three other staff members in the examination room for various unknown reasons while the patient was being seen. This issue appears to be related to lack of adequate space.

The Monitoring Team anticipates that medically-related privacy issues will be adequately addressed when the State implements medical clinic renovations as shown in the building plans that the Monitoring Team reviewed.

Privacy in the Context of Mental Health Services

With respect to the provision of mental healthcare services, the Monitoring Team notes that adequate space for evaluating and treating inmates in the infirmary for mental health purposes remains problematic. This has been somewhat improved through the use of cubicles in the infirmary setting. Except for the pretrial housing units, staff reported that the office space for assessing and treating mental health caseload inmates was not adequate from a sound privacy perspective. The office in the medium security building adjacent to the infirmary was significantly improved as compared to the previous site visit. The Monitoring Team believes that the office space issues will be eventually remedied by the construction of the new mental health building and the addition to the medical infirmary. It is the Monitoring Team's hope that once this construction is complete, the State will have little trouble reaching substantial compliance with respect to this provision.

F. Recommendations

- At Baylor, the Monitoring Team recommends that the State/CMS should continue to ensure that clinical encounters occur in settings that provide visual and/or auditory privacy.

- At JTVCC, the Monitoring Team recommends that the State ensure that health care providers conduct patient interviews and physical examinations in a manner that permits auditory and/or visual privacy, and that health care and security personnel should work together to ensure that adequate examinations are performed while maintaining a safe environment for staff and other inmates.

- At HRYCI, the State/CMS should ensure that clinical encounters occur in settings that provide visual and auditory privacy.

- At SCI, until the State completes construction of the new building and medical clinic renovations, the State/CMS should make every effort to ensure that clinical encounters occur in settings that provide visual and auditory privacy.

- With respect to mental health, at JTVCC, the State needs to implement procedures to ensure adequate security staffing to escort and observe private mental health encounters for inmates on PCO status in the infirmary.

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[41] to occur. Generally accepted professional 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.[42] 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;
- 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.[43] *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, this provision requires the State to conduct mental health assessments for newly admitted inmates. With respect to readmitted inmates, this provision only requires the State to review the health records of that individual instead of

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[41] 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.

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

[43] 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.

conducting a full assessment. The State has chosen to conduct assessments on all admitted inmates, regardless of whether they have been previously incarcerated or not. As such, the Parties have agreed that as long as the State continues to conduct full assessments, review of health records of readmitted individuals is not necessary because the State is exceeding this standard by conducting full assessments on all inmates.

B. Baylor

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

Again, the Monitoring Team reviewed 10 records of individuals who entered Baylor between March and June 2009 and whose records were selected because the Monitoring Team knew they had been identified as having a chronic disease. In nine out of ten records, the health assessment was performed within one week of entry. The exception was an individual who had recently been discharged, approximately a month and a half prior to this new intake and this individual did not require a complete assessment. However, according to policy, this person should have had a targeted mini-assessment utilizing the prior data and obtaining an interval history and update on the current problems. However, no mini-assessment, or any assessment, was performed for this individual. In addition, the Monitoring Team found one patient for whom it was identified that she had a serious disease, but no follow up visit was scheduled. Finally, there was one individual who was identified as having two chronic diseases but one disease was not addressed during the health assessment.

With respect to mental health, the Monitoring Team refers to its findings in paragraphs 29 and 34.

C. JTVCC

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

Although the timeliness of the health assessments has improved, three out of 15 patients' records reflected a late health assessment. More importantly, there were quality problems with at least five of the 15 records reviewed. The quality problems consisted of problems with the initial chronic disease visit, which is done in lieu of the general health assessment. The problems included not obtaining an adequate history, not obtaining an appropriate assessment, or not obtaining an appropriate plan.

An additional four of the records that the Monitoring Team reviewed were records of individuals transferred into the facility. The major problem with the transfer process was that the nurses were not documenting in the record whether patients on medications were arriving with the medications that are currently prescribed for them. The nurses should be cataloging in the medical record the current medications that should be received and documenting whether all of those medications are received. When they are not received, the nurse must take appropriate action to insure that there is no medication discontinuity.

With respect to mental health, the Monitoring Team refers to its findings in paragraphs 29 and 34.

D. HRYCI

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed 20 of patients who entered the system between January 1, 2009 and mid-April 2009. Of the 20 records the Monitoring Team reviewed, five records reflected that the patients had neither a health assessment nor an initial chronic disease visit, four reflected that the patient had had one or the other type of assessment (in the case of an inmate with a chronic illness, an initial chronic disease visit within the required timeframe in lieu of a health assessment is acceptable), but the assessments occurred between three and twenty days after the inmates had been in the facility for a week.

In addition to problems with timeliness of the assessments, the Monitoring Team also found quality issues in that items identified during the intake screen were not mentioned during the health assessment, including some chronic diseases. There also continues to be a problem with the advanced-level providers seeing new intakes with chronic diseases using a follow up clinic form. This does not allow them to take an adequate disease-specific history, and therefore, prevents a complete understanding of the nature of the patient's problems. This has been discussed with staff during at least the last three cycles of visits, and yet the Monitoring Team did not see substantial improvement.

With respect to mental health, the Monitoring Team refers to its findings in paragraphs 29 and 34.

E. SCI

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the records of 20 new intakes. All of the records contained a health assessment or an initial chronic disease assessment, performed within the required one week timeframe. Thus, with regard to timeliness, the Monitoring Team's finding is substantial compliance.

Eleven out of 20 records had quality deficiencies with regard to the health assessment. There were two common patterns of deficiencies. One type of problem consisted of the initial chronic care visit not being conducted in a manner consistent with DOC's clinical guidelines. The departures from the policies and procedures include not ordering appropriate tests, or not assessing the patient's disease control correctly. A second pattern included not elaborating on positive findings found in the intake screening history. In addition, there was one record in which the health assessment form was filled out but in the physical exam space there was a reference to the initial chronic care visit form. The corresponding initial chronic care visit form referenced the physical exam being documented on the health assessment form. Thus, though both forms were utilized, this patient did not have a documented physical exam.

With respect to mental health, the Monitoring Team refers to its findings in paragraphs 29 and 34.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State:

- Continue to perform the health assessments timely, but insure that people who have had a recent health assessment and are returning receive a mini health assessment as required by policy.
- As a component of your quality assurance program, review the quality of the health assessments on an ongoing basis and provide feedback to those individuals performing health assessments, so that their performance will improve.

At JTVCC, the Monitoring Team recommends that the State:

- Continue to monitor the provision of health assessments/initial chronic disease visits, to insure that they occur within the required timeframes. Although the Monitoring Team monitors against a 14-day timeframe, the internal policy is to complete these visits within seven days of entry.

- Monitor the performance of the clinicians performing these health assessments/chronic care visits, insuring that they are elaborating on positive responses in the history and assessing disease control in a manner consistent with the department's clinical guidelines.
- Monitor that an appropriate plan is ordered and implemented with regard to both diagnostic and therapeutic intervention.
- Train the nursing staff with regard to the transfer process and their need to document medications which should be received and whether or not those medications are received.

At HRYCI, the Monitoring Team recommends that the State insure that:

- Staff performing the intake/initial chronic disease visit understand DOC policy as well as relevant clinical guidelines and insure that after they have reviewed the intake screen their performance complies with those elements.

At SCI, the Monitoring Team recommends that the State:

- Implement a program of ongoing review and feedback by the site medical director of the work of the individuals performing the health assessments so that over time the performance improves. Although at the outset a significant proportion of records should be reviewed for appropriate feedback, as performance improves the quantity and frequency of the reviews can be diminished.

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 the State to be in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed eight records of patients who had been referred for specialty services between March and June 2009. In these records, the Monitoring Team attempted to identify an order and request for these services, along with a progress note indicating the reason for the service. In addition, the Monitoring Team looked for the report from the offsite service provider, as well as a follow up visit with the clinician in which the findings and plan were discussed. In all eight records, the Monitoring Team found the required documentation, thus the finding of substantial compliance.

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

C. JTVCC

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed eight records of patients sent offsite for specialty care or offsite procedures, such as scans or diagnostic scoping procedures. Four out of the eight records contained problems. The types of problems the Monitoring Team identified included lack of results from procedures performed, lack of a follow-up visit by the primary care clinician, lack of a "Return From Offsite Nurse Encounter Form", and lack of follow up of specific recommendations from the consultant.

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

D. HRYCI

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the consultation process, looking at the time frame between initial request and date of appointment. In general, most appointments occurred within four to six weeks of the initial request. The Monitoring Team also looked at the justification for the appointments (as evidenced in the documentation in the medical records), as well as the follow-up care. The Monitoring Team reviewed seven records of patients whose outside appointments were requested during the first quarter of 2009. In most of the records, there was a documented note indicating the reason for the request and an order for the request. In addition, most of the records reflected that upon the patient's return to the facility, there was a note by the nurse indicating the patient's return. However, in four out of seven charts, there was no follow-up visit by the primary care clinician in which there was a documentation of a discussion with the patient regarding findings and future plans. The review of this aspect needs to be part of the HRYCI quality improvement program. There was also one record in which the report of the services provided offsite was not available in the record when the Monitoring Team reviewed it.

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

E. SCI

1. Assessment

The Monitoring Team found the State to be in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed seven records of patients sent offsite for consults or other tests, such as ultrasound. In each of the records there was an initial progress note explaining the reason for the referral. There was also an order and a consult request form. All of the visits were obtained in a timely manner. When the patient returned, there was appropriate follow up, both initially by nursing staff and subsequently by the primary care clinician. On the basis of the appropriateness of the referrals, the timeliness of the services and the appropriateness of the follow up, this area is in substantial compliance.

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

F. Recommendations

At JTVCC, the Monitoring Team recommends that the State:

- Monitor this process with regard to the presence of documents required for follow up.
- Monitor this process for the presence of nurse encounter forms at the time of patient return from the offsite service.
- Monitor the quality of professional performance with regard to both nursing and primary care clinician performance with regard to insuring continuity.

At HRYCI, the Monitoring Team recommends that the State:

- Utilize the nursing visit on return to the facility to insure that documents are available and that the follow up visit with the primary care clinician is scheduled.
- Monitor this program as part of your quality improvement monitoring activities.

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.[44]

Generally accepted professional standards require a treatment plan for a special needs inmate to 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

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[44] 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.

- 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 BCHS 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.

During the Monitoring Team's review of Baylor, JTVCC, and SCI, the Monitoring Team noted a problem in how discharge medications are dispensed. Planned and unplanned releases are done without a psychiatrist reviewing the discharge medications an inmate receives. When an inmate is set to be released, rather than the psychiatrist issuing a discharge order, nursing staff orders medication from the pharmacy, as long as the current physician's order has not expired. The inmate is then given this full prescription. The reason that this practice causes a concern is that, typically, with respect to psychotropic medications, inmates are not allowed to keep these on their person while incarcerated. Obviously, when they are released, they will be in possession of these medications. A doctor might choose to give a lesser supply of medication or a different medication if the doctor believes that the patient cannot manage his or her medications or may be self-injurious.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. <u>Findings</u>

As this is a small facility, there were only three patients on the special accommodation list. For each of these patients, there had been a multi-disciplinary meeting in which the particular problems which complicated the program's ability to meet the patient's needs were discussed. In addition, strategies for improving outcomes were also identified. Where possible, there was a discussion of response to the recent interventions.

With respect to mental health, a rating of partial compliance is given as opposed to substantial compliance due to the Monitoring Team's concerns over the current process of dispensing discharge psychotropic medications. The State needs to demonstrate there is psychiatrist oversight in generating discharge prescriptions.

Women on the special needs unit reported they received 30-day supplies of medication upon release and outpatient referrals and housing assistance. A recently initiated discharge planning log was reviewed and it lists inmates who have left since 5/17/09 and their referral information.

C. JTVCC

1. Assessment

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

2. Findings

JTVCC is a facility that collects complicated patients from around the rest of the system. Thus, it has far and away the largest number of complex patients to monitor and manage. Many of them have medical, behavioral and mental health problems. The BCHS Medical Director has taken over the responsibility of chairing the committee responsible for treatment or accommodation plans. He clearly understands which types of patients are appropriate for this program and has begun selecting the appropriate patients from the current list to remain in the program. In addition, he understands that the current deficiency with the special accommodation program is that, although staff is using the special accommodation form in their discussions about patients, they are not identifying specific improvements to be achieved, quantifying goals, and then measuring the success of their implementation strategies against these goals. Thus, although the program has begun to develop some momentum, it clearly needs some maturation in order to improve its effectiveness.

The Monitoring Team reviewed five records of patients on the list. Each of them had been seen and had been discussed, as documented on the forms, but none of the records contained clearly defined goals and metrics used to determine whether or not those goals would be achieved.

The Monitoring Team met with the pharmacy technician on July 29, 2009. He is receiving referrals from mental health on inmates scheduled for release. Either he or the nursing staff will pull the inmate's medical record for review and check the current MAR for current prescriptions and place an order with the pharmacy. When the medication arrives, it is placed in a plastic bag with the referral order and placed in a bin. When receiving notifies the pharmacy that someone is being processed to leave, medical staff is supposed to bring the discharge medications to that area where they are dispensed to the inmate. There are no tracking forms and the inmate does not sign to indicate receipt of the medication. The technician stated that only a "low number" of inmates actually get their medication based on his observation that most

medications in the bin are returned to the pharmacy because they are not given to the inmates. The State is aware that they did not have a method to track this process and no means of assuring that the medications that do make it to receiving are actually given to the inmate.

No out of stock problems were reported and refills usually arrive within 1-2 days of request. Most psychiatry medications are formulary and the technician reported no problems in obtaining non-formulary medications in a timely fashion.

D. HRYCI

1. Assessment

The Monitoring Team found HRYCI to be in partial compliance with this provision of the MOA.

2. Findings[45]

The Monitoring Team reviewed the records of four patients who are part of the treatment or accommodation plan special needs program. The Monitoring Team learned that medical staff has been having meetings to discuss these cases and during those meetings, they use a special form to document the patient's problems, the special need to be addressed, and any goals and plans. Apparently, there is a later discussion at an operations meeting with custody. However, there is no documentation in the medical record indicating the impact of those later discussions on the plans to manage these patients. It was also clear from the Monitoring Team's review that some patients were considered to be part of this program when they really did not have any clear cut special needs, and in other instances, patients were in the program but should have been discharged from it after significant progress had been made. The new DOC Medical Director participated in this entire review and indicated that he would be providing leadership to this program at each of the sites so that appropriate patients were in the program and monitored on a regular basis for an appropriate period of time.

With respect to mental health, the Monitoring Team notes at the time of its April 2009 visit that the State had not recently conducted any QI studies with respect to discharge medications. The Monitoring Team reviewed the parole medications log which demonstrated poor compliance with this provision. For instance, over a three month period, only four of 22 inmates signed for medications when released.

[45] The absence of any discussion regarding a lack of psychiatrist review before discharge medications are dispensed at HRYCI should not be interpreted as this problem not existing as well at HRYCI. This problem, which exists at the other three facilities, was not discovered until after the Monitoring Team's April 2009 visit to HRYCI. The Monitoring Team will investigate this during its September 2009 visit to HRYCI.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed a list of approximately 20 names of patients who were listed as being part of this program. The Monitoring Team pulled a sample of five records which the Monitoring Team reviewed and discussed both with the HSA and with the State DOC medical director. It appears that there were people placed on the list inappropriately. A major criteria utilized at the facility was if a patient had written to the governor's office or the commissioner's office about issues they were added to the list for participation in this program, even if the resolution of their problem was fairly straightforward. In the Monitoring Team's discussion, the Monitoring Team encouraged the state medical director or the BCHS director to participate in these meetings to provide guidance with regard to not only who should be included in the program but also how these patients' unique issues are to be addressed.

With respect to mental health, the Monitoring Team was informed by staff that the facility employed an active discharge planning process for sentenced inmates that includes a two-week supply of discharge medications, linkage with community mental health providers, assistance with housing and entitlements. The Monitoring Team reviewed logs for discharge medications and community mental health linkages, and was concerned that the two logs generally did not list the same inmates. As most mental health inmates are receiving some sort of medications, it is troubling that inmates' names do not appear on both lists.

Pre-trial inmates reported very little discharge planning, except for medications, which was consistent with the information obtained from the staff.

F. Recommendations

- At Baylor, the Monitoring Team recommends that the State continue with its efforts to identify problematic patients and to hold multi-disciplinary meetings to insure that there is a consistent approach to these difficult patients.

- At JTVCC, the Monitoring Team recommends that the State continue having the DOC Medical Director chair the committee and train staff how to implement the special accommodation form and program.

- At HRYCI, given the Monitoring Team's discussions with the DOC Medical Director, the Monitoring Team would recommend that he provide leadership to this program and insure that when the group meets to discuss these complex patients, the discussion includes a multi-disciplinary team, including both custody and mental health, as well as any other disciplines that may be relevant. These discussions can then be summarized

according to the format of the currently used form. The Monitoring Team would recommend that these topics not be added to an already overloaded agenda for the operations meetings, but handled at a separate meeting.

At SCI, the Monitoring Team recommends that the State:

- Be clear as to the specific reasons why a given patient is included in the special needs program.
- Specify what outcomes are to be achieved with regard to those specific problems.
- Detail the specific strategies that are to be utilized.
- Hold follow up meetings to assess the effectiveness in 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 a policy with respect to drug and alcohol withdrawal that conforms to generally accepted professional standards. *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. According to generally accepted professional standards, 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. Assessment

The Monitoring Team found Baylor to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed five records of patients who had been assessed as potentially going into withdrawal from either alcohol or drugs. In each record, staff had identified the need to implement the withdrawal protocol. The withdrawal protocol requires that nurses perform an assessment on each shift for the number of days that the protocol is ordered and this is usually four or five days. In the Monitoring Team's review, none of the five records had documented nursing assessments for each shift during the timeframe that they were to be monitored according to the protocol. It is possible that this problem exists in part because patients in withdrawal are housed in general population, not in the infirmary, which lacks the bed space for the housing of these patients. The end result is that nurses are not performing required withdrawal assessments.

C. JTVCC

1. Assessment

The Monitoring Team found JTVCC to be in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed five records of patients who were identified on entry to the facility as being in alcohol or substance withdrawal. In each instance, the patients were admitted to the infirmary in a timely manner. While in the infirmary they generally received nursing assessments utilizing the CIWA scale[46] three shifts per day over a four or five day period. There were occasional instances in which nurses failed to document an assessment but these were exceptions rather than the rule. In instances where the severity of the findings on the assessment warranted contacting the physician, physician contact was documented.

[46] The CIWA scale is the Clinical Institute Withdrawal Assessment of Alcohol scale, and is a tool that is used to rate different withdrawal symptoms an inmate might exhibit.

D. HRYCI

1. Assessment

The Monitoring Team found HRYCI to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed four records of patients who entered the system and were monitored for their drug and alcohol withdrawal. The Monitoring Team saw a significant improvement in the use of the withdrawal protocol, including use of the CIWA forms. The main problem that remains is that the nurses, according to the protocol, are required to contact the physician when the monitoring indicates this is warranted. There is no documentation in a few of these records that such contact occurred, nor is there any indication of what the doctors recommended. In addition, when the doctors have written notes, their notes do not refer to their having reviewed the nurse monitoring and the subsequent CIWA score obtained. Thus, to obtain substantial compliance the implementation needs to include good communication in both directions between nurse and advanced level provider and vice versa.

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 six records of patients for whom the drug and alcohol withdrawal protocol was used. In general, there was improvement from the Monitoring Team's prior review. In the first four records, the nursing performance was appropriate, with the exception of one day in which the protocol form was not utilized. In those first four records, in general, the patients were in good control. There was only one instance in which the protocol required physician notification, and that did take place.

In the last two records, however, there were instances in which the physician should have been notified, but this did not happen. The critical aspect of these protocols is not just standardization of the assessment of people in withdrawal, but also the requirement to notify the clinician when the severity of the withdrawal symptoms exceeds a given level. In two of the three records where the symptoms exceeded the level the physician was not notified.

F. Recommendations

- At Baylor, the Monitoring Team recommends that the State develop a strategy to insure that nurses coming on to a shift are always aware of which individuals in population are

under the alcohol and drug withdrawal protocol and therefore require an assessment on each shift.

- At JTVCC, the Monitoring Team recommends that the State continue monitoring this process on some intermittent basis.

At HRYCI, the Monitoring Team recommends that:

- The nurses must document their discussions with the advanced level provider whenever such discussions occur and the documentation should include any instructions from the advanced level provider.

- The physicians, when they write their notes, should document that they have reviewed the nurse monitoring and should use that data in their approach to the patient.

At SCI, the Monitoring Team recommends that the State reinforce with the nursing staff the need to contact a clinician and document that contact n the record whenever the severity score exceeds the designated level.

16. Pregnant Inmates[47]

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.*

B. <u>Assessment</u>

The Monitoring Team found Baylor to be in substantial compliance with this provision of the MOA.

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

C. Findings

The Monitoring Team reviewed seven records of patients who were pregnant in the period between March and June 2009. In each record, the Monitoring Team found documentation that the patients were followed consistently by the obstetric program and received not only the appropriate tests, but also multi-vitamins, minerals and, where indicated, immunizations. Thus, the program was in substantial compliance. There was only one deficiency and that was in one record of a patient who had delivered. The patient returned to the facility and the nurse, upon return, did not document in the offsite encounter report the fact that the patient was post-partum.

17. Communicable and Infectious Disease Management

A. Relevant MOA Provision

Paragraph 17 of the MOA provides:

> 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. 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 policies and procedures, and practices related to infection control and communicable disease screening programs.

An RN has been appointed as ICN and has been in this position for several months. She has received some training from the ICN from another facility that has an effective ICN program in place.

There are computerized logs to track PPD testing for staff and inmates, hepatitis B and C status and treatment for inmates, hepatitis B vaccination status for staff and reportable/reported diseases. The new ICN has done an admirable job in implementing the this program at Baylor. Clinical aspects of the program are in place and running well. As examples: PPD tests were done and read on 10 of 11 applicable inmate health records (91%) reviewed for nurse sick call. One test was never planted and this was referred to the Delaware DON for follow up; eight of eight employee health records (100%), had documentation of current PPD testing or symptom review (for those previously testing positive); eight of eight (100%) employee health records had documentation of hepatitis B vaccine status (either consents with record of shots or refusals). There was documentation that the negative pressure isolation room is functioning appropriately and testing is occurring as required by OSHA (monthly when room is not occupied). A cleaning schedule for the clinic area is posted and implemented. The area appeared clean and orderly.

There was no documentation of who is on the IC Committee or minutes of meetings for a facility committee. There were minutes from a statewide IC meeting and MAC meetings at which some IC issues were discussed.

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 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 facility has a new ICN who has been in place since March 2009. She has received training for the position.

The ICN has instituted paper and computerized tracking logs for several communicable disease tracking functions, including inmate tuberculin skin testing, communicable disease reporting, discharge planning for patients with communicable diseases, and training. There are systems in place now that were not present at the previous visit. According to the ICN, testing for STDs and other infectious diseases are done on inmate request, or when an inmate presents with signs or symptoms.

There is not yet a facility Infection Control Committee and or formal meetings. Presently, the ICN attends regional infection control meetings, the Medical Audit Committee (MAC) meetings, and staff meetings at which some infection control issues are discussed.

Review of 22 records for inmate PPD status revealed that 17 (77%) of the 22 were current in testing, which confirms the ICN assertion that the facility was 60-75% complete on updating inmates PPD testing.

Review of 10 clinical staff files revealed that nine of 10 (90%) were current in PPD testing and all had documentation of Hepatitis B vaccination status. Review of a tracking file for staff also revealed that clinical staff had N-95 fit testing done or were in process.

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 evaluated this provision by reviewing policies and procedures related to infection control and communicable disease screening programs. The Monitoring Team reviewed 16 inmate records to determine compliance with annual TB skin testing. The Monitoring Team reviewed 10 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.

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 that is reviewed annually. The contents of the infection control manual were consistent with current CDC 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.

The facility has conducted infection control meetings with minutes reflecting OSHA and facility requirements. The facility Infection Control Committee (ICC) has had one quarterly meeting since the last monitoring visit, reported at the monthly CQI and MAC meetings, and reported at the bimonthly Operations meetings.

Of the 16 inmate records reviewed for compliance with TB testing, all revealed that the inmate had an annual TST performed; however, in two cases, the results had not yet been recorded in the health record, but were recorded in DACS. In another case, the inmate was lost to follow up testing because of the way the previous test had been documented in DACS, according to the IC Nurse.

The Monitoring Team also reviewed ten employee records. All were compliant for TB skin testing, Hepatitis B vaccination data, annual OSHA training and annual fit testing for the N-95 respirator masks.

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 provision by reviewing policies and procedures, and practices related to infection control and communicable disease screening programs.

On the last two site visits, the Monitoring Team found that the communicable and infectious disease control program was weak; there has been no significant improvement. This appears to be largely due to personnel and supervision issues.

CMS has extensive infection control policies and procedures; however, they have not been fully implemented. There have been no infection control meetings since February 2009. These meetings are key to monitoring infectious/communicable disease trends related to tuberculosis skin testing, Methicillin-Resistant Staphylococcus Aureus ("MRSA"), or sexually transmitted disease trends, as well as environmental sanitation and infection control issues.

In the Monitoring Team's discussion with the ICN, it was apparent that she did not fully understand communicable diseases and reporting requirements. For example, she reported a patient to the health department who tested positive for hepatitis B surface antibodies; however, this laboratory result signifies that the patient has immunity to hepatitis B, which is the result of previous infection or vaccination, and not acute or chronic infection.

Review of environmental inspections that this nurse participated in showed significant problems in the housing units such as a leaking urinal with subsequent positive environmental cultures (*e.g.*, E. coli), yet documentation in these reports does not reflect corrective actions regarding this and other environmental problems.

Discussion with health care leadership revealed that they have been aware of the personnel issues since the Monitoring Team's last visit, yet no meaningful supervisory corrective action has taken place.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State:

- Form an IC Committee and hold meetings per policy, to monitor the program, including sanitation reports, communicable and infectious disease trends, prevention and other OSHA issues.

- The IC Nurse should fit test all health service staff for the N 95 respirator, at a minimum, and security staff as necessary.
- Label refrigerators and ensure contents are appropriate based on the labels, *i.e.* specimens in one with a biohazard label; medications in one with a 'medications only' label; food in one labeled 'food only.'
- Assemble personal protective equipment (barrier gowns, masks, gloves, eye shields, caps, booties) in an immediately accessible area that is clearly labeled and ensure staff is educated on its location and proper usage.
- Train inmate workers on the use of spill kits (which the facility has) and the proper way to clean blood and body fluid spills; document this training.

At JTVCC, the Monitoring Team recommends that the State:

- Health care leadership should establish an Infection Control Committee and hold meetings quarterly, at a minimum, with minutes that reflect content of the meetings.
- Continue to reduce the inmate tuberculin skin testing backlog until all inmates are current.
- Assign responsibility for sanitation tasks in the clinic, infirmary, and pharmacy.

- At HRYCI, the Monitoring Team recommends that the facility continue to maintain the Infection Control Program and all compliance requirements.
- At SCI, the Monitoring Team recommends that the State/CMS leadership take necessary actions to establish an adequate infection/communicable disease control program that includes ongoing supervision to ensure that the program is functioning well.

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 generally accepted professional standards, 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. <u>Assessment</u>

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

2. <u>Findings</u>

To assess clinic space and equipment, the Monitoring Team toured the clinic, medication and administrative space, interviewed staff and inmates and observed clinical encounters. The Monitoring Team reviewed each area with respect to sanitation, organization, medical equipment and supplies, lighting, access to hand-washing, and the provision of privacy.

The medical clinic area has been expanded; the administrative offices have been moved across the hall; the medication room has also been moved across the hall to a larger space.

Sanitation and organization in the medical clinic, administration area and medication room have improved. There is a posted cleaning schedule and the charge nurse signs off on it daily. Clutter has been reduced. Space in the medication room is still tight but the room itself is larger and medications are well organized. The health record room is well organized and neat. Health records are kept on shelves in a locked room; out cards are used for accountability. Food and vaccines were found in refrigerators labeled with a biohazard label.

Exam rooms are uniformly equipped with the equipment being in working condition; the only room without a sink is the room used for nursing sick call (exam room I). There was a bottle of hand sanitizer available in the room. All rooms have doors that can and are closed for privacy when in use.

At the time of the Monitoring Team's visit, the infirmary and PCO rooms were not occupied. There is a functioning camera for visual observation of the two infirmary rooms and PCO room and the camera is located in exam room I and monitored by the sick call nurse when the rooms are occupied. During the initial tour, no officer was noted to be stationed in the clinic area.

C. JTVCC

1. Assessment

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

2. Findings

To assess clinic space and equipment, the Monitoring Team toured the medical clinics in the main unit and Maximum Security Complex. The Monitoring Team reviewed each area with respect to sanitation, medical equipment and supplies, lighting and access to hand-washing. This area was close to substantial compliance, lacking only in consistent sanitation and disinfection in medical areas, and ensuring that all medical equipment was working properly.

With respect to sanitation, there were posted schedules of sanitation and disinfection activities in selected medical clinics (the infirmary and pharmacy/medication room), but staff has not been assigned to perform these duties and they are not being carried out. There were no posted sanitation and disinfection activities noted in the satellite clinics in the Maximum Security Complex or Pre-Trial clinic.

In the main medical clinic, hallway floors were generally clean but the pharmacy/medication room floor was not clean. There were two bathrooms in the administrative area, one that, according to staff, had been thoroughly cleaned the week prior to the Monitoring Team's visit; but the other in the staff break room that was not clean.

There was a hallway that contained a room where biomedical waste was stored that also was not clean. The Monitoring Team spoke with an officer about this, who informed us that inmates were generally not allowed in the hallway where the biohazardous room was located. Thus, because the State cannot use inmate labor to clean this area due to security concerns, the State should arrange for staff members to perform cleaning tasks.[48]

In the Maximum Housing Complex, satellite clinics were well organized and generally clean, although again, floor sanitation could be improved. Staff reported that the floors were cleaned on a weekly basis.

With respect to medical equipment and supplies in the main clinic, examination rooms were well-equipped and supplied, with access to hand-washing. The exception was the Medical Director's examination room, where otoscope/ophthalmoscope equipment had not yet been installed in the room.

The Maximum Security Complex satellite clinics were medically equipped and supplied; however, in two clinic rooms (Building 22 and 23) the blood pressure cuff was either nonfunctional or absent. In the building 23 clinic room, an oxygen tank was missing the regulator to control oxygen flow and was therefore not functional.

The pre-trial clinic room was clean, well-equipped and supplied, but the sink was leaking and cloth towels were placed around the edges of the sink to soak up the water. At the time, the Monitoring Team toured the clinic, the towels were saturated and had also saturated nearby paper towels.

There was documentation that the unoccupied respiratory isolation rooms were tested monthly for the negative pressure requirement.

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 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,

[48] There were housekeeping sanitation schedules posted in the infirmary and pharmacy areas. The Monitoring Team discussed revisions and additions that should be added with the ICN. Although sanitation schedules have been posted, health care leadership has not assigned staff these duties. These duties are not being performed, which is not surprising given that no staff is assigned or held accountable for completion of these duties.

access to hand-washing, and the provision of privacy.

Since the Monitoring Team's last visit, improvements in sanitation were observed in all areas, although the medication room floor was not clean.

The most significant obstacle to substantial compliance is insufficient clinical space on the East and West sides to permit clinical encounters to consistently be performed with adequate visual and auditory privacy (see discussion of provision 11 of the MOA). On a positive note, rooms have been designated in the East side housing units to conduct nursing sick call. These rooms have an examination table and sinks for access to hand-washing and their use could potentially be expanded. The rooms also have cabinets but they cannot be locked and are therefore not used to store medical supplies. Instead, nurses transport medical equipment and supplies on a cart. The Monitoring Team inspected the equipment and supplies and found that the otoscope was not functional and staff did not have reliable equipment to measure temperature[i].

In the booking area, nurses conduct medical screening in an adequately-sized room that has an adjacent room to store medical records. This area was relatively clean and better organized since the Monitoring Team's last visit. However, the Monitoring Team did not observe a sanitation schedule posted for this area.

The Monitoring Team did not observe unlocked controlled substance or stock medications as occurred at the Monitoring Team's last visit. There were however, controlled substances for disposal stored in a locked box that were not being counted each shift.

A continuing concern is that for the medical screening process[49], the inmate is still 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. This arrangement is not conducive to obtaining a thorough medical/mental health history because if an inmate believes that important but sensitive personal medical information will be overheard by others, he will be less likely to divulge such information.

E. SCI

1. <u>Assessment</u>

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

2. <u>Findings</u>

[49] The medical screening process 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.

To assess clinic space and equipment, the Monitoring Team toured the medical clinics in the MSB, and pre-trial. The Monitoring Team reviewed each area with respect to sanitation, medical equipment and supplies, lighting, access to hand-washing, and the provision of privacy. As noted in the privacy section, the Monitoring Team also reviewed plans to renovate the MSB medical clinic and toured the new building which will house mental health and dental services.

The MSB medical clinic was better organized and cleaner than the Monitoring Team found at the Monitoring Team's last site visit. However, due to limited office and clinical examination space, maintaining cleanliness and disinfection is challenging. There were no schedules of sanitation and disinfection posted in the clinic.

The clinical examination room used by the clinician was adequately equipped and supplied, but the small booths used by nurses to conduct sick call were not. The Director of Nurses office was somewhat cluttered and the Monitoring Team found a puncture resistant container full of discarded medications under her desk. Health records were stored in unlocked cabinets in the main hallway. The Monitoring Team anticipate that many of these findings will be resolved with the renovation of the medical clinic area.

In the pre-trial area, there were two rooms that are used to clinically evaluate patients. The room used by clinicians was fully equipped and supplied. It had adequate lighting and a sink for hand-washing. The second room was a multi-purpose room used by nurses to conduct sick call and other activities. It was a somewhat cramped room with a wall-mounted oto/ophthalmoscope but no examination table. There were small medication, laboratory, and health records rooms, which were well organized.

With respect to sanitation, there was no posted schedule of sanitation and disinfection activities in any of the clinics. Staff reported that inmate cleaning activities included emptying trash, and sweeping and mopping floors. The clinic floors were not as clean as the hallway floors.

F. Recommendations

- At Baylor, the State/CMS should continue to monitor the clinic space and equipment to ensure equipment remains functional, the spaces remain clean and organized and staff maintains inmate privacy for clinical encounters.

At JTVCC, the Monitoring Team recommends that:

- The State/CMS should ensure that medical equipment and supplies are standardized and checked daily to ensure that they are functional.
- The sink in the pre-trial clinic should be repaired.
- Facility health care and custody leadership should ensure that sanitation/disinfection schedules in all clinical areas are posted and routinely take place.

At HRYCI, the Monitoring Team recommends that:

- The State/CMS should continue to explore ways to expand the use of existing space to provide adequate clinical examination space that affords adequate privacy.
- The State/CMS should ensure that medical equipment and supplies are standardized and checked daily to ensure that it is functional.
- Facility health care and custody leadership should ensure that sanitation schedules in all clinical areas (including the medication and booking room) are posted and routinely followed.

At SCI, the Monitoring Team recommends that:

- The State/CMS should continue to explore ways to expand the use of existing space to provide adequate clinical examination space that affords adequate privacy.
- The State/CMS should ensure that medical equipment and supplies are standardized and checked daily to ensure that they are functional.
- Facility health care and custody leadership should ensure that sanitation/disinfection schedules are posted in all clinical areas and that this sanitation and disinfection routinely takes place.

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.

Generally accepted professional standards require 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.[50] 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[51] 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

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[50] "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 regarding (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.*

[51] 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.

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 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 the State to be in partial compliance with this provision of the MOA.

2. Findings

To review inmate access to care, the Monitoring Team reviewed the sick call logs for the 90 days prior to the Monitoring Team's visit, and then reviewed the records of patients who were scheduled for nursing sick call services during the period of March 2009 to May 2009. The Monitoring Team randomly selected 12 records of inmates' sick call requests and the resulting scheduled encounter. In addition, the Monitoring Team reviewed the health records for the appropriateness of the nursing evaluation and timeliness of physician referral, if any. Staff training records were reviewed and revealed that the two RNs who were performing sick call had been trained on the Nursing Protocols as part of Orientation and/or ongoing training.

The Monitoring Team found that in 12 of 12 records (100%), the initial screening of sick call requests was occurring on a timely basis. In nine of nine applicable records (100%), patients were seen by a nurse or clinician within 72 hours as required by the MOA. In nine of nine applicable records (100%), the patient was assessed by a RN.

However, some areas remain problematic. In four of eight records (50%), the nursing diagnosis was not specific based on the clinical findings. In one of eight records (12.5%), a referral should have been made and was not. In three of seven records (43%), the referral visit was not timely. One visit took place six days after referral; in two records there was no documentation of a referral visit, however, there were medication orders written the same day as the sick call visit. In nine of nine applicable records (100%), sick call requests describing clinical symptoms, resulted in an encounter with a nurse or ALP.

During a group meeting with four inmates, all said they are usually seen the next day after putting in a sick call request. One inmate complained that Unit 5 was out of sick call request forms (sometimes referred to in this report as "Health Service Request" or "HSR" forms) and that nurses collecting the forms were not accepting requests written on other paper. One inmate complained that she had to wait about six months for a dental appointment. This information was passed on to the DON for follow up.

Record review also revealed that the RNs conducting sick call were rarely using the protocol forms that would ensure complete assessments, more specific nursing diagnoses and

proper referrals.

Access to Mental Health Care

With respect to access to mental health care, the Monitoring Team found that the State was in compliance with the requirements of this paragraph that requests for mental health care be screened within twenty-four hours of submission, and also that patients are seen within the next 72 hours of that screening.

C. JTVCC

1. Assessment

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

2. Findings

To review inmate access to care, the Monitoring Team selected 37 records of inmates who were scheduled in DACS for nurse sick call from April to June 2009. The Monitoring Team selected appointment entries from DACS that were listed as 'attended,' 'rescheduled,' and 'open' to assess the outcome for each patient. The Monitoring Team reviewed a total of 43 encounters in the 37 records. The sample of records included inmates housed in the main complex, pre-trial, and the Maximum Security Complex (SHU and MHU).

The Monitoring Team reviewed each record to determine the timeliness of care by a nurse or health care provider once the sick call request was received. To assess the accuracy of information reported in DACS, the Monitoring Team also compared the date the patient was scheduled to be seen with the actual date the patient was seen as shown in the health record.

As compared to the Monitoring Team's last site visit, the Monitoring Team found modest improvements in access to care; however, there are still systemic deficiencies throughout the process, including consistent and timely collection of sick call forms, nursing triage, timeliness, and adequacy of nursing evaluations and completed referrals to a clinician. On a positive note, registered nurses are now conducting sick call.

With respect to record review, the Monitoring Team's review showed that in eight (19%) of 43 encounters, the Monitoring Team was unable to find a patient-generated sick call request, progress note, or nursing protocol to correspond with the DACS appointment. Assuming that all inmates complete a sick call request, in order to generate a sick call appointment, it suggests that some sick call requests are lost or misfiled with the patient consequently not being seen.

In 27 (77%) of 35 applicable sick call requests, staff documented the date of receipt on the sick call request. Thirteen (37%) of 35 sick call requests were triaged within 24 hours of receipt. In the 35 encounters reviewed, 17 (49%) were seen in a timely manner, seven

(20%) were not seen in a timely manner, and 11 (31%) were not seen at all. Thus, 51% of patients were either not seen by any provider in a timely manner, or at all. Of 10 nurse-generated referrals to a provider, 1 (10%) was seen in a timely manner, two (20%) were not seen in a timely manner, and seven (70%) were not seen at all. Therefore, there continue to be serious issues with access to a clinician.

The Monitoring Team review included records of seven inmates from MHU. In four of seven records, the Monitoring Team found no sick call requests or progress notes showing the patient was seen by any provider. Of the remaining patients, only two of the three were seen for their complaint in a timely manner.

The Monitoring Team reviewed 10 encounters of patients in the SHU. Seven of 10 were seen by a nurse in a timely manner; however, in several cases, the nurse did not conduct an assessment, but instead documented that the patient had been previously seen and the issue resolved. However, the Monitoring Team's review did not corroborate the nurse's determination, as in some cases the patient was previously seen, but for a different complaint.

In the SHU, in addition to health record review, the Monitoring Team reviewed clinician encounter data for the period of mid-June to the last week of July 2009. The Monitoring Team's review showed a pattern of frequent rescheduling of patients in the SHU with lack of timely rescheduling. During the period of June 12-30, only 61 (73%) of 82 clinician appointments were seen on the day the patient was scheduled. The remaining 21 (27%) appointments were rescheduled and a clinician saw these patients an average of 5.3 days after the initial appointment (range 1-11 days). Staff reported that during the month of June, the SHU had a clinician assigned three days per week and security staff did not consistently escort patients.

For the period of July 1-30, of 132 scheduled appointments, 83 (63%) were seen as scheduled, 37 (28%) rescheduled and 12 appointments (9%) were refused. Of those that were rescheduled, the average length of time that the patient was rescheduled was 2.6 days (range 1-6 days). Again, staff reported that security staff does not consistently escort patients to appointments, and the week prior to the Monitoring Team's visit, it took all day for a clinician to see three patients due to escort issues.

From the Monitoring Team's review and discussions with staff, the Monitoring Team is also concerned about access to care in the pre-trial area. For example, in one case, a patient's symptoms—which could have indicated a deadly disease—were present for at least four months and still the patient had not been seen by a provider who could definitively diagnose and treat his condition.

In addition, staff reported that frequently, security staff does not escort pre-trial patients to either the pre-trial or main medical clinics. For example, during the Monitoring Team's site visit, three patients from pre-trial were not escorted to the clinic for their intake physical examinations.

With respect to security practices that also affect access to care, the Monitoring Team found that clinicians and nurses are sometimes unable to perform adequate examinations

because security staff is resistant to uncuffing the inmate. In one example, the Monitoring Team found a note in a record in which the clinician documented being unable to examine the patient's shoulder due to shackling of the affected limb. Clinicians reported that when inmates are shackled behind their back it is not possible to lay the inmate flat and perform an adequate abdominal examination. Health care staff reported that their requests to briefly uncuff the patient, or cuff them in an alternate manner, is met with resistance, at times requiring staff to communicate up the security chain of command to receive approval for what should be a routine component of health care delivery. Lack of professional autonomy to conduct an appropriate history and physical examination poses a risk of delayed diagnosis and treatment of serious medical conditions.

Finally, during the Monitoring Team's review of access to care, the Monitoring Team incidentally noted cases in which patients with serious medical problems were completely lost to follow-up. The specifics of those cases have been shared with the State to demonstrate the seriousness of this issue. In summary, there continues to be serious problems with access to care at JTVCC.

Access to Mental Health Care

With respect to mental health care, the Monitoring Team was told by mental health staff that there are delays in receiving inmate's requests for mental health care in a timely manner. This is due to delays by nursing staff in picking up these referrals. However, once mental health receives the referral, the inmate is generally seen by a mental health clinical within 72 hours.

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 reviewed lists of patients who were scheduled for health care services on three separate days in April to determine what percentage of patients were seen as scheduled. The monitoring team also reviewed more than 30 health records selected from a DACS printout of nursing sick call visits that were scheduled in the 120 day period prior to the Monitoring Team's audit. The sample included 10 records of patients in segregation.

The Monitoring Team's overall finding was that there are still significant problems with timely access to care. It appears that multiple factors contribute to access problems including limited clinic space to conduct clinical activities; patient movement issues due to counts, insufficient escort staff and institutional emergencies (*i.e.* "musters"); lack of RNs to conduct sick call; inability to locate the patient record, and DACS scheduling problems.

Although there has been success in increasing the absolute number of clinical appointments taking place, it is not keeping up with the demand for health care services. For example, the Monitoring Team reviewed the number of completed health care appointments (*e.g.* lab, chronic care, nurse sick call) on the West side clinic for the period of April 13-15, 2009. The Monitoring Team found that for each of these days, 64%, 55% and 69%, of scheduled appointments were completed, respectively. Staff believed that some of these patients may have been seen prior to their scheduled appointments, so the Monitoring Team reviewed an additional 23 records of patients who were noted as not being seen. Of this number, the Monitoring Team found that four (17%) were seen the day following their scheduled appointment, nine (39%) were seen within three days and 10 (43%) were never seen. None of the patients in this sample was seen prior to their scheduled appointment.

Of particular concern is access to care for patients in segregation. The Monitoring Team noted that in the sample described above that seven of the 10 patients not seen were housed in segregation. In several records, the patient had submitted multiple sick call requests (*e.g.*, five and six requests) and was still not seen.

In addition, from the records selected from DACS, the Monitoring Team also found persistent problems with access to care. Of 33 patient encounters reviewed, nine (27%) patients were seen in a timely manner by a nurse or clinician; 17 (52%) were not seen in a timely manner (range= 5-12 days) and seven (21%) were not seen at all. Thus, 72% of all patients were either not seen in a timely manner or at all. The Monitoring Team found that the information in DACS with respect to patient status is not consistently accurate.

The Monitoring Team also assessed the time frame between nurse referral and a clinician visit. In six of nine records in which a nurse referred the patient to a clinician, there was no documentation that a clinician saw the patient. The Monitoring Team also noted that in two of the six records in which no clinical evaluation took place, the nurse obtained a verbal order for medication.

With respect to collection of health service requests and initial nursing triage decision, the Monitoring Team's review showed that the majority of forms were date-stamped and signed by staff as to when they were received; but on none of the forms did a nurse document a triage decision (*i.e.* routine or urgent). This is an important component of determining access to care. For example, a patient reported a symptom that should have prompted a quick turnaround to be seen by a clinician, and, although a nurse triaged the form the day after he submitted his sick call request, the nurse did not document a disposition, and the patient was not seen until a couple of weeks later.

The Monitoring Team also noted that nurses are not seeing patients with dental pain but triaging them directly to dental services which may not occur in a timely manner.

The Monitoring Team was advised that RNs now conduct sick call. However, this practice was only recently implemented and the Monitoring Team's review showed that the majority of patients were seen by LPNs. Moreover, during the Monitoring Team's audit, the RN

designated to conduct sick call was ill, and sick call on the East side was cancelled. Health care systems cannot be reliant upon a single individual and this suggests there is insufficient RN staffing (see discussion of discussion of provision 6 of the MOA).

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, it is the Monitoring Team's understanding that factors remain that affect patient flow and prevent timely access to care.

For example, patients from the same housing units are escorted as a group to the clinic for medical appointments (*e.g.*, labs, doctor appointments, etc). A new group of patients is not brought to the clinic until all patients in the previous group has been seen and escorted back to their housing unit. Thus, if the lab technician completes her lab draws before the doctor completes his appointments, she must wait to receive a new batch of patients. This practice may be related to insufficient numbers of correctional officers available to escort patients when services have been completed.

The Monitoring Team also understands that during inmate counts, clinic staff is not permitted to have access to patients via 'out counts'. Finally, the Monitoring Team was advised that frequent code reds or 'musters' (*i.e.* disturbances requiring officer response) shut down all movement, including medical staff in transit for activities such as medication administration. All these factors contribute to limited access to patients that contribute to not meeting the demand for services.

Access to Mental Health Care

With respect to mental healthcare, the Monitoring Team reviewed the referral log book, used by the State to track compliance with this provision and to record responses to sick call requests. When entries were completely documented, compliance with this provision was evident as the log showed timely responses to mental health referrals. However, this log did not document response times by the psychiatrists and in many cases log entries were incomplete and there was no way to verify the timeliness of the responses with respect to these.

E. SCI

1. Assessment

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

2. Findings

To review inmate access to care, the Monitoring Team reviewed health records of patients who were scheduled for nursing sick call services during the period of February to April 2009. The Monitoring Team randomly selected 20 records of inmates who were housed in pre-

trial, and MSB.

The Monitoring Team found that access to care has improved since the Monitoring Team's last visit. Positive changes include: nurses are collecting and triaging sick call request forms in a timely manner; improved use of the DACS scheduling system; registered nurses conducting sick call; and increased use of nursing protocols.

However, some areas remain problematic. Although nurses collect and triage patient requests in a timely manner, nurses are not consistently seeing patients within 48-72 hours. In only 10 of 16 (63%) applicable records was the patient seen in a timely manner by any health care professional. However, in four of five cases where the nurse directly referred the patient to another health care provider, the visit did not take place in a timely manner. For example, in one case, a nurse did not see a patient and referred him directly to an advanced-level provider. Although the nurse's referral was appropriate, the appointment with an advanced-level provider did not take place for three weeks, at which time the patient had to have a minor procedure that might have been avoidable. In another case, a patient submitted two sick call requests, the nurse did not see the patient but appropriately referred him to an advanced-level provider, who did not see the patient until 10 weeks later. Although the timeframe in which this patient was seen may not have altered the course for him, in other cases, timeliness may be critical to a positive clinical outcome. Therefore, it is important for nurses to see all patients presenting with symptoms in order to evaluate the urgency of care.

The Monitoring Team also assessed the timeframe between nurse referral and a clinician visit. The Monitoring Team's review showed that only four (50%) of eight referred patients were seen in a timely manner, if at all.

The Monitoring Team's review also showed that, although RNs are conducting sick call more frequently, LPNs continue to perform an independent nursing assessment that is not consistent with the scope of their licensure.

With respect to security practices that affect access to care, the Monitoring Team noted that the frequency of inmate counts during the day shift limits staff access to patients. For example, there are four inmate counts from 8 a.m. to 4 p.m., each one taking approximately 45 minutes. This is approximately three hours of down time during an eight hour period. During this time, inmates are not routinely placed upon out-count status[52] to be seen in the clinic. Although some down time in the clinic is useful to review laboratories and perform nonclinical activities, this amounts to almost 40% of the time when clinicians are available to see patients, and may contribute to the Monitoring Team's findings of delayed or unsuccessful clinician referrals.

In addition, the Monitoring Team was advised that, for security reasons, only five patients are allowed in the MSB clinic at any one time. Thus, if there are two patients with

[52] Normally, all inmates go back to their housing units for count. An outcount is when inmates are permitted to remain where they are, and housing unit officers account for them using this term.

dental staff and two patients with a clinician, nurses can only see one patient in the clinic. Although this policy may be appropriate given the size of the clinic, it contributes to inefficiencies in seeing patients. Hopefully, medical clinic renovations with an adequate waiting room will permit more patients to be in the clinic at one time.

Access to Mental Health Care

With respect to mental healthcare, the Monitoring Team observed that while mental health staff was able to see inmates who had made requests very quickly, there were significant delays in getting inmates into doctor's clinics when that was needed.

F. Recommendations

At Baylor, the Monitoring Team recommends that:

- The State/CMS should ensure that nurse referrals to a primary care provider take place in a timely manner and that advanced level providers document a visit note for referrals from sick call at the time the visit occurs.
- The State/CMS should conduct quality improvement studies with respect to the quality of assessments and timeliness of referrals.
- CMS should encourage the use of the nursing protocol forms.

At JTVCC, the State/CMS should put systems in place to ensure that:

- Staff reliably collect, date stamp and triage Health Service Requests in a timely manner.
- Staff schedule and see patients for nursing sick call in accordance with their clinical condition.
- Sick call is conducted with auditory and visual privacy and honors requests to uncuff inmates as necessary to perform adequate examinations.
- Clinician referrals take place as scheduled in a timely manner.
- The State/CMS should conduct CQI studies related to the identified problems, implements corrective strategies, and monitors results.

At HRYCI, the Monitoring Team recommends that:

- The facility Warden and health care leadership, in collaboration with central office health care leadership, explore practices to expand access to patients while maintaining a safe and secure environment. This would include an assessment of correctional officer staffing available for patient escort.
- The State/CMS should subsequently conduct quality improvement studies with respect to access to care.
- The State/CMS should assess and if necessary supplement registered nurse staffing patterns to provide the resources necessary to ensure timely access to an appropriately qualified health care professional.
- The State/CMS should ensure that registered nurses document the triage decision on the

HSR and ensure that patients receive an appropriate evaluation within 72 hours, and sooner if clinically indicated.

- The State/CMS should ensure the integrity of the information entered into DACS with respect to patient status.
- With respect to mental health, the State should conduct monitoring of the referral log book to ensure that entries are completely recorded.

At SCI, the Monitoring Team recommends that:

- The State/CMS should ensure that registered nurses document the triage decision on the HSR and ensure that patients receive an appropriate evaluation within 72 hours or sooner if clinically indicated.
- The State/CMS should conduct a staffing assessment to ensure a sufficient number of RNs are available to conduct sick call.
- The State/CMS health care leadership should collaborate with the Warden to explore practices to expand health care access to patients while maintaining a safe and secure environment.
- The State/CMS should conduct quality improvement studies with respect to the timeliness of initial access to care, quality of assessments, and timeliness of referrals.

20. Isolation Rounds

A. Relevant MOA Provision

Paragraph 20 of the MOA provides:

> The State shall ensure that medical staff[53] make daily sick call rounds in the isolation areas, and that nursing staff[54] make rounds at least three times a week, to give inmates in isolation[55] adequate opportunities to contact and discuss health

[53] 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.

[54] 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.

[55] 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.

and mental health concerns with medical staff and mental health professionals[56] 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 the inmate population.[57] J-E-09; P-E-09. Generally accepted professional standards require that, upon notification that an inmate is placed in segregation,[58] a qualified health care professional review 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[59] 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.[60]

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[56] "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.

[57] 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.

[58] 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*.

[59] "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.

[60] 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.

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.* Generally accepted professional standards require that documentation of isolation rounds be made on individual logs or cell cards,[61] or in an inmate's health record and include: (1) the date and time 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 the State is in partial compliance with this provision of the MOA.

2. Findings

As discussed in the Fourth 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 time frame of a few days. Then there is accommodation, such as a change in housing or a return to the inmate's previous setting with a loss of some privilege for a while. 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 eight health records and segregation rounds forms; not all inmates with rounds forms were found listed in the log book, which did indicate the date of admission and release from segregation. In seven of eight rounds forms reviewed (88%), the date notified and other information was documented in the top section of the form, including whether the inmate was receiving medications, had any medical or mental health conditions that precluded placement and that mental health staff was notified of the inmate's placement in segregation. The release date was not documented anywhere on the form. Since the rounds form covers a calendar year period and can be used to document more than one placement in segregation during a year, determining when an inmate was placed in and released from segregation is difficult, unless staff document on the back of the form.

In summary, although the logs show rounds are being made in eight of eight forms reviewed (100%), it is not possible to know that the provisions of the MOA are met without documentation of the dates of placement and release from segregation on the form.

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

With respect to mental healthcare, the Monitoring Team notes that the use of disciplinary segregation remains limited and short lived at Baylor. Inmates placed in disciplinary segregation are generally not placed on that status for longer than one day. At the time of the Monitoring Team's visit in June 2009, no inmates on the mental health caseload were housed in segregation.[62]

C. JTVCC

1. Assessment

The Monitoring Team found that the State is in partial 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 daily by medical staff for this population. The medical staff now documents rounds on the MARs for the month and days listed on a particular MAR. Instead of a medication, the term "Seg Rounds" is placed on the MAR and the rounds documented by nurse initials in the date squares, as they do for a medication. For inmates not receiving medications, there was a MAR for "Seg Rounds." Missing from the MAR documentation were the start and stop dates for inmate placement in and discharge from segregation.

Mental health staff makes rounds on alternate days and documents their rounds in DACS. With respect to mental healthcare, the Monitoring Team observed mental health rounds for inmates in isolation and found these rounds to be adequate. The Monitoring Team observed that the isolation unit in Unit C that the Monitoring Team expressed concern about, continues to be used for mental health caseload inmates. In the Fourth Report, the Monitoring Team expressed concern about this room's use because its proximity to steam pipes caused the room to be extremely hot. This is concerning, especially for mental health inmates who might be taking medications that make them especially sensitive to heat. Additionally, the Monitoring Team discovered that custody staff in this housing unit did not have access to keys to open cell doors. This is problematic for obvious reasons, including the inability to address medical emergencies if they are unable to access the inmate.

[62] Despite the infrequent use of segregation status, the State still must comply with privacy requirements. Initial evaluations for inmates placed on disciplinary segregation must be conducted in a private and confidential setting. The Monitoring Team informed staff at Baylor of this requirement during its previous visit in the Fall of 2008, but these interviews continue to be conducted cell-side. (See discussion of provision 11 of the MOA.)

D. HRYCI

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed a logbook containing segregation round forms for inmates placed in segregation. These forms permit documentation of rounds for a 12-month period and may contain multiple placements in segregation. Therefore, documenting when the inmate was placed in and released from segregation is key to evaluating whether rounds were made in compliance with MOA requirements.

The Monitoring Team reviewed at least 10 records of segregation rounds contained in the log book. In most cases, the staff member completing the form filled out the top of the form indicating when the inmate was placed in segregation. However, staff 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. Based on the documentation provided to the Monitoring Team, it was not clear that rounds were consistently performed three days a week by nursing staff as required by the MOA.

The Monitoring Team incidentally noted that the DON reported that their policy is that rounds now must be done seven days a week by nursing staff; however, according to forms the Monitoring Team reviewed, nursing rounds were not being performed on weekends.

With respect to mental healthcare, the Monitoring Team observed that an experienced mental health clinician has been assigned to perform mental health rounds in the segregation units. Additionally, the Monitoring Team notes that the segregation rounds form has been revised, as was recommended in the Fourth Report, so that there are now spaces to list when the inmate was both placed in and released from segregation. Finally, the Monitoring Team observed mental health rounds and observed they were completed in a competent manner.

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 a logbook containing segregation round forms for inmates placed in segregation. These forms permit documentation of rounds for a 12-month period and may contain multiple placements in segregation. Therefore, documenting when the

inmate was placed in and released from segregation is key to evaluating whether rounds were made in compliance with MOA requirements.

The Monitoring Team reviewed at least 10 records of segregation rounds contained in the log book. The forms were completely filled out and demonstrated that nursing staff made daily rounds and that mental health staff were making rounds every other day, accompanied by appropriate notes.

With respect to mental healthcare, the Monitoring Team observed that mental health rounds were being performed three times per week, as required by this provision. This was confirmed by discussions with inmates and a review of appropriate logbooks.

F. Recommendations

- At Baylor, the health care staff should document the date(s) the inmate was placed in and released from segregation on the rounds form.

- At JTVCC, health care leadership should continue to ensure that rounds take place in accordance with the requirements of the MOA.

At HRYCI, the Monitoring Team recommends that:

- CMS should amend the isolation/segregation rounds form to provide for dates of admission and release from segregation for multiple entries.
- Health care leadership should ensure that rounds take place in accordance with the requirements of the MOA and/or local policy requirement.
- With respect to mental health, the Monitoring Team repeats its recommendation from the Fourth Report that the isolation unit in Unit-C not be used for inmates on the mental health caseload due to heat risk related issues.

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 and consistent with generally accepted professional standards. 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.[63] 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 BCHS. The Level 3 grievance process is permitted to take up to six months from the filing of the grievance.

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

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 Baylor to be in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the status of grievances as of the date of the Monitoring Team's arrival. The Monitoring Team found that, with regard to both level 1 and level 2 grievances, the facility was up to date. There were no grievances which had not been responded to within the required timeframes. Between January and May 2009, there were a total of 94 grievances filed, or an average of 18 per month. The lowest month was April, in which nine were filed; the highest month was May, in which 31 were filed. The numbers in terms of timeliness suggest that the grievance program is working fairly well.

With respect to mental health care-related grievances, the Monitoring Team notes that mental health staff is notified by the HSA or their designee when there is a grievance pertaining to mental health treatment. When informed, mental health staff will interview the inmate within a day in an effort to resolve the issue.

C. JTVCC

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

There is significant improvement over the Monitoring Team's previous visits. However, during the Monitoring Team's visit the reports from the grievance system reveal that there were 10 level 1 grievances that remained open beyond seven days. There were also 38 level 2 grievances open beyond 37 days. There were zero level 3 grievances open beyond 180 days. This represents substantial improvement for a facility which, given the complexity of its patient population, receives a higher number of grievances than other facilities. Staff is to be commended for implementing a process that appears to be catching up to and eliminating the enormous backlog that existed.

With respect to mental health care-related grievances, the State has begun separating mental health grievances from general medical grievances. Currently, all grievances are initially forwarded to the DON who then forwards mental health grievances to mental health staff. Once mental health staff receives them, they are addressed in a timely manner.

D. HRYCI

1. Assessment

The Monitoring Team found HRYCI to be in substantial compliance with this provision of the MOA.

2. Findings

At the time of the Monitoring Team's visit, there was no backlog for level 2 or level 3 grievances and there were two level 1 grievances, which were one to two days past due. There is an excellent grievance coordinator at this facility. However, the Monitoring Team did identify that when she is on vacation, a substantial delay develops, since there is not a trained back up to fill in for her and continue the process during the time she is gone.

E. SCI

1. Assessment

The Monitoring Team found SCI to be in substantial compliance with this provision of the MOA.

2. Findings

At the time of the Monitoring Team's review, there were a total of only seven outstanding grievances for SCI. There were two level 1 grievances, which had been outstanding greater than seven days, but there were zero level 2 grievances outstanding greater than 37 days and there were zero level 3 grievances outstanding greater than 180 days. The program is not only responding timely but also attempting to analyze patterns of grievances in order to determine whether systematic changes will result in a decrease in submission of grievances.

With respect to mental healthcare-related grievances, the Monitoring Team notes that mental health staff is now involved in the grievance process with respect to mental healthcare-related grievances. There has been only one mental healthcare-related grievance filed since the Monitoring Team's previous visit in the Fall of 2008.

F. Recommendations

- At Baylor, the Monitoring Team recommends that the State continue to try and analyze specific issues for which grievances are being filed, and then implement changes that will address those issues.

- At JTVCC, the Monitoring Team recommends that the State continue implementing the current process with the goal to have level 1 and level 2 grievances up to date prior to the Monitoring Team's next visit.

- At HRYCI, the Monitoring Team recommends that the State insure that there is a trained back up for the grievance coordinator so that delays and backlogs don't occur when she is not available.

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 generally accepted professional standards, an adequate chronic disease[64] 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.[65] *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 Baylor to be in partial compliance with this provision of the MOA.

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[64] 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*.

[65] 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.

2. Findings

The Monitoring team reviewed 22 records for care of the following diseases: Asthma (5), Diabetes (5), HIV (5), Hypertension (5) and Seizures (5). There were no patients on anti-coagulation during this audit period. In three instances, the same patient's record was used to assess more than one disease. Thirty-nine chronic disease clinic visits were reviewed as well as progress notes, orders, intake screenings, laboratory data and other relevant material in the medical record. The total number of patients at the facility with each of these diseases could not be determined since disease logs remain incomplete or inaccurate.

The current Medical Director has been in place since August. In the intervening ten months since the last audit, she has grown into her role and has responded well to training and constructive comments such that there was marked improvement in the quality and continuity of care since the last visit. Patients were seen in chronic care clinic in a timely fashion after intake (many in less than six days), thereafter followed regularly in the clinic as well as having appointments to adjust treatment of their chronic disease documented in the progress notes. The documentation generally was complete. In discussing patients with the Medical Director, it is apparent that she knows her patients. The majority of patients had their disease entities well controlled, with the exception of those who were refusing treatment. Refusal of care was documented in the notes by the providers. Although signed refusals of care were generally obtained by nursing staff, rarely was the type of care refused or were the consequences of this refusal written on the form. Additionally, the procedure and related forms for obtaining informed refusal of treatment do not meet generally accepted professional standards.

Appropriate laboratory data was ordered on patients with chronic diseases (*e.g.* HgA1c in diabetics, anticonvulsant levels in seizure patients); however, there still is a disconnect in obtaining current laboratory data so that it is available at the time of the clinic appointment. When tests were not available, they were ordered at the time of the appointment, usually drawn shortly thereafter, and reviewed and addressed in a timely manner. Additionally, most laboratory tests ordered at any time were co-signed in a timely manner. Both of the above demonstrate an improvement since the last audit. There was some improvement in the filing of laboratory data as well, although several charts did not have recently ordered results filed.

In general, the medical record was organized. There were problem lists in all of the records reviewed, with a complete listing of medical diagnoses; however, in a preponderance of patients with concurrent mental health diagnoses, these were not on the problem list in spite of multiple visits with mental health staff. Substance use/abuse issues also tended not to be on the problem list.

C. JTVCC

1. Assessment

The Monitoring Team found JTV to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team selected charts of inmates from both general population and Special Management, as different physicians and NPs provide care in these areas. One physician follows patients in general population, which is probably inadequate for the patient load, given the systems in place. A second physician is responsible for primary care in special management, which has a smaller patient case load. There are also three NPs at the facility. In addition, a physician from another facility consults on HIV and Hepatitis C positive patients in both areas of JVTCC. It appears that the on-site practitioners have a hands off approach to these two entities and refer to the consultant even for cases which do not require medication treatment, such as HIV patients with high CD4 counts and non-detectable viral loads. This approach creates discontinuity in the overall treatment of these patients, an unduly heavy case load for the consultant, and, at times, duplication or absence of services. Some examples: (1) a patient was referred to the consultant, but the necessary lab studies were not ordered or (2) the consultant orders a complete battery of tests; however, either the CD4 count or viral load was not performed, the primary care provider does not review the labs, note this and reorder the missing tests. When the specialist sees the patient in either of these cases, data needed to treat the patient is not available, ultimately creating both a delay in the treatment of the patient and wasted appointments with the consultant.

The Monitoring Team reviewed 28 records of patients from General Population for care of the following diseases: Anti-Coagulation Therapy (7), Asthma (5), Diabetes (5), HIV (3), Hypertension (6) and Seizures (2). In these records, 46 encounters (chronic care clinics and progress notes) were reviewed as well as doctor's orders, laboratory reports, consultant reports and other miscellaneous documents. In addition, the Monitoring Team reviewed 20 records from the Special Management Housing for care of the following diseases: Anti-Coagulation Therapy (0-no patients on anti-coagulation), Asthma (5), Diabetes (2), HIV (3), Hypertension (5) and Seizures (5). In these records, 34 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. Although lists of patients by disease were available from the DACS system, these lists were not accurate and on many occasions, when records were pulled for review using these lists, the patient did not have the stated disease entity.

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. There was no substantive documentation regarding the patient's history on many of the encounters. Physical exams tended to be the same on every patient rather than focused exams relevant to the patient's medical problems. Particularly in general population, there was no discussion in the assessment and plan of the provider's thought process. At times, assessments were made with little or no objective data or were inconsistent based upon the data provided. For the general population patients, appointments were not as ordered and several patients were

lost to follow up for significant periods of time. Orders were frequently not transcribed in a timely manner. (See discussion of provision 4 of the MOA.)

There was significant over-ordering of laboratory tests, creating an overload of the system without benefit and frequently to the detriment of the patients. The reason for the over-ordering appears to be twofold. In the Max Units, the providers have no confidence that the tests that they order will be obtained. In general population, one provider related that she was told that she needed to order a complete panel of tests on all chronic disease patients every three months. Additionally, some of the tests ordered are not considered routine testing and it is unclear why they are being ordered on either an initial or repeat basis (*i.e.* routine Protime/INR on patients with no risk of coagulopathy and/or not on anti-coagulation treatment, thyroid testing on patients without signs or symptoms of disease and those not in a risk group for thyroid disease). With the volume of tests ordered, an additional problem was created: sign off of laboratory tests occurred in the expected timeframe (48 hours during the week, 72 hours on weekends) only once for the 30 test panels tracked (3% of the time). For many of the tests, there was no documentation of review at any time.

At times, some tests within a panel of laboratory tests ordered were not obtained. For example, CD4 counts and viral loads were always ordered together in HIV positive patients, but frequently one would return without the other. It was inconsistent which of the two returned, such that in one patient, the CD4 count returned with the first set of labs, the viral load with the second and third set and the CD4 count with the fourth. Additionally, there were times when providers ordered tests which either were never performed or the results of which never returned to the record.

In general population, laboratory results were reviewed and signed off on by a single NP rather than the provider who ordered the tests. This is problematic for several reasons. First, the person reviewing the tests does not know the patient or the reason the tests were ordered. Second, unless this person carefully reviews the original order, he or she may not be aware if all the requested tests were obtained. Third, this person did not take action on abnormalities, but instead referred the record back to the ordering provider. This process created delays in treatment, especially since ordered appointments frequently did not occur in the timeframe specified, if at all.

There were several medical records problems that had an impact on chronic disease care as well. Problem lists were still incomplete, including listing of the audited chronic disease. Sheet protectors have been placed over the flow sheets. Several items were then placed within the sheet protector such that it needed to be removed from the record to access the data on sheets behind the first one. Furthermore, this discouraged the addition of data to the flow sheets. Instead of using a progress note to add additional data to the chronic disease form, providers wrote on the back of the page, making this information less accessible, as it may not be noticed and if it was, one had to turn the entire record over to read the information.

A new chronic care nurse has been hired who appears to be taking ownership of the clinic. Hopefully, she will be able to institute changes so that the efficiency of the chronic disease clinics improves.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed five medical records from the chronic care caseload for each of the following diseases: anti-coagulation, asthma, diabetes, HIV, hypertension and seizures. A total of 60 chronic care visits were reviewed, as well as multiple progress notes that related to chronic disease care. The most striking improvement at the facility was in the state of the medical records, believed to be due to the addition of a statewide Medical Records Director. For the most part, it appears that information was filed in the records in a timely fashion and placed in the appropriate section. The multiple sections for clinical care (intake, progress notes, sick call, infirmary, chronic care) continued to be a barrier to continuity, as it discourages providers from reviewing entries in sections other than the one they were using. This was discussed with both the Medical Records Director and the Regional Medical Director, who will review the issue. The majority of patients with chronic diseases were seen in the clinic after intake in accordance with policy. Although there were a few significant outliers, most patients were subsequently seen in the timeframe designated by the provider. There continued to be duplication of services with patients getting both a physical exam and a chronic care visit rather than completing the physical on the chronic care form when appropriate. Additionally, one of the providers frequently chose not to record findings on the chronic care form, leading to incomplete documentation of the evaluation of these patients.

There were still concerns regarding the clinical care of the patients. Although on the previous visit it appeared that the chronic care nurse was no longer taking the patient history, it was revealed on this visit that she continued to ask the questions and the provider merely transcribed the answers. This practice not only diverted the nurse from the task of seeing that the clinic was running efficiently, but it also dissociated the provider from active engagement with the patient. In turn, this led to an apparent lack of ownership of the care of individual patients by the provider. Additionally, in several records, the initial chronic care visit form was not completed at the time of the first visit and was replaced with a brief progress note with an incomplete history and no patient assessment except for occasional vital signs.

The provider for the majority of chronic patients was on a three-week vacation during the time reviewed. This overlapped for a week with a vacation for the other chronic care provider. It did not appear that there was routine coverage of these patients during this time period. Although a physician was in the facility to see patients with acute needs and to review some of the returning laboratory results, it did not appear that any meaningful action was taken on these results, as it appeared that the results were reviewed without the medical record. Additionally, abnormal results were not referred back to the primary provider, leading to discontinuity of care. Assigning providers to tasks rather than to a panel of patients can add to

the problem of discontinuity of care. Additionally, it appeared that there is poor communication amongst the providers regarding both clinical issues and schedules. The cumulative effect of the factors described above is that providers did not adequately follow changes in the patient's medical status.

On a positive note, the new Regional Medical Director was aware of many of these issues and had begun taking action with the providers on these prior to the Monitoring Team's audit.

E. SCI

1. Assessment

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

2. Findings

There has been some improvement in the timeliness of chronic care appointments, but overall, little has changed since the last audit. The improvement in the appointment timeliness is most likely related both to the Medical Director being at the site four days a week and the addition of more providers. Most patients were seen every three months, or more frequently when this was ordered, in conjunction with the chronic care clinic visits. Appointments requested at other times were more problematic and there were several instances when a clinic appointment ordered by a provider did not occur. The patients were eventually seen in chronic care clinic, but this lapse resulted in both a significant delay and discontinuity of care, as generally the patients were not seen by the provider who ordered the interim appointment.

In spite of the Medical Director putting in well over 40 hours a week, his clinical responsibilities appear to have precluded him from addressing the administrative responsibilities expected of a Medical Director, including oversight of the other providers' quality of care and working with the HSA and DON on administrative issues of clinical importance. These duties are critical, as there were significant disparities in the quality of care amongst the providers, as well as administrative issues that impact the quality of care. Additionally, there were serious legibility issues with several of the providers. The new CMS Regional Medical Director was aware of the provider disparity problem and had started the process of evaluating and replacing providers.

Patients still were not assigned to a specific provider, but saw whoever was covering the clinic on a specific day. This resulted in significant problems with continuity of care. Several patients were seen by three different providers in a two month period with little coordination of the care amongst the providers. In one case, one provider was writing orders in response to laboratory values and another provider was seeing the patient in the clinic. The notes do not document that either provider acknowledged the care by the other. While it is not always

possible to have the same provider see the same patients all of the time, there must be efforts to coordinate care, and provide continuity of care.

There has been no improvement in the timeliness of laboratory testing review. Although there was a system in place for this, it did not achieve the goal of timely review by the person who ordered the testing. Instead of the results being sent to the ordering provider for review, a single provider reviewed most incoming laboratories, generally on Thursday and Friday. At times, it appeared that this was merely to get a signature on the laboratory result, as in many cases no substantive action was taken on abnormal results. There were instances where a repeat value should have been ordered to substantiate that a change in a value was real, but this was not done.

Many orders were still not taken off in a timely fashion. This is discussed in detail elsewhere in the report (*see* discussion of provision 4 of the MOA).

F. Recommendations

At Baylor, the Monitoring Team recommends the following:

- Flow sheets for tracking laboratory tests and consultant appointments such as HgA1c and eye appointments should be standardized. There is currently more than one tracking form for diabetes in use in the Delaware system. Additionally, flow sheets for HIV care would also be helpful. A system to ensure that these flow sheets are in the records and completed for all patients with the disease entity should be developed.
- The current refusal form should be reviewed and consideration given to replacement. Even without replacing the form, training is needed as to what constitutes a proper informed refusal as well as the use of the form, such that what is being refused and the potential consequences of the refusal are clearly stated in language that patients can understand.
- Mental health diagnoses and substance use/abuse should be noted on the problem list.
- Laboratory tests necessary to make clinical decisions should be drawn in a timeframe prior to the chronic care clinic that ensures the results are both current and available to the provider at the clinic visit.
    - A tracking system should be developed to ensure all ordered laboratory results are obtained and filed in a timely manner.
    - The system should also ensure that critical results are immediately called to a physician with documentation in the progress notes of the interaction.
    - Ongoing audits should be performed to assess if that laboratory and radiology results are being filed in accordance with policy.
- Patients entering with a diagnosis of seizure disorder should have verification scrutinized so there is clear documentation of this diagnosis.
    - Patients with drug or alcohol induced seizures should not be started on anti-epileptic medication, which 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 when there is a recent drinking history.

- Consideration should be given to development of additional intake protocols such as the one that appears to now be in place for ordering precautions on seizure patients at intake. This has resulted in marked improvement of this expectation since the last audit when no patients had precautions ordered.

At JTVCC, the Monitoring Team recommends the following:

- Education of providers as to degree of control of various chronic diseases should occur. Posting a chart which lists definitions for degree of control and status of the various chronic diseases in the exam rooms might prove helpful.
- The problems with timeliness of chronic disease appointments and patients lost to follow up for significant periods of time need to be addressed.
- The ordering of unnecessary laboratory testing and the problems created by his practice was discussed with the site Medical Director. She will be discussing this at the next provider meeting as well as monitoring provider practices.
- A log containing the following should be developed: all laboratory tests, including date and time ordered, drawn, results returned, sent to the provider for review, should be maintained. The new phlebotomist has begun tracking of labs, but since she has been on site only a few weeks, the results of her efforts were not in evidence at this audit.
- The current system for provider review of laboratory reports should be part of the CQI process so that the reasons for current delays in provider review can be ascertained and remediated. Ideally, results should be reviewed by the provider who ordered them. All reports should be reviewed upon receipt to assure significant abnormalities are addressed immediately. Additionally, this should address assuring that the necessary laboratory reports are current and available to providers at the time of the chronic disease appointment.
- A program to follow anti-coagulation treatment was discussed with the CMS Statewide Medical Director, the site Medical Director and the chronic care nurse. The chronic care nurse will be taking ownership of this.
- Use of the existing provider flow sheets for diabetic patients should be implemented.
- Primary care providers should take ownership for the care of the whole patient including HIV disease. Providers who do not demonstrate competence in primary care management of HIV positive patients should be provided with additional training. A Board Certified Infectious Disease Specialist should be assisting with the care of these patients.
- Measures to assure timely transcription of orders should be instituted.
- Providers should do careful assessments of stated diagnoses. Patients, who after evaluation do not have the chronic disease initially claimed or whose disease has resolved (*i.e.* patients who lose weight with resolution of hyperlipidemia), should be discharged from the clinic.
- Accurate logs of patients with various chronic diseases should be maintained.
- A system for medication renewal should be developed so that patients do not go without needed medications resulting in deterioration of disease control.

At HRYCI, the Monitoring Team recommends the following:

- The nurse assigned to the chronic care clinic should occupy her time running the clinic rather than attending to and doing the work of the provider.
    - Procedures should be developed for tracking patients who need to be seen back in less than the routine 90 days. If patients do not show up for the appointment, this should be investigated and the patient reappointed to the clinic.
    - A system 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 the procedure and ongoing compliance audits performed to assure that providers have the necessary information to assess and treat patients appropriately.
- To promote continuity of care, providers should be assigned a panel of patients and see these patients for all their needs (chronic care, sick call, medication refills, etc.) unless an urgent event occurs when the assigned provider is unavailable.
- Also, to promote continuity of care, all clinical encounters should be in chronological order rather than in separate sections by the type of encounter. This format makes it easier for providers to have a more comprehensive view of the patients; in the limited time available to see patients, the multiple sections are a barrier to thorough provider review.
- Communication amongst the providers should be enhanced so that all providers are aware of the status of the sickest patients and schedules can be coordinated.
- Meaningful vacation coverage should be in place.
- Before starting HIV medications on either medication naïve patients or those who have been off of their medications for over a month, there should be, at a minimum, verbal consultation with the HIV specialist prior to starting medication.
- A protocol for provider notification when a patient misses one or several doses of critical medication should be developed and implemented.
- A protocol should be developed and implemented that indicates at what readings of abnormal vital signs, blood glucoses, etc, providers are to be notified. These values should be posted in nurse work areas and exam rooms.
- A procedure to verify seizure disorders at intake should be developed and staff trained to the procedures. This should include what additional actions are to be taken for these patients at intake, such as ordering a lower bunk, drawing of AED levels, etc.
- The Regional Medical Director should continue to audit the use of the chronic care forms and the quality of documentation of the various providers and put corrective actions in place for those who fall below generally accepted professional standards of care.

At SCI, the Monitoring Team recommends the following:

- The SCI Medical Director and other providers should remain exclusively at the site.
- Oversight of HIV care at all sites including SCI should be provided by an Infectious Disease (ID) specialist, especially for initiating and changing medications. Site providers should not initiate or change medication without consulting with the ID specialist. Additionally, the ID specialist should develop protocols for the site providers to follow

regarding frequency of laboratory testing and appointments. Charts of this information are readily available on the CDC website (www.cdc.gov) and could be printed out and posted for all providers system wide.

- The Medical Director should provide oversight and training of the other physicians and the nurse practitioners. Although this was discussed at the previous site visit, it has not yet occurred. The CMS Regional Director should explore his interest in performing this task with the current Medical Director. If he wants this responsibility, his performance of the task should be reviewed.
- Training of providers to appropriate documentation, including the importance of legibility, should occur.
- Providers should be educated as to appropriate timeframes for follow up after a change in a patient's treatment regimen.
- Patients should be assigned to a specific provider who sees them for all routine visits, reviews all their laboratory results and writes the majority of the orders. The assigned provider should also see the patient for urgent visits when possible.
- As was previously noted, the current organization of the medical record contributes to discontinuity, as each type of clinical encounter is in a separate section. This has been discussed with both the CMS Regional Medical Director and the CMS Regional Medical Records Director. They are currently in the process of reviewing the organization of the record and have it on the agenda for the meeting of all providers.
- A new system for sign off of laboratory values, procedure results and off-site visits should be developed and implemented to assure documented review in 24-72 hours by the ordering provider.
- The Provider Documentation Tool for Diabetes should be in all records and kept current.
- A new system for recording fingerstick glucose results should be implemented as well as a system for weekly provider review of these results on all diabetic patients. During the visit, it was noted that CMS has such a form which was previously used.

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[66] who are detained at the Facilities for more than one (1) month. The 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.

[66] The term "juveniles" means "individuals detained at a facility who are under the age of eighteen (18)." *See* MOA II.H.

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. Assessment

The Monitoring Team found Baylor to be in partial compliance with this provision of the MOA.

2. Findings

Immunization status was reviewed in conjunction with chronic disease care. Documentation was based on entries in the designated portion of the problem list as well as documentation on the Influenza permission slip and patient history of immunization prior to entry. It is possible that additional patients received these vaccinations, but these were not found in the medical record. It appeared that there were days when patients were called down for Influenza vaccination, as many patients received their vaccination on the same day; however, a more robust vaccination program needs to be developed. Additionally, there needs to be a uniform documentation method for immunizations. The current health maintenance flow sheet does not have sufficient space for documentation of yearly vaccinations over many years. This has been discussed with the State Medical Director, who will be working on this issue.

- Influenza vaccination rate 54% (7/13)
- Pneumovax rate 38% (5/13)

C. JTVCC

1. Assessment

The Monitoring Team found JTVCC to be in non-compliance with this provision of the MOA.

2. Findings

Records of patients followed in chronic disease clinic who had medical problems for which Influenza and Pneumococcal vaccine are recommended were reviewed. Substantial ground has been lost in this area. Whereas in the audit of April 2008 69% of patients had received Influenza vaccine, in the current audit, this had dropped to 2.1%. Only 2.8% had documentation of Pneumococcal vaccine as opposed to 42% in April 2008 and nearly 50% in November 2008. Patients who did have documentation of Pneumococcal vaccine tended to have received it prior to transfer to JTVCC.

D. HRYCI

1. Assessment

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

2. Findings

The adult population with chronic disease was more problematic, as only 20% of patients (4/20) who should have received or been offered an influenza vaccine had documentation of this. It was learned that there was some confusion about who was responsible for giving the vaccination to these patients. Nursing staff had the expectation that this was being done in the chronic disease clinic and the clinic provider thought that nursing was administering the vaccine to all patients. This was compounded by the clinic provider disagreeing with the guideline, therefore not ordering influenza vaccine on these patients. The CMS Regional Medical Director is addressing the issue. Fifteen percent (3/20) of patients that would be expected to have documentation of pneumococcal vaccine had documentation of having received it. Since the audit of May 2008, this represented a decline for both influenza and pneumococcal vaccine from 92% compliance to 20% and 15% respectively.

The Monitoring Team reviewed the records of eight juveniles who entered HRYCI between January and April of 2009. All of these individuals were screened timely, and all of these either arrived with documentation of their status or records were retrieved from the state database and patients were brought into compliance with an up to date status. The process of reviewing the juveniles and insuring their immunization status appears to be working well.

E. SCI

1. Assessment

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

2. Findings

Since the last visit, there was a decrease in the percentage of patients vaccinated for both influenza and pneumonia. Documentation of vaccination was not consistently placed on the vaccine flow sheet. For many patients, the influenza consent was placed in the record, but the administration of the vaccine was not written on the flow sheet.

- Influenza
  - This was considered as given if the patient received it in last year's cycle or the recently begun cycle for this year.
  - Eight out of 16 for whom it was appropriate had received influenza vaccine (42%).
- Pneumococcal Vaccine
  - For four out of 14 for whom it was appropriate, there was documentation in the record that they had received Pneumovax (29%).
- Hepatitis
  - Three out of five patients for whom hepatitis vaccination would be considered important received this vaccination (60%).
  - It also appears that many other patients were started on the series of hepatitis vaccination, but this was not quantified.

F. Recommendations

At Baylor, the Monitoring Team recommends the following:

- Revise the current health maintenance documentation tool so that there is adequate space to document immunizations and other health maintenance needs over longer periods of time.
- Develop an immunization program to ensure appropriate vaccination of patients, especially those with chronic disease.

At JTVCC, the Monitoring Team recommends the following:

- Immunization process should be developed as an infectious disease program rather than as part of the chronic disease appointment. During influenza season, all patients with disease entities for whom the vaccine is recommended should be seen in a short term stand alone Immunization clinic. For example, for diabetic patients, this could be added to fingerstick checks for several days.

- A standardized system of documentation should be developed. Currently, the area on the health maintenance flow sheet is being used inconsistently, if at all.
- As many of the patients at this facility are in for long periods of time, a flow sheet that documents over longer periods of time would be desirable.

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. Generally accepted professional standards require that institutions maintain a self-medication or KOP program,[67] 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**.**

[67] "Self-medication programs" are programs which "permit responsible inmates to carry and administer their own medications." 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 and close to substantial compliance.

2. Findings

The Monitoring Team evaluated compliance with this area by reviewing the prescription process, observing nurses prepare and administer medications to inmates, and reviewing medication storage and room organization.

As noted previously in this report (see discussion of provision 4 of the MOA), the Monitoring Team found persistent problems with the timeliness, completeness, and accuracy of nursing transcription of clinician orders. The Monitoring Team's review showed that in only six of 10 applicable records (60%) did a nurse transcribe the order on the day it was written. The average transcription time for this sample of records was five days (range two to seven days). Consequently, delays in order transcription resulted in patients not receiving medications in a timely manner (range two to nine days). The two medication nurses confirmed that if a medication is ordered that they do not have in stock, they usually get it filled at a local pharmacy in order to administer to the inmate timely. If a non-formulary medication is not ordered locally, it may result in administration delays.

The Monitoring Team observed two nurses administering medications to a total of 16 inmates. In general, the nurses were professional and followed proper nursing procedures for administering medications. The medications were administered in the appropriate time frame as well. Medication administration was done with the nurses in the medication room and through a window. A correctional officer was outside the window with the inmates. The correctional officers were performing the oral cavity checks but not consistently. Mouth checks were not done for 10 of 16 inmates observed during pill call.

If one nurse administers medication, time frames are extended beyond the standard one hour before and one hour after the designated time on the MAR. One of the nurses reported that if she has to give medications alone, it takes her 3.5 hours. Review of assignment sheets for one week in May revealed that there were two week days and both weekend days where one LPN was assigned medication administration; for the same week, there was one weekend evening where there was only one LPN assigned to medication administration. The DON indicated to the Monitoring Team that she has started cross training RNs on the medication system with the goal that they will assist with medication pass when there is only one LPN on duty.

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 compliance with this area by reviewing medication prescribing practices, observing nurses administer medications to inmates, and reviewing MARs. Although there have been some improvements in medication administration practices in some areas of the facility, these improvements are not yet uniform and medication administration continues to be problematic

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. In the main unit, medication room staff reported that, due to count, the 1600 hour medication pass never begins before 1630. Staff may wish to adjust the standard administration time to 1700 to accommodate this schedule. Three nurses (RN, LPNs) are dedicated to each medication pass. According to the DON, this has enabled staff to complete each medication pass within 60-75 minutes.

In the main unit, a pilot program is underway where one nurse takes a medication cart and MARs to three housing units (T1, T2, W), which enables the nurse to pour medications and sign the MAR at the time of administration and to be in compliance with nursing practice standards.

However, this does not include narcotics and they are still pre-poured in the pharmacy area into improperly labeled plastic bags and transported to the other medication pass sites. The other medication cart (for S, E, and V) remains in the pharmacy and the nurse pre-pours all medications into improperly labeled paper/plastic bags. The medications for the main pill call window are all still pre-poured into improperly labeled paper/plastic envelopes.

The Monitoring Team observed the 1600 medication administration time and found it took 20 minutes to complete. The nurse indicated that due to room space and time pressure between count and supper time, she cannot pour the medications at the time of administration. If this was done, medication administration practices would comply with the nursing practice standards since all other aspects of the window pill call were in compliance.

In the Supermax Housing Unit (SHU) and the Maximum Housing Unit (MHU) medication times have been changed to match the main compound. An RN is assigned to in each unit and progresses through each building until medications have been administered. The Monitoring Team's review showed that medication administration in the SHU started at 3:00 p.m. and finished at 4:50 p.m., which is timely for the scheduled 1600 medication administration time.

Nurses continue to pre-pour medications each morning for the 1600 pill call and document administration of medications before they actually administer the medication. The nurse and security staff indicated that this is done to save time in the afternoon. Staff reported that the nurse who pours the medication is the same nurse that administers the medication. It is never appropriate to document an action before it has been performed. This practice raises serious questions about the credibility of the MAR and as previously recommended, should be discontinued. An analogy would be correctional officers documenting suicide rounds before they have been done, with intent to correct the documentation if the round is not carried out.

Other elements of medication administration not done in accordance with nursing practice standards included not confirming the identity of the patient with a name badge or photo ID, or having the patient state his name and ID number. In addition, when the Monitoring Team observed medication administration, security staff rushed the nurse, reminding her multiple times of the need to complete the process in time for chow. Nurses should never be rushed when giving medications since this can lead to medication errors. It also does not permit the nurse to respond to patient questions or concerns regarding his medications.

In the main pharmacy, the Monitoring Team observed a nurse pour medications from properly labeled blister packs into improperly labeled envelopes. The medication envelopes were packed in a canvas bag and taken to various buildings for administration (S, E, and V). The MAR books remained on the medication cart in the medication room. The nurse indicated the MARs would be signed when they returned from the other buildings. The nurse indicated that she would know which medications were given because the envelopes would be empty. Again, nurses should document administration (or refusal) of medications at the time of medication administration. This could be accomplished by transporting the MARs with the nurse or having medication rooms established in other locations in the facility.

The Monitoring Team observed a nurse administer medication to 13 inmates from the main compound medication window. The nurse did document medication administration at the time of administration, checked identification, and did oral cavity checks but had pre-poured the medication to save time. The pre-pouring of medications is not in compliance with generally accepted professional standards, and may lead to medication errors.

The Monitoring Team observed the medication administration process in the SHU. The nurse (accompanied by the correctional officer) went from cell to cell to administer medications. Again, there was no objective way to confirm the inmate's identity by ID badge or photo. There was no inmate ID on the cell door. Oral cavity checks were not performed on every inmate by the nurse or correctional officer. As noted above, the nurse documented administration on the MAR with her initials at the time of the medication pour in the morning. If the inmate refused a medication at the actual administration between 3:00 to 5:00 p.m., the nurse indicated she would add a circled R to her initials on the MAR when she returned to the medication room. As cited above, documenting administration of medications in advance of doing so is not in accordance with generally accepted professional standards, and raises questions regarding the credibility of the MAR.

With respect to mental health medications, the Monitoring Team observed that

medication noncompliance referrals submitted by nursing staff are infrequent. The Monitoring Team believes this is due to the fact that clerical staff review MARs for medication noncompliance but apply a narrow definition of medication noncompliance. The State's policy related to medication noncompliance contains three definitions of noncompliance, but staff at JTVCC appears to consider medication noncompliance to occur when inmate misses three consecutive doses, which is but one of the three definitions.

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 area by reviewing medication prescribing practices, observing nurses administer medications to inmates and reviewing MARs.

In general, the Monitoring Team's review showed that medication orders are not transcribed and medications are not received in a timely manner. Moreover, the Monitoring Team noted several medication errors that resulted in missed doses, duplication of doses and continuation of prescribed medications beyond order expiration dates. There were also systemic failures to provide current MARs for the nurses to document administration of medications. In January, nurses did not have access to new MARs until January 5 or 6, 2009. Nurses used December 2008 MARs to determine who received medications (even though some orders may have been discontinued) and did not document receipt of medications anywhere in the medical record. This occurred again on a more limited basis in March 2009.

With respect to the medication administration process, the Monitoring Team noted that nurses were in compliance with generally accepted professional standards, but the administration process is extended, typically taking 3-4 hours. Details of the Monitoring Team's review are described below.

Record review shows that prescription medications are prescribed when clinically indicated, administered, and delivered only upon the order of a physician, dentist or other legally authorized individual. Administration of over-the-counter ("OTC") medications by health care personnel is documented in the record. Per nursing staff, inmates have access to inhalers and other as needed medications (*e.g.*, nitroglycerin).

At HRYCI, medication administration is a decentralized process whereby nurses go out to the housing units with medication carts to administer medications to patients. Prescription medication is administered predominantly using stock medications rather than patient specific prescriptions. The Monitoring Team randomly reviewed 20 stock medications, noting that one of 20 had exceeded its expiration date. There is no accountability system in place

for use of stock medications from the carts or in the pharmacy. Pharmacy staff indicated this issue was under review.

With respect to the medication administration process, the Monitoring Team observed two nurses administer morning medications to inmates on both the East and West sides. Nurses conformed to generally accepted professional standards in most aspects of the procedure, including oral cavity checks. Nurses documented administration of medications at the time they were given. However, review of MARs show that nurses do not consistently use approved abbreviations (which are found on the back of the MAR). In addition, when patients miss medication doses, nurses do not document the reason on the back of the MAR.

Medications are not consistently administered in a timely manner (*i.e.* one hour before or after the designated time on the MAR). Nursing staff on East and West sides reported that medication pass consistently takes 3-4 hours.

In the morning, the designated time for administering morning medications is 0800 (the acceptable window period is 0700 to 0900). During the Monitoring Team's visit, medication administration was started late due to time allocated to medication preparation. Medication administration on the East side started at 0910 and on the West side at 0850. As a result, some of the medications still were being given at 1100. Failing to adhere to designated administration times is not only inaccurate with respect to medical record documentation, but also presents a risk of insufficient time between dosing and may increase the risk of medication side effects.

The Monitoring Team also observed a nurse administering insulin to diabetic patients. In this particular housing unit, 17 insulin dependent diabetics were clustered for the purposes of administering insulin. The nurse stood at a window outside the unit and each inmate approached the window, checked his blood sugar and then the nurse handed the syringe to the inmate for self-administration. Following administration, the nurse took back the syringe and properly disposed it in a puncture-resistant container. The nurse reported that in a 20 minute period he had only seen four patients. Extrapolated, it would take 80 minutes to see all 17 patients. Not only is this inefficient with respect to nursing time, but because insulin should be given in relationship to meals, it poses a risk that patients who receive their insulin well in advance of meals will have hypoglycemic reactions. Consideration should be given to escorting insulin dependent diabetics to a centralized area for blood sugar checks and insulin administration.

Nursing staff reported to the Monitoring Team that evening medication administration starts at 1700 or 1730. The time designated on the MARs for administration is 2000 hours (8 p.m.). This results in HS (hour of sleep) and other medications being administered outside of accepted nursing practice hours as mentioned above.

The Monitoring Team also reviewed 21 medication orders to assess the timeliness and accuracy of medication administration.

The Monitoring Team found that physician orders were generally complete and

legible, but five (24%) of 21 orders lacked a route of medication administration (*e.g.* oral).

In seven (33%) of 21 orders the clinician legibly dated, timed and signed the order. In the remaining 14 records, the clinician did not time the order. This prohibits evaluation of the timeliness of order transcription.

In eight (38%) of 21 records the order was transcribed on the day the order was written. The remaining 13 (62%) orders were transcribed from 1-6 days after the order was written. This is an improvement from the Monitoring Team's last visit. The Monitoring Team also found several verbal or telephone orders taken by a nurse were unsigned by the ordering physician.

Fifteen (75%) of 20 applicable orders were accurately transcribed. In the five records that the order was not accurately transcribed the reasons were attributed to: incorrect transcription onto the medication administration record (MAR): delayed transcription resulting is missed doses of medication; and incorrect medication start dates.

With respect to timeliness of medication administration, 10 (50%) of 20 records showed that the medication was not received in a timely manner (range = 2-11 days). The Monitoring Team noted several medication errors such as missed doses, duplicate dosing, and continuing medications beyond the expiration date. In one case, the record showed that a hypertensive patient on the mental health caseload did not receive his blood pressure medication for a whole month and the record did not show documentation to explain why.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team evaluated compliance with this area by reviewing medication prescribing practices, observing nurses administer medications to inmates, and reviewing MARs.

As noted previously in this report (*see* discussion of provision 4 of the MOA), the Monitoring Team found persistent problems with the timeliness, completeness, and accuracy of nursing transcription of clinician orders. The Monitoring Team's review showed that in only seven of 18 applicable records did a nurse transcribe the order on the day it was written. The average transcription time for this sample of records was three days (range 1-7 days). Consequently, delays in order transcription resulted in patients not receiving medications in a timely manner (range 3-10 days).

As previously discussed, nurses do not follow generally accepted professional

standards with respect to transcribing orders. Although nurses did completely transcribe new orders onto MARs, they did not consistently transcribe medication renewal orders onto MARs, instead taking shortcuts by simply crossing out previous order dates, or over-writing the previous dosage with a new dosage. The Monitoring Team found two medication errors as a result of this practice.

MARs that documented the administration of Keep on Person (KOP) medications (as opposed to nurse administered medications) were confusing and did not demonstrate that the patient received continuity of medications. This is because nurses should, but do not document the administration of medication refills to correspond with the original order. For example, if an order for a medication has 3 refills, the refills should be documented together on the MAR, but nurses often are not following this procedure. The Monitoring Team discussed this at length with health care leadership.

With respect to the medication administration process, the Monitoring Team observed a medication administration in MSB in which the nurse did not follow generally accepted professional standards. This was demonstrated by the nurse pre-pouring medications, documenting administration of medications in advance of giving them, and not consistently requiring the inmate to show his identification card. The nurse had the MARs with her when she administered medications, but did not use the MARs because she had pre-poured the medications. She indicated that she did not normally bring MARs, but was told a few days prior to the audit that she should do so, which might indicate re-training. Although inmates presented themselves to the officer for oral cavity checks, the correctional officer did not conduct them for most inmates.

F. Recommendations

At Baylor, the Monitoring Team recommends the following:

- Health care leadership should ensure that orders are transcribed in a timely manner and that stock medications are utilized to provide essential medications (*e.g.*, mental health, chronic disease, antibiotics) until the patient's medication arrives or that medication is obtained locally if not in stock.
- The State and CMS should ensure adequate oral cavity checks are performed consistently by security staff.
- The DON should implement procedures to ensure there is adequate staffing so medication administration will adhere to the timeliness standard for the three medication administration times at the facility.

At JTVCC, the Monitoring Team recommends the following:

- Nurses should follow generally accepted professional standards with respect to administering medications. This includes administering medications from properly labeled containers, pouring medications for administration immediately prior to administration (including narcotics), properly identifying the patient at the time the

medication is given, and documenting medications onto the MAR at the time they are administered.

At HRYCI, the Monitoring Team recommends the following:

- Health care leadership should ensure that orders are transcribed in a timely manner and that medications are given within a one hour window period of a designated time. Staff should document using approved abbreviations and reasons for missed doses.
- Health care leadership should perform CQI studies regarding the causes of medication errors and implement corrective strategies.
- Health care and facility leadership should ensure that insulin doses are properly administered in relationship to meals.
- A system of accountability for stock medications should be developed and implemented.

At SCI, the Monitoring Team recommends the following:

- Health care leadership should ensure that orders are transcribed in a timely manner and that stock medications are utilized to provide essential medications (*e.g.*, mental health, chronic disease, antibiotics) until the patient's medication arrives.
- Nurses should adhere to generally accepted professional standards in administration of medications, which includes: proper identification of patients; pouring medications at the time of administration after comparing the medication label to the MAR; documenting at the time of administration; and performing adequate oral cavity checks.
- Health care leadership should perform CQI studies on all aspects of the medication distribution and administration system, and implement targeted corrective strategies.

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 compliance with this area by reviewing continuity of essential (*e.g.*, mental health, chronic disease) medications upon arrival, intrasystem transfer, and throughout the inmate's stay at Baylor.

In a sample of 10 records, the Monitoring Team's review showed problems with continuity of medications for newly arrived patients with mental health disorders and chronic diseases. The Monitoring Team found that in six of nine applicable records (66%) bridge orders were written. Within this sample of nine records, bridge orders were written for five of seven (71%) mental health patients. Of three applicable inmates who were transferred to Baylor, two of three (66%) had bridge orders.

With respect to continuity of medications after arrival, two of three applicable health records in this sample showed lapses of medication, with one patient missing seven days and the other five days of medication. No documentation of referral to a physician was found.

With respect to noncompliance counseling, the Monitoring Team found that in two of two applicable records (one medical and one mental health) there was no documentation of noncompliance counseling for the period missed.

With respect to mental health medication administration, the Monitoring Team notes that nursing staff is verifying prescriptions. However, the Monitoring Team believes that the State should conduct some level of peer review or a QI to measure the clinical adequacy of responses given by on call medical staff in lieu of a face-to-face evaluation. In certain circumstances, the Monitoring Team noted cases where inmates would enter the facilities on medications but have then abruptly discontinued. More troubling was the fact that there did not appear to be any monitoring of these inmate's withdrawal from the medications.

C. JTVCC

1. Assessment

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

2. Findings

The Monitoring Team evaluated compliance with this area by reviewing continuity of essential (*e.g.*, mental health, chronic disease) medications upon arrival, intrasystem transfer, and throughout the inmate's stay at JTVCC.

In a sample of 14 records, the Monitoring Team's review showed problems with continuity of medications for newly arrived and existing patients with mental health disorders and chronic diseases. In only one of four applicable records were bridge orders written for mental health and medical patients.

For example, one inmate whose health record was reviewed arrived at the facility suffering from two serious chronic diseases, and a mental health condition. He was taking a medication for his mental health condition upon arrival but this medication was not bridged, and he was not seen by mental health until almost four months after he arrived. His medications to treat one of his chronic diseases were not renewed until six days after his arrival.

In another example, another patient on mental health medications transferred from HRYCI and his medications were not renewed until three weeks after his arrival.

With respect to continuity of medications after arrival, only four (36%) of 11 records showed continuity of medication orders for patients with chronic diseases and mental health conditions. The remaining seven (63%) records showed one or more lapses in medication orders. This is a decline from the Monitoring Team's previous site visit.

One HIV patient's medications lapsed for three weeks; another HIV patient's prophylactic medication orders expired twice with lapses of five and 14 days respectively. The Monitoring Team believes a contributing problem is the reliance on a physician from another facility to provide primary HIV care, instead of having the facility physicians see patients in a timely manner. Another factor in medication discontinuity is that the chronic disease physician has not consistently kept appointments and patients have to be rescheduled, which has apparently led to medication discontinuity.

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 area by reviewing continuity of essential (*e.g.* mental health, chronic disease) medications upon arrival, intrasystem transfer and throughout the inmates stay at HRYCI.

The Monitoring Team reviewed 21 medication orders of which 11 were mental health and 10 were medical medications. The Monitoring Team found problems with continuity of medications, particularly with bridge medications for newly arrived patients with mental

health disorders and chronic diseases. In five of 11 records of mental health medications, bridge orders were not written and/or medication orders expired before being renewed by the psychiatrist. The Monitoring Team found examples in which detainees admitted directly from a mental health setting with the names and doses of medications did not have their medications renewed in a timely manner. The Monitoring Team also noted that although most mental health patients saw a mental health worker the following day, the worker did not consistently notify the physician to obtain orders. In addition, record review showed that a psychiatrist did not initially see mental health patients for 14 days or to follow-up patients before their bridge medications expired.

For medically related orders, the Monitoring Team noted that bridge medications were more often written in a timely manner but in five of 10 cases medications were not delivered to the patient in a timely manner (range 3-11 days, average = 6.6 days).

With respect to mental health medication administration, the Monitoring Team notes that psychiatrist contacts do not occur frequently enough to monitor the initiation and adjustments in medications. Specifically, these infrequent contacts make it difficult to monitor the clinical response, the presence or absence of side effects and the need for any adjustment in the prescribed dosage. Additionally, the Monitoring Team noted substantial problems with respect to medication continuity.

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 compliance with this area by reviewing continuity of essential (*e.g.*, mental health, chronic disease) medications upon arrival, intrasystem transfer, and throughout the inmate's stay at SCI.

In a sample of 20 records, the Monitoring Team's review showed problems with continuity of medications for newly arrived patients with mental health disorders and chronic diseases. The Monitoring Team found that in only three of nine applicable records were bridge orders written.[68] Within this sample of nine records, no bridge orders were written for four of seven mental health patients and no bridge orders were written for two medical patients.

With respect to continuity of medications after arrival, four (20%) health records in this sample showed lapses of medication orders for patients with chronic diseases. In addition, the Monitoring Team's random review of MARs also showed multiple lapses in

[68] Bridge orders are orders written for a medication prescription to continue when inmates come to a facility already taking a given medication. The bridge order provides for the medication to be continued until the inmate can be evaluated, and the need for such medication confirmed.

delivery of medication refills. Alternately, one patient received too many refills for the amount of medication ordered.

The Monitoring Team believes that a contributing factor to problems with medication continuity is the manner in which nurses transcribe medication orders (*i.e.*, failure to fully transcribe medication renewal orders). In addition, nurses do not document refills associated with a given medication order chronologically on the MAR (*i.e.*, refills for a medication order may be documented on several MARs instead of a single MAR). This makes it difficult for nurses to readily identify patients in need of medication refills.

With respect to noncompliance counseling, the Monitoring Team found that there was a system to identify and counsel mental health patients who were noncompliant with their medications. When patients were noncompliant with their medications, noncompliance counseling was occurring but not as consistently as desired. In a sample of five mental health records, medication noncompliance counseling took place in five of nine opportunities.

With respect to mental health, the State has developed and implemented a policy and procedure regarding telepsychiatry. This is relevant to continuity of medication issues as many medications are prescribed via telepsychiatry. The Monitoring Team reviewed the State's own audit which demonstrated problems with bridging orders and other continuity of medication issues.

F. Recommendations

- At Baylor, the State/CMS should ensure that quality improvement studies are implemented to monitor continuity of medications from medical reception through discharge to identify and address causes of medication discontinuity.

- At JTVCC, the State/CMS should ensure that quality improvement studies are implemented to monitor continuity of medications from medical reception through discharge to identify and address causes of medication discontinuity.

- At HRYCI, the State/CMS should ensure that quality improvement studies are implemented to monitor continuity of medications from medical reception through discharge to identify and address causes of medication discontinuity.

- At SCI, the State/CMS should ensure that quality improvement studies are implemented to monitor continuity of medications from medical reception through discharge to identify and address causes of medication discontinuity.

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 generally accepted professional standards, 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 and close to substantial 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 new pharmacy space is larger than the previous space, and it allows for two medication administration windows, and large locking cabinets for storage of medications. Narcotics are stored double locked in a separate cabinet and are counted each shift. The space was fairly neat, clean and the medications were organized and labeled in the storage cabinets. Exception: eye wash bottles were found with pills beside nasal spray and inhalers. Internal and external medications should be stored separately.

A sample count of five narcotics revealed all were accounted for; however, shift count documentation for April, May and June revealed that once each month a night shift nurse signature was missing from the count.

A sample of five stock supply prescription medications revealed all were current (not expired). There is no accountability mechanism and this could be problematic because of the potential for drug diversion, or the administration of medications without a valid order.

Sharps are kept in the clinic area. A sample count of insulin syringes and lancets was correct.

Discontinued/expired medications are boxed and picked up daily by the pharmacy. At the time of observation, there were three boxes packed and waiting for pick up.

Medication vials are stored in the clinic. Of four multi-dose medication vials, one was not dated when opened; therefore, expiration could not be determined.

When an inmate paroles, pharmacy nurses package a 30 day supply of medications for the inmate if they know in advance of discharge. If they do not know in advance, the nurse gives the inmate their medications that are on hand.

The medication refrigerators in the pharmacy and the clinic were clean, contained only medications and the temperature was being monitored. However, the 'medication only' refrigerator in the clinic area had a biohazard label on the door. Per the infection control nurse, that was a mistake and had been stuck on the refrigerator a long time ago. There is potential for someone to put a biohazard (such as a laboratory specimen) in the refrigerator because of that label. This is an OSHA issue.

C. JTVCC

1. Assessment

The Monitoring Team found that JTVCC is in non-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 medications and medication waste. As noted at the previous visit, the main pharmacy/medication room is of insufficient size for pharmacy operations and medication administration, resulting in a cramped and cluttered environment. The floor was dirty. Staff verified that inmate porters were not allowed in this area, and staff was expected to clean the area. There was still clutter on the floors and on cabinets; therefore it was not possible to access all surfaces to clean them.

Attempts had been made to better organize the room, new shelves had been added, some medications were labeled, and some of the clutter had been cleared away. When new drug shipments arrive, boxes sit on the floor until medications can be put away. The IC Nurse had posted a sanitation schedule in the pharmacy but the tasks were not being completed per the schedule. No one was assigned responsibility for completing the tasks. Refrigerator temperatures were not being documented daily; there were 12 dates missing from July at the time of the monitoring visit.

The Monitoring Team found that narcotics and other controlled substances were double-locked. Narcotics were being administered using mostly inmate-specific blister packs and some stock supply. Documentation revealed that controlled substances were counted at almost every shift. There were three missing signatures for the two months in the current book; all were at the 2300 shift count. This was an improvement from the previous visit. It took staff only 20 minutes to complete the narcotic count at 3:00 p.m. (also an improvement). The count was accurate for all narcotic medications.

Needles and syringes were double locked and, per the log book, counted at every shift. During observation of the 3:00 p.m. shift count on 7/29/09, the count was found to be incorrect, with one 3cc syringe not accounted for. After investigation by an RN, the 3 cc syringe was found to have been used the day before (7/28/09) but not documented on the log. There had been two shift counts since that time, which indicated counts were correct.

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 there was still no accountability for the use of stock medications.

In all medication rooms, the Monitoring Team conducted a random inspection of stock supplies of medication and found expired doses of Coumadin/warfarin in the main pharmacy, and in one satellite clinic in Building 22. In addition, nursing staff were reusing patient-specific plastic bags that were over a year old to package these unit doses of warfarin that were being used for stock purposes. This should not be done because what is contained in the package is not the same as what is contained on the pharmacy label.

The Monitoring Team also found that nurses were not returning expired medications to PharmaCorr as required by their written policy. On 7/28/09, the Monitoring Team observed a nurse in the main pharmacy popping pills from blister packs into a plastic wash basin. The basin was about 1/3 full of pills. Upon inquiry, the nurse explained she was going to dispose of expired medications and had to pop them out of the blister packs before disposing of them in the biohazardous waste. Upon further inquiry, the nurse said she had been told to dispose of expired medications this way by another nurse. The DON confirmed this was the process as advised by PharmaCorr. One of the Pharmacy Techs reported that PharmaCorr said to destroy all pills that were expired, even full blister packs and only discontinued prescription drugs with more than four pills in the blister pack should be returned to the Pharmacy; that discontinued/expired narcotics are to be kept onsite and destroyed by the pharmacist.

The PharmaCorr Policy book dated 2008 indicates the following under general guidelines to determine whether or not to return drugs to PharmaCorr:

- Do not return Clinic Stock Medications without the written approval of your site administrator and the PharmaCorr Director of Pharmacy.
- Partial packages will be evaluated based on the reusability and only when the Monitoring Team can coordinate lot numbers.
- Return all cards.
- Return all partial cards.
- Do not return controlled substances.

JTVCC is not in compliance with these written instructions from PharmaCorr. The Monitoring Team unsuccessfully tried to call the PharmaCorr pharmacist to confirm and clarify the current policy and to discuss the discrepancy observed on site. Disposing of the many expired medications in the manner observed takes valuable nurse time. The volume being

disposed of indicated that regular purging of expired medications is not being performed, which increases the potential for drug diversion (especially since there is no accountability for stock medications) and is against pharmacy policy. In other facilities the Monitoring Team has reviewed, staff reports that non-narcotic expired medications are returned to the pharmacy for incineration/destruction.

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 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 and pharmacy technicians should be commended for the excellent organization. Shelves storing medications were labeled clearly and internal and external drugs were appropriately separated from one another. The refrigerator, counters, floor and sink were clean. However, in the booking area, food was found in the medication refrigerator.

Inspection of medications showed that 11 out of 11 opened multi-dose vials had been dated when opened, and none were expired. Of five over-the-counter medications sampled, none was expired.

The Monitoring Team previously has expressed concerns regarding the management of narcotics and other controlled substances. 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 two nursing signatures were missing from the narcotics count log during April. Two signatures were also missing from the sharps count log during April.

Narcotics are now available in unit dose packaging, which allows nursing staff to sign out individual packages in the pharmacy and return unused doses to the pharmacy count. There were still a few narcotic medications in blister packs and these were signed out one pill at a time and placed in paper envelopes with inmate and medication name for administration to the inmate.

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 provision by inspecting the medication room and assessing access to, storage of, and safe and appropriate disposal of medication and medication waste.

In the Maximum Security Building ("MSB") clinic, the Monitoring Team found that the medication room was small and cramped with makeshift shelving and cabinetry. There was no posted schedule of sanitation and disinfection activities to be performed. Although staff made efforts to keep the room organized and clean, this was difficult due to its small size. These issues should be resolved with the renovation of the medical clinic.

The Monitoring Team found that narcotics were double locked and checked each shift. In a random count, all narcotics were accounted for. Needle and syringe counts were correct as well. Internal medications were appropriately stored separately from external medications. In a random selection of 10 stock medications, the Monitoring Team found that none was expired.

The medication refrigerator was clean and stored only medications (*i.e.*, no food or laboratory specimens). Nurses checked temperature logs daily.

A concern was that a full container of wasted medications was being stored under the DON's desk. This should be kept in the medication room for proper disposal.

The pre-trial medication room was also small but sanitation and organization were improved. Narcotics were double locked and accounted for. The Monitoring Team's random check of 10 stock medications showed that one had expired in March 2009. There was no system of accountability for stock medications in any area.

F. Recommendations

At Baylor, the Monitoring Team recommends the following:

- The health care leadership should develop an accountability system for stock medications that is periodically checked to detect diversion or improper administration.
- All narcotic shift counts should be signed by the incoming and outgoing nurse on all shifts.
- Remove the biohazard label from the clinic 'medication only' refrigerator.
- All multi-dose vials of injectible medication should be dated when opened and discarded

per policy/manufacturer recommendation, when expired.

At JTVCC, the Monitoring Team recommends the following:

- The Facility/CMS should ensure there is adequate space to perform all the functions of the pharmacy in an environment that is clean and organized, to reduce the risk of medication errors and improve the adherence to Pharmacy Policy, Nursing Standards, and State and Federal Laws.
- CMS should educate/monitor nursing staff relating to responsibility for the accuracy of narcotic and sharps counts at change of shifts.
- CMS should confirm an appropriate disposal method for non-narcotic expired medications with PharmaCorr, since their guidelines are somewhat ambiguous.

At HRYCI, the Monitoring Team recommends the following:

- Health care leadership should establish an accountability system for stock medications in all areas of the facility and monitor compliance with new procedures for control of narcotics.

At SCI, the Monitoring Team recommends the following:

- The completion of the MSB medical clinic renovations should address medication room space issues and provide adequate cabinetry and access to a sink. The State/CMS should ensure that sanitation/disinfection schedules are posted and implemented.
- The State/CMS should ensure that medications to be discarded are appropriately stored and disposed of.

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*.[69]

B. Baylor

1. Assessment

The Monitoring Team found Baylor to be in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed three records of patients who were sent offsite for emergencies and eight records of patients who were seen onsite for emergencies. In general, patients were seen timely and follow up occurred timely when they returned. The Monitoring Team found one instance in which an important emergency room report was not available and one instance in which a nursing assessment was insufficient and should have triggered a contact

[69] 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.

with the physician. The Monitoring Team also identified one patient in whose case the clinician performing the intake screen should have contacted the physician, as this intake inmate was status post bariatric surgery and this creates some potential nutritional complications. Overall, the responses were in compliance with regard to timeliness and follow up.

With respect to mental health, the Monitoring Team notes there is a process in place under which inmates will be hospitalized at DPC when the need arises. There have been two transfers since January, but both were court ordered, as opposed to having been initiated by mental health staff at Baylor.

C. JTVCC

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed eight records of patients who presented with emergency problems, some of whom were definitively handled onsite, and some of whom were sent offsite. The major problem the Monitoring Team identified was nursing performance in some instances. The Monitoring Team also found patients sent offsite for whom critical offsite documents were not available. In general, responses were timely but improvements certainly can be made with regard to professional performance.

With respect to mental health, the Monitoring Team notes that the State continues to provide after-hours crisis coverage among the mental health clinicians. Additionally, the issue described in the Fourth Report regarding lack of access to a gurney with wheels has been resolved.

D. HRYCI

1. Assessment

The Monitoring Team found HRYCI to be in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed four records of patients who were sent offsite because of emergency problems and in each instance, the Monitoring Team did not find any delays at the time of the emergency, neither with respect to accessing services, nor with regard to being sent out. In addition, in general patients received good follow-up care on return.

E. SCI

1. Assessment

The Monitoring Team found SCI to be in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed six records of patients sent offsite on the basis of emergency problems. In each of these records, the response to the emergency was timely and the follow up was generally appropriate. There were a few instances in which documentation from the hospital was not present in the chart.

F. Recommendations

At Baylor, the Monitoring Team recommends the following:

- Screeners should be trained so that when patients enter and are identified as having had prior bariatric surgery, the physician should be contacted so that special orders may be provided.
- Nurses should be reminded of the approach to assessing patients with chest pain.
- A strategy should be implemented to assure timely retrieval of emergency room reports.

At JTVCC, the Monitoring Team recommends the following:

- Implement an ongoing systematic review of nursing performance with regard to urgent care services, utilizing the urgent care log and providing feedback to nurses in order to facilitate performance improvement.

At HRYCI, the Monitoring Team recommends the following:

- Track all patients who are seen emergently or urgently (sick call add-ons) and conduct CQI audits to determine if routine care might have prevented the emergent or urgent visit. Take action on any patterns that emerge from the audits.

At SCI, the Monitoring Team recommends the following:

- Insure tracking and receipt of documents from the hospital, including emergency room encounter forms, as well as discharge summaries.

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. In addition, the findings regarding provisions 17 and 18 provide further discussion regarding the availability of safety equipment.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team found Baylor to be in substantial compliance with this provision of the MOA.

2. <u>Findings</u>

More than 90% of all staff had the required first aid, CPR and AED training. Personal protective equipment was not immediately available in the health care delivery area. There was documentation that some staff had been fit-tested for the N95 respirator masks[70] but there were very few tests were completed. At a minimum, all health service staff should be fit tested for this mask.

C. JTVCC

1. <u>Assessment</u>

The Monitoring Team found JTVCC to be in substantial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team's review of records of officers revealed that better than 90% had the required CPR and First Aid training. Personal Protective Equipment was located in a clearly labeled box and cabinet in the emergency room of the main clinic. The ICN said she had educated staff as to its location.

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[70] Face masks and N95 respirators are devices that may help prevent the spread of germs from one person to another. *See* http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/MedicalToolsandSupplies/PersonalProtectiveEquipment/ucm055977.html.

D. HRYCI

1. Assessment

The Monitoring Team found HRYCI to be in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the records of security staff and all of the records reflected that security staff were up to date with their training and had the appropriate protective gear available.

E. SCI

1. Assessment

The Monitoring Team found SCI to be in substantial compliance with this provision of the MOA.

2. Findings

As indicated previously, better than 90% of the individuals with regard to security staff has documented CPR and first aid training. In addition, medical staff is all current with regard to this 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[71] 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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[71] "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 finds the State to be in partial compliance with this MOA paragraph.

2. Findings

During its June 2009 visit, the Monitoring Team noted that many of the space and staffing issues at Baylor had been resolved. Staff informed the Monitoring Team that mental health clinicians are not having any difficulties in having specimens drawn for laboratory tests, and receiving results in a timely manner. However, in speaking with the psychiatrist at the facility, it was his experience that there is a fluctuation in timeliness due to the lack of consistent nursing staff and the absence of an HSA.

As will be noted in the findings of other provisions of the MOA, the Monitoring Team observed that the time between follow-up visits with the psychiatrist and mental health staff is not adequate. The follow-up time should be dictated by any changes in medication regimen, initiation of new medications, and reassessment of clinical response. The maximum amount of time for follow-up is 90 days; simply setting each follow-up appointment at 90 days without regard for the foregoing items is not appropriate. The Monitoring Team also was informed that although mental health staff have weekly meetings on Mondays, neither the psychiatrist or the mental health clerk attend these meetings.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

During its visit to JTVCC in July 2009, the Monitoring Team noted the following improvements since its December 2008 site visit:

- The mental health leadership positions at JTVCC were currently filled by competent clinicians at the time of the Monitoring Team's visit.
- The State had made continued improvements in obtaining laboratory tests, but some of the physicians noted that problems continue. For instance, the ordering physician's name often is not entered into the system, so the results of an ordered laboratory test do not filter back to that person.
- The process related to the supervision of unlicensed clinicians appears to be functioning well.

- The psychiatrists' staffing allocations have improved, and, reportedly, so have the overall mental health clinical allocations.
- Compliance continues with mental health isolation rounds.
- Compliance exists with respect to initial mental health screening.
- Mental health grievances are now being tracked by mental health staff.

However, significant problems with compliance exist, and the recommendations related to those problems are summarized in relevant sections of this report and include the following:

- A policy and procedure should be developed relevant to the PCO status for selected SHU inmates who remain in the SHU. Specifically, it is the Monitoring Team's recommendation that a policy for a behavioral management plan be developed and implemented regarding such inmates.
- Operational policies need to be reviewed in order to make sure they are consistent with statewide policies and procedures.
- Implement and QI the impact of the mental health assessments relevant to the disciplinary process.
- Nursing staff needs to be supervised regarding notification of mental health provisions in policy E-09.
- Medical records issues remain include the following:
    - Access to the healthcare record needs to be improved.
    - Filing issues need to be remedied.
    - Initiation of a statewide uniform filing system and color coding needs to be implemented
- Mental health staffing allocation shortages continue, including psychiatric coverage.
- A system-wide staffing analysis should be performed as previously recommended and discussed with DOC staff.
- Inadequate office and programming space with specific reference to the infirmary, Compound housing units C & E and the MHU-SNU.
- Treatment services consisting primarily of medication and welfare checks by mental health counselors, except in the SNUs.
- The sick call process is problematic from a timeframe perspective as summarized elsewhere.
- The continued lack of space that results in inadequate sound privacy remains a very serious concern.
- JTVCC should implement a procedure to ensure adequate security staffing to escort and observe private mental health encounters for inmates on PCO status in the infirmary, train health care and security staff, and monitor the implementation.
- Review of records indicated that some inmates are lost to psychiatric follow up or visit frequency does not appropriately match the need for reassessment after medication change especially in the presence of active symptoms. A review of the process of how follow up visits are tracked may help correct some of these problems. The psychiatrists are encouraged to review these continuing problems in their monthly meetings.
- Mental health staff is not meeting the minimum required monthly routine mental health

visit (RMHV), including inmates in the SNU. This needs to be tracked by the supervisors and handled as a performance issue.

- 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 that are treatment plan driven based on individualized needs. Programming is currently limited by both programming space and staffing allocation issues.
- Although there have been continued efforts to provide programming to the seriously mentally ill inmates, competition for treatment space with education and dentistry on the MHU side severely hampers the ability of mental health staff to run an effective program. Access to classroom space on the main compound appears to be less problematic.
- Need for an improved treatment team concept in the SNU with specific reference to more involvement by the psychiatrist and correctional officers, which appears, in part, to be a staffing allocation issue.
- The quality and frequency of treatment planning continues to be poor. Although some plans are demonstrating improved specificity, this remains an area the needs continued supervision and monitoring.
- Several charts did not even contain treatment plans.
- Access issues to inpatient psychiatric hospitalization for inmates in need of such treatment is also very problematic due to both lack of bed availability and staff perceptions regarding access to DPC. Specifically, key staff at the facility did not know that they could request hospitalization at Delaware Psychiatric Center.
- No programming is available for those inmates housed on PCO for weeks or months at a time other than very brief cell side contacts. This state of complete isolation, especially for those men in single occupancy cells is counter-therapeutic.
- Implementation of discharge medication is lacking.
- Placement of inmates in C-isolation and lack of adequate monitoring of the temperature within the cells. In addition, until the time of the site visit, correctional officers in this housing unit had inadequate access to opening the cell doors.
- The SHU continues to need cleaning within the fenced in areas.
- Medication noncompliance is inadequately identified and/or monitored.
- An infirmary cell used for PCO purposes continues to have an inadequate toilet. While the plumbing of the toilet is functional, it is not in the nature of a toilet that the Monitoring Team believes comports with generally accepted professional standards relating to treatment of mentally ill inmates.
- Documentation issues of 15 minutes checks in the infirmary was problematic.
- Clinical follow-up regarding post discharge PCO status inmates was problematic.
- The need for a more robust quality improvement process.

D. HRYCI

1. <u>Assessment</u>

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. **Findings**

During its visit to HRYCI, the Monitoring Team noted the following improvements since its last site visit:

- Improved office space in the infirmary and on the east side is now available.
- Access issues to inpatient psychiatric hospitalization for inmates in need of such treatment reportedly have been improved statewide, although no transfers have been successfully attempted/initiated from this facility by the mental health staff (in contrast to court ordered hospitalizations) since the last site visit.
- A statewide mental health director has been hired as well as a local mental health director at HRYCI.
- A statewide director of medical records has been hired.
- Segregation rounds are now assigned to just one mental health clinician.
- Policies and procedures relevant to mental health assessments in the context of the disciplinary process and regarding clinical supervision are in the early stages of implementation.

Additionally, the Monitoring Team noted that the State had maintained the following improvements that had been noted in previous reports:

- The intake mental health screening assessments occur in a timely manner.
- The mental health staff generally continues to respond in a timely manner to sick call requests and new assessment referrals.
- Suicidal inmates are being identified and transferred to the infirmary on PCO status.

The Monitoring Team also noted significant problems with compliance including the following:

- Psychiatrists' allocation shortages, and use of multiple psychiatrists.
- Mental health counselor allocation shortages.
- DOC and CMS have not completed annual comprehensive staffing plans to compare required services, time necessary by discipline to provide those services, and a comparison to the current minimum required staffing levels by discipline per DOC policy C-07.
- Treatment services consist primarily of medication and welfare checks by mental health counselors.
- The quality of treatment planning remains poor even for inmates with special needs (see MOA #35).
- There is a paucity of therapeutic activities offered at this site. Rather, most caseload inmates are assigned journaling activities and given educational handouts as their counseling treatment. Even on the special needs unit, there are limited group activities

with an attendance size and space issues (*e.g.*, only dayroom space available for programming) that hampers the delivery of quality problem focused treatment. The Transitions Unit continues to lack a developed program (see MOA #37).

- During the August 2008 site assessment, the Monitoring Team reported the following:
  - "Based on prior recommendations of the monitoring team, the Department of Correction has classified sentenced inmates requiring treatment for special mental health needs to the Special Needs Unit at JTVCC. As a result, only one sentenced inmate is currently being housed in the Transitions Unit."
  - However, during this site visit, ~ 33% of the inmates on the transition unit were sentenced inmates, which is a problem because the treatment offered for inmates with longer stays will differ from those with shorter stays.
- Inadequate discharge planning services.
- Continued medication management issues (see paragraphs 4, 24, 25, and 54).
- Patterns of difficulty in completion of laboratory monitoring, especially with the use of lithium and Depakote, continue.
- Policies and procedures relevant to suicide prevention (specifically, PCO status) are not being completely implemented (see MOA 46, 47, 50, 51).
- The mental health CQI system remains rudimentary.

E. SCI

1. <u>Assessment</u>

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. <u>Findings</u>

The Monitoring Team noted the following positives at SCI during its May 2009 visit:

- As noted in previous reports, the leadership provided by the mental health director at SCI continues to be excellent.
- Review of records indicated the presence of reasonable documentation although improvement is still needed related to the content of the treatment plans.
- The staffing vacancies issues have been resolved for about five months, which have resulted in better compliance with various MOA provisions.
- Policies and procedures have been developed regarding telepsychiatry, which have helped to standardize this process.

The Monitoring Team notes that problems with mental health treatment remain, which are little different than reported during the previous site visit. These problems are addressed elsewhere in the report, but are mentioned briefly summarized 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,
- continued use of an inadequate toilet in a PCO cell,
- significant medication management issues, including continuity of medication issues, and
- a more robust QI system is needed.

The Monitoring Team also notes that the construction project for the mental health building and the infirmary addition should be a major step in alleviating the office space issues. However, the Monitoring Team is concerned that some of the current sound privacy issues may be related to custody staffing allocations.

F. Recommendations[72]

At Baylor, with respect to the weekly mental health staff meetings, the Monitoring Team strongly recommends that all staff attend these meetings.

At SCI, the Monitoring Team recommends that the State complete the construction projects, QI the medication management continuity issues, and continue to provide training and supervision related to treatment plans.

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

[72] 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.

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. Also, this provision of the MOA requires that the psychiatrist 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, shall have medically appropriate autonomy for clinical decisions at the facility, and shall supervise and oversee the treatment team.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. <u>Findings</u>

The psychiatrist at Baylor provides approximately 16 hours of coverage per week. The Monitoring Team recommends that the State conduct a staffing analysis to determine whether this amount of coverage is adequate. While the psychiatrist believes he has adequate time to see all the women on the caseload, the Monitoring Team believes that more time might be needed.

C. JTVCC

1. <u>Assessment</u>

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. <u>Findings</u>

As part of the Fourth Report, the Monitoring Team conducted a staffing analysis to demonstrate that JTVCC had insufficient staffing levels to meet the needs of its mental health population. The conclusions of that analysis demonstrated that the facility needed at least an increase of a 1.0 FTE psychiatrist position to adequately meet the needs of its population. At the time of the Monitoring Team's July 2009 visit to JTVCC, the State had not conducted its own independent analysis.

While the State has increased staffing by 0.5 FTE at JTVCC, the Monitoring Team believes that the staffing levels at JTVCC are still inadequate to meet the needs of its mental health caseload, and therefore repeats its recommendations from Fourth Report.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

Currently at HRYCI, there are fifty hours of psychiatrist' coverage provided by four different contract psychiatrists. During its April 2009 visit, the Monitoring Team was informed that beginning the next month, this coverage would be provided by one full-time psychiatrist (40 hours per week on site) and a contract psychiatrist (10 hours per week). The coverage scheme used prior to May was problematic from the perspective of the timing of the coverage provided (*e.g.* off-hours and, at times, cancellations at the last minute) as well as lack of daily and regular coverage by the same psychiatrist in the infirmary setting. The new staffing scheme should resolve these problems. Additionally, the Monitoring Team repeats its recommendation from the Fourth Report that the State add a 0.5 FTE psychiatrist position.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The psychiatrist allocation for SCI is 24 hours/week, which was being provided on site during Mondays, Tuesdays & Fridays by the psychiatrist for the past two months. He was reported to often be providing as much as 32 hours of psychiatric services on a weekly basis.

Services via telepsychiatry are provided on a two 4-hour clinics per week basis. Telepsychiatry has become more standardized since development and implementation of relevant policies and procedures. The improvements in the telepsychiatry process are the reasons for the improved assessment.

F. Recommendations

At HRYCI and JTVCC, the Monitoring Team recommends that psychiatrist staffing be increased by an additional 0.5 FTE position.

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

With respect to mental health, the Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

In the Third Report, the Monitoring Team recommended that the State create a specific consent form for Lamictal because of the serious, life-threatening side effects the drug can cause. During its June 2009 visit, the Monitoring Team learned that the State had created such a form. However, the language used in the form is too technical to be appreciated by a lay person or inmate. For instance, the form describes "Steven Johnson syndrome", and the Monitoring Team recommends that this term be replaced by more descriptive terminology.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

With respect to medication noncompliance issues, it appears the staff is screening for noncompliance issues, but staff might not be using the full scope of definitions outlined in the DOC policy on medication noncompliance. This finding is based on interviews with nursing staff. As a result, the full extent of noncompliance issue might not be realized.

The Monitoring Team also incorporates their findings for paragraphs 4, 24, 25, and 54.

D. HRYCI

1. Assessment

With respect to mental health, the Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team found that the State has adopted the policy required by this provision of the MOA. The Monitoring Team also incorporates its findings for paragraphs 4, 24, 25, and 54 of the MOA. The State continues to need improvement with respect to appropriate medication administration and maintenance of appropriate MARs.

E. SCI

1. Assessment

With respect to mental health, the Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team incorporates their findings for paragraphs 4, 24, 25, and 54

F. Recommendation

At Baylor, the Monitoring Team recommends that the State revise the consent form for Lamictal so that inmates will be better able to understand what they are consenting to.

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 provisions 8 and 9 of the MOA. The Monitoring Team found that greater than most of the security staff at each of the Facilities had received training in accordance with this provision of the MOA, but at SCI the health care staff did not have their initial suicide

training. Therefore, the Monitoring Team found that the Facilities are in partial 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 finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team found that mental health screening is performed in a timely and effective manner. However, despite improvements in the nursing component of medication verification and physician contact for telephonic bridging orders, there remain concerns over the adequacy of the bridged orders, and the management and review of withdrawal symptoms when inmate's medications are abruptly discontinued upon their booking.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team incorporates its findings for paragraph 10 of the MOA. Specifically, timely and appropriate initial screenings (including the mental health screen required by this provision of the MOA) are being performed.

D. HRYCI

1. Assessment

With respect to mental health, the Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team observed that mental health screenings are occurring in a timely and appropriate manner, as noted in the findings for paragraph 10. However, significant problems continue to persist regarding the provision of timely bridging orders for psychotropic medications.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team's review of records demonstrated that the mental health screenings are occurring in a timely manner. In eleven out of twelve charts reviewed, screenings occurred in a timely manner. However, as discussed with respect to the findings for MOA 25, the Monitoring Team found problems with bridging orders, which need to be fixed before the State comes into compliance with this provision.

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 the State to be in partial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team observed that the State appears to be responding in a timely manner to referrals from the screening process. However, one third of the chart audits sampled demonstrate a signed refusal by an inmate of all mental health services. A rejection of services by an inmate should not alleviate the requirement that staff generate am initial mental health evaluation, to the best of their ability given the refusal. This should be done sufficiently enough to reach a determination of the competency of the inmate to refuse treatment.

C. JTVCC

1. <u>Assessment</u>

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. <u>Findings</u>

The Monitoring Team incorporates its findings for MOA paragraph 19.

D. HRYCI

1. <u>Assessment</u>

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team incorporates its findings for MOA paragraph 19. As noted therein, timely responses to referrals to psychiatrists remains problematic.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team reviewed the records of eight inmates on the mental health caseload to assess the timeliness of screenings and mental health assessments. The Monitoring Team found that in seven of the eight records, the inmate was screened within 24 hours. Additionally, in seven of the eight records, the mental health assessment occurred within 72 hours as required by this provision. With respect to responses to sick call requests, in nine out of nine charts, responses to sick call requests were made in a timely manner.

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. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

The inadequacy of treatment plans remains a problem at Baylor. The quality of these plans remains poor with treatment plans providing limited and superficial problem identification and intervention development. For example, one inmate's treatment plan lists her problem as having trouble getting up in the morning, and the treatment plan is for the inmate to go to bed earlier. There is no indication in the plan of a host of other problems this inmate has which contribute to her situation.

The Monitoring Team was informed that the State has implemented training and supervision with respect to this area. However, the training efforts had only just begun at the time of the Monitoring Team's June 2009 visit, so it was too early to determine whether these efforts would fix the problems related to treatment plans.

C. JTVCC

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

The quality of treatment plans and the frequency in which they are updated continues to remain low. In fact, in reviewing this provision, the Monitoring Team examined the charts of eleven inmates on the mental health caseload whose records should include treatment plans. Only two of these charts contained adequate treatment plans. The remainder either contained treatment plans that were not updated, failed to address the inmate's problems, and in some cases was not even in the chart. This is an area that remains a major problem area and requires continued supervision, training, and monitoring.

D. HRYCI

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

Staff reported very little change with implementation of the elements of this MOA paragraph. In general, the content of the plans is more descriptive, however the actual treatments described are not accurate. This is most clearly noted when the clinician labels the required routine monthly visit as "1:1 psychotherapy" which is a formalized process of treatment as opposed to a brief functional update of the counselor by the patient of their current needs, problems and successes. In other words what the psychiatrists label "psychotherapy" is basically monitoring of the inmates. The content of the progress notes found in these inmates' charts does not support the delivery of psychotherapy.

E. SCI

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

Since the publication of the Fourth Report, the State has conducted training relevant to the development of treatment plans. The Monitoring Team's review of records demonstrated an improvement in the quality of the treatment plans, however the quality of mental health treatment plans continues to vary widely.

The Monitoring Team reviewed fifteen charts and found that eleven of the fifteen or 73% had adequate treatment planning recorded in the record. Charts were deficient in the specificity of the treatment interventions or occasionally fell out because of a problem with timeliness.

F. Recommendations

At all facilities, the Monitoring Team recommends that the State continue to monitor and track the quality of treatment plans through supervision and/or peer review.

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

With respect to mental health, the Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team has previously recommended that the fixed bed that exists in the PCO cell be repositioned and a second bed added. This would eliminate the need for the current practice, which occurs infrequently at Baylor, and results in a second inmate being housed on the floor. The Warden decided that instead of repositioning the single bed, plans are under way to renovate four cells for use as PCO housing. These renovations had not yet occurred at the time of the Monitoring Team's June 2009 visit. In the meantime, overflow patients remain on the floor.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

All inmates on PCO status, regardless of their security level, are placed in cuffs when out of their cells. The Monitoring Team believes it is inappropriate to treat all mental health PCO patients in this fashion, and further believes there is no security or mental health rationale to do so in a blanket manner. By treating all such patients as if they are dangerous to others and thus are high security inmates, it places a stigma on these inmates, and limits access to them, making it difficult to provide therapy to them. Additionally, as described earlier, many clinical contacts in the infirmary occur without adequate sound privacy.

It is expected that the psychiatric coverage in the infirmary will increase to 5 days per week with the addition of the 0.5 FTE psychiatrist position.

Review of records of inmates on PCO status in the infirmary indicated that clinical contacts were usually performed at the cellfront.

Responses to urgent referrals remain prompt. However, once someone is moved to PCO status they only receive daily checks while on watch. There is no programming offered inmates housed on PCO in the infirmary or the SHU to help relieve symptoms or provide rehabilitative services. Some inmates continue to be housed at this level for weeks at a time with little access to recreation, reading material, or mental health treatments other than mediation.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

As noted in the Fourth Report, there still remains only three days per week of on-site planned coverage by a psychiatrist. The Monitoring Team believes this is inadequate coverage. The staffing issues were discussed with mental health staff who informed the Monitoring Team they are considering instituting a daily mental health clinician coverage schedule for crisis intervention purposes

There have been no new referrals from HRYCI initiated by mental health staff since March 2008.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

As noted in previous reports, the Monitoring Team continues to express concern over the housing situation for inmates on PCO status. 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.

The Monitoring Team was informed that construction projects, currently underway, will remedy the issues described above.

F. Recommendations

The Monitoring Team recommends that the State make attempts to develop programming to address the needs of inmates on PCO for extended periods of time, including private face to face counseling contacts utilizing psychotherapeutic techniques proven effective in addressing the individual's needs.

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 finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The mental health professional assigned to the special needs unit has established an excellent rapport with the women on the unit and is very accessible to them. Programming on the special-needs unit currently consists of 7.5 hours per week per inmate of staff run meetings. Included in this figure are daily community meetings totaling 4 hours per week. All inmates on the unit are offered the same program and group therapies. There should be a minimum of 10 hours of individual treatment plan-driven, meaningful structured activity, counseling, education,

community meetings, and recreational activities. Treatment programs are not driven by individual treatment plan needs and therefore are not individualized. This is problematic because activities may include topics not pertinent to the treatment needs of the majority of the inmates participating, but because there are so few groups, inmates may attend because they will not otherwise have activities in which to participate. Few women on the unit were currently employed in the facility.

Additionally, it was noted that programming increased to an average of 7.5 hours per week on June 5, 2009 from 6 hours. The average group's size is equal to one half the unit size or 17 women. Clinical staff reported that during times of vacation, sick leave, or other staff absences elsewhere in the facility, the unit counselor is pulled to cover new intakes and sick call request elsewhere in the facility. During those times programming on the special-needs unit does not occur.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team observed that the amount of structured therapeutic activities available to the average SNU inmate is not tracked, but appears to be less than ten hours per week. The Monitoring Team believes that ten hours is the minimal level of adequacy. This time could include meaningful employment or education. However, only a few of the SNU inmates have jobs and only a couple were in classes.

Staff at the facility informed the Monitoring Team that each SNU unit is staffed by a mental health clinician and on a part-time basis by an activities therapist and a psychiatrist . Staff also indicated that it was very common that scheduled therapies on the MHU SNU held in the classrooms are cancelled due to other services using the classrooms. This was not reported to be a problem for the compound SNY.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Transition Unit (TU) houses inmates with serious mental illnesses who are unable to function adequately in the general population. One third of the inmate population in the TU were sentenced during the time of the Monitoring Team's visit.

Staff reported that all of the group therapies on the TU continue to be performed in the day room common area. There were approximately 9 such groups per week and they were not individualized for a particular inmate. About 35-40 inmates were in each of these groups. Programming needs are inadequate to meet the needs of 40 seriously mentally ill inmates. The treatment space is inadequate and not conducive to therapeutic interactions. Group size drives psycho-educational and community meeting type groups only. Programming is not individualized nor is it treatment plan driven.

There is not an appropriate space for programming. Currently, the facility is using a dayroom. In addition to overall poor acoustics, which do not lend themselves to effective groups, there is disruptive noise pollution via the overhead PA system.

Inmates on this unit described poor access to the outdoor recreational area, lockdowns ranging from 1-3 times per week related to temporary pulling of assigned correctional officers, and access issues with the psychiatrist. These inmates were complimentary of the interactions on the unit with the assigned correctional staff and described the limited available group therapy to be helpful. A lack of discharge planning was reported by the inmates. The inmates also stated that if they do not track when their medication is due to run out and ask for a renewal, it may go out of stock. Two men stated they had not received their medication for 2 and 3 days respectively.

Inmates on this unit complained that they have delayed access to the psychiatrist despite having serious mental disorders and medication complications affecting compliance with treatment regimens. One inmate complained that he had not been seen even with being housed for two weeks on the unit. His record had been previously reviewed (case number 3) and the reviewer independently determined the same deficiencies in his care as his verbal report.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team spoke with mental health staff who informed the Monitoring Team that group meetings were occurring in each housing area. These groups were all currently focusing on anger management, but future group sessions would cover grief or loss of parenting for the incarcerated parent. Mental health staff also reported difficulties in initiating

groups because there were problems obtaining approval for handouts for participants. This problem was reported to have been remedied during the Monitoring Team's visits.

The Monitoring Team also spoke with several inmates who reported little or no access to private mental health encounters other than telepsychiatry.

F. Recommendations

At Baylor, it is recommended that steps be taken to cover for staff absences so that the programming requirements for the special-needs inmates are not compromised. Furthermore, programming on the unit needs to be more varied and robust to meet the needs of the residents and provide at least 10 structured therapeutic activities per week.

At JTVCC, the Monitoring Team recommends that the State conduct a QI to examine the amount of structured therapeutic activities available to the average SNU inmate

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.

As part of this paragraph, the State is required to conduct two separate assessments when inmates with serious mental health illnesses are placed in isolation. First, the State must conduct an initial assessment when the inmate is placed in isolation to ensure that the placement with not be harmful to the inmate as a result of their illness. Second, the State must conduct a disciplinary assessment to determine whether the inmate's mental health illness was a contributory factor in the incident which gave rise to the inmate being placed in isolation.

B. Baylor

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The State has implemented a policy to ensure that inmate's mental health conditions are taken into consideration when that inmate is disciplined or placed in Isolation. As use of isolation at Baylor is quite limited, this provision is not implicated as much as it is at other facilities.

C. JTVCC

1. Assessment

The Monitoring Team finds the State is not in compliance with this MOA paragraph.

2. Findings

The Monitoring Team reviewed an audit completed by the State with respect to this provision and found that mental health assessments of inmates with serious mental illnesses who are placed in isolation are not routinely being performed. This is due to the fact that custody staff are not notifying mental health staff that such an inmate is in need of a mental health assessment.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team incorporates its findings for paragraph 2. While a policy is in place governing this provision, based on interviews with staff, the Monitoring Team does not believe this policy has been fully implemented at the facility. Staff reported that implementation of the policy has been problematic from the perspective of referrals for the disciplinary assessment. Specifically, referrals from nursing appear to be lacking. Most referrals that have been generated have resulted from a review of the movement sheets or via the mental health rounds process.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

In reviewing this provision, the Monitoring Team was informed by mental health staff that eight inmates who were disciplined and referred for mental health assessments were seen the same day, and one other inmate was seen the following day. In eight of these cases, there were no mitigating factors. In the remaining case, it appears mental health staff initially determined the inmate should not have been sanctioned because of his condition, but that determination was later changed because staff felt the inmate was feigning mental illness symptoms. While this determination might have been the correct one, the subsequent assessment and discussion were not documented at all, as they should have been.

While the State does appear to be doing both types of assessments required by this provision, there is a problem with the disciplinary assessment which warrants the partial compliance rating. Although the State is completing disciplinary assessments, they are doing so without reviewing the incident reports which arise from the underlying incident which caused the inmate to be placed in isolation. The Monitoring Team does not believe the State can be in substantial compliance with this paragraph until it takes this fundamental step and takes into consideration the incident report when completing disciplinary assessments.

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. <u>Assessment</u>

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. <u>Findings</u>

The Monitoring Team observed that inmates are assessed and seen appropriately when housed in isolation.

C. JTVCC

1. <u>Assessment</u>

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. <u>Findings</u>

The Monitoring Team was informed by staff that mental health has had some difficulty receiving notification when an inmate is moved to isolation. In order to remedy this situation, the Mental Health Clerk is now responsible for printing a list of inmates in isolation each morning to check for any new inmates in isolation and determine if any are on the mental health caseload.

The State is conducting isolation rounds as required by this paragraph.

The Monitoring Team also incorporates their findings for paragraph 38.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

Within the weeks preceding the Monitoring Team's April 2009 visit, the State initiated use of the "DOC Initial Mental Health Segregation Assessment" form. The Monitoring Team reviewed this form and believes that it should contain an entry under which the person filling out the form could assess whether the inmate is a suicide risk. This form should also reference the need to assess the presence of any clinical contraindications to placement in the segregation housing unit.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team found that isolation rounds required by this provision are still occurring in a manner consistent with this paragraph.

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 finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The logbook at Baylor, required by this paragraph of the MOA, now contains all necessary components.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team found no changes in the State's performance with respect to this provision, and therefore the substantial compliance rating continues.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The logbook at HRYCI, required by this paragraph of the MOA, now contains all necessary components.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The logbook at SCI continues to contain all necessary components.

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.

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. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team notes that the State's compliance has decreased from a substantial to partial compliance rating for this paragraph. As part its review the Monitoring Team found 9 of 11 (82%) charts that had the approved PCO initial assessment recorded in the chart with the risk assessment status selected. Most of these charts lacked any narrative accompanying the counselors assessment.

Eight of these same 11 charts (73%) followed the policy requirements for step down and post-PCO review. Several charts recorded these entries on routine mental health progress notes, in abbreviated progress notes in the general medical section, or on a treatment plan update. Since the current policy only specifies a SOAP ("Subjective, Objective, Assessment, and Plan") note format, Baylor was given credit for all these instances.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team found no changes at JTVCC since its last visit.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team found no changes at HRYCI since its last visit.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team found no changes at SCI since its last visit.

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 finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team noted that the State now has a tracking tool in place at Baylor to monitor what records are requested and received by the facility. The number of relevant records present also substantiates the conclusion that the State has made improvements in this process.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

Despite the partial compliance rating, the Monitoring Team notes significant improvement under this paragraph. The Monitoring Team noted that the State now has a tracking tool in place at JTVCC to monitor what records are requested and received by the facility. However, during the last report the Monitoring Team reported that staff reported that they are making requests as required by this paragraph but provided no evidence that the requests were being made. The Monitoring Team stated that it wished to see evidence of these requests during the present monitoring cycle, but during its July 2009 visit, the Monitoring Team was presented with no such evidence. That is the reason why the State is not in substantial compliance with this provision at JTVCC.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The State has recently begun using a log to track data relevant to this provision. Specifically the log lists "Release of Information" ("ROI") requests made by the State. However, only a few ROI were actually documented in the log which leads the Monitoring Team to the conclusion that the State is not routinely requesting this information.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team found no changes at SCI since its last visit.

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[73] 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.

B. Baylor

1. <u>Assessment</u>

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. <u>Findings</u>

The Monitoring Team notes no changes with respect to this provision at Baylor and finds the State continues to be in substantial compliance.

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[73] 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.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team randomly selected medical records of inmates on PCO status. The review of these records identified problems in the area of seven and twenty-one day follow-up visits. Specifically, the rates of completion of the seven and 21-day post-PCO follow-up visits was below the acceptable threshold established by the parties. Additionally, some initial suicide risk assessments were not present in the records. The Monitoring Team noted that documentation maintained by the State was improved, especially in terms of noting whether follow-ups had indeed occurred.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team notes no changes with respect to this provision at HRYCI and finds the State continues to be in substantial compliance.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

In the Fourth Report, the Monitoring Team expressed concern that inmates were being placed on suicide precautions in cells that are not safety cells and considered this a treatment issue related to this provision due to the fact that it affects the clinical safety needs of the inmate. During its May 2009 visit, the Monitoring Team noted no changes with respect to this provision. However, the Monitoring Team notes there is construction projects underway to build a new mental health building and an infirmary addition. These two projects should remedy the problem described.

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[74] 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 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. <u>Assessment</u>

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. <u>Findings</u>

While the records reviewed by the Monitoring Team, an audit conducted by CMS demonstrated results falling below those indicative of substantial compliance. As a result of

[74] 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.

these results, the State has developed and implemented a staff training initiative on PCO placement.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The assessment given above is a downgrade from the substantial compliance rating given in the Fourth Report. The reason for the downgrade is due to the fact that in four out of eleven charts reviewed, suicide risk assessments were either not present as required by this provision, or were inadequate. This paragraph of the MOA requires that these assessments occur within 24 hours of the initiation of suicide precautions. In three of the four above referenced charts, there were no assessments in the chart. In the fourth, the assessment indicated the inmate was not a threat to himself or others, despite notes elsewhere in the chart that the inmate had made statements alleging he wished to harm himself and despite references elsewhere that the inmate had made previous attempts.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team finds that the State is in compliance with everything in this provision, except for the part related to treatment plans. The Monitoring Team found that treatment plans are generally very generic in nature and are not individualized. The Monitoring Team further incorporates its findings with respect to paragraph 35.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team reviewed the records of several inmates on PCO status. All of these inmates' records contained risk assessments. However, the documentation of some of these requests had room for improvement. Additionally, follow-ups consistent with policies and procedures occurred.

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. <u>Assessment</u>

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. <u>Findings</u>

The Monitoring Team notes that facility wide multidisciplinary meetings began on May 29, 2009. Prior to that date, there were no weekly multi-disciplinary meetings occurring

that include staff other than the counselor and psychiatrist monitoring a patient's progress. The Monitoring Team has assessed this as a partial compliance because the meetings were only occurring for a short time at the time of the Monitoring Team's visit in June 2009.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team found no changes at JTVCC since its last visit.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

In the Fourt Report, the Monitoring Team noted that multidisciplinary meetings occurring weekly at HRYCI were not including facility level custody staff as required by this provision. During this monitoring cycle, the Monitoring Team learned that facility level custody staff is still not included in these meetings.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team found no changes at SCI since its last visit.

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 finds the State to be in partial compliance with this MOA paragraph.

2. <u>Findings</u>

The Monitoring Team found no changes from those reported in the Fourth Report. PCO I inmates are still housed in the infirmary. A single room houses up to two inmates at once.

PCO II and III housing at the time of the audit does not meet the expectations of four secure safety cells. The Warden at Baylor investigated this area and informed the Monitoring Team that stainless steel sinks and commodes as well as other safety equipment had arrived at the facility and installation of these items was expected to be completed in July 2009.

Two weeks before the Monitoring Team's June 2009 visit, a new internal policy was established to ensure that all after-hours PCO admissions are sent to an infirmary. The change resulted from an increased number of suicide attempts after inmates were placed on lower PCO levels by second hand telephonic reports, instead of after face-to-face evaluations. Under the new policy, nursing staff will call the on-call psychologist to conduct an evaluation before the inmate is placed on lower PCO levels. All inmates are placed on PCO I until a face-to-face evaluation by a mental health professional can be completed. Problems have not occurred at Baylor but this policy was implemented state wide. There have been no serious attempts at Baylor.

The current policy requires 24 hours between each step down level. The policy hasn't been formally changed but the State is considering a change under which inmates will be placed on level I but can be shifted off that level in less than 24 hours if mental health staff determines the inmate does not require that level of observation.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team found no changes from its previous three visits to the facility. Of continued significance is JTVCC's continued use of a toilet in one of the cells used for suicide watch called a "squat toilet", which is a floor-level toilet fixture that is connected to plumbing. Despite the Monitoring Team's hopes that the State would follow the success of a pilot program initiated at HRYCI and use a stainless steel toilet instead of this squat toilet, no changes have yet been made.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team found no changes from its previous visits to the facility. Of continued significance is HRYCI's continued use of a squate toilet in one of the cells used for suicide watch. During the previous monitoring cycle, the State improved the type of toilet used in one of the two suicide resistant cells, but despite the Monitoring Team's hopes that the State would implement the same improvement in the other cell, no changes have yet been made.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team notes that the infirmary area is a very tight space and has conditions which are worsened by the presence of excessive clutter on the floor. The Monitoring Team also spoke with inmates who revealed they are hesitant to reveal to staff when they are symptomatic because the conditions of confinement while on PCO are not ideal. Specifically, dependence on an officer to flush the toilet and the perception of staff being unprofessional were cited as additional humiliations for the inmates.

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 finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team notes no changes with respect to this provision at Baylor and finds the State continues to be in substantial compliance.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team was informed by staff that problems related to sound privacy, noted in previous reports, have not been resolved. Although it was noted in the Fourth Report that renovations would hopefully fix these problems, that has not been the case. The rooms were not designed adequately from a privacy standpoint. For instance, the walls stop short of the ceiling and thereby do not allow for adequate sound privacy. The Monitoring Team tested this out and was able to hear comments made inside the room from outside the room.

Privacy problems are affected by a lack of security staff at times to take inmates out of their cells, as well as safety issues. During the Monitoring Team's July 2009 visit, logbooks documenting the 15 minute custody checks were requested for inmates on PCO status in the infirmary. The Monitoring Team was informed that the documentation had not yet occurred due to other job duties at that time, although the fifteen minute checks were being performed on a staggered basis. These logbooks should be completed immediately after the check is completed.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team continues to be concerned with the fact that interventions are not occurring in a setting with adequate sound privacy. Previously referenced renovations have been completed to the old pharmacy room and these renovations have added a new examination room that provides adequate sound privacy. However, when conducting assessments and clinical interventions, the State will have a security officer in the room when the evaluation is being completed. While this might be an acceptable practice if the inmate is a danger to himself or others, the State is taking this action irrespective of the threat the inmate might impose. Therefore, the Monitoring Team does not believe the State is offering adequate privacy considerations to these inmates.

On another note, it appears from a review of the log books that 15 minute observations of PCO inmates are not staggered intervals as required by this provision.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team notes no changes since its previous visits. However, the Monitoring Team had difficulties determining whether the 15-minute checks were occurring on a staggered basis as required by this paragraph, and recommends the State document this in the future.

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 finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team notes no changes with respect to this provision at Baylor and finds the State continues to be in substantial compliance.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team reviewed the records of eight inmates, and found that in three of them there was no documentation that required step-down observations were occurring. The problems found in these records were consistent with the PCO tracking log. While one day follow-ups appeared to be occurring in a consistent manner, problems remain with seven and twenty-one day follow-ups occurring consistently.

D. HRYCI

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team reviewed the PCO log in assessing this provision. This review demonstrated problems with meeting the required frequency of post-observation contacts. Additionally, there were problems with the establishment of treatment plans as required by this provision.

E. SCI

1. Assessment

The Monitoring Team finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team refers to its findings for paragraph 47.

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. Assessment

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

C. Findings

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. As reported in the Fourth Report, 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[75] and a psychological autopsy[76] 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")

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[75] 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.

[76] 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.

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. The inmate is sent to the State Medical Examiner for a review of the inmate's body.[77] 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 finds the State to be in substantial compliance with this MOA paragraph.

2. Findings

The Monitoring Team has not been able to assess this provision because there have been no deaths or suicide attempts to properly assess this paragraph. However, the State does have a policy in place which meets the requirements of this paragraph, and the Monitoring Team finds it is unreasonable to wait a potentially unlimited time for a death.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team reviewed the M&M review files of six patients who died between November 2008 and July 2009. Within these six records, the Monitoring Team found a hand written Medical Society assessment of each death, along with an onsite review of the death and then a committee summary of the death. The committee summary was very sketchy and did not appear to necessarily address relevant issues. From the documents, it appears that responsibility for documenting these committee reviews was assigned to a non-clinician. This

[77] 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.

probably contributed to the decrease in the quality of these documents. The files also lacked sign in sheets for the participants in these committee meetings, other than for one of the six deaths.

The mental health experts reviewed four M&M reports during their July 2009 visit to the facility. The Monitoring Team observed that these reports lacked the detail and substance that should be present. These reports should more accurately describe the events with details such as time frames between critical events.

D. HRYCI

1. Assessment

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that the State has policies and procedures in place in compliance with this provision of the MOA. The Monitoring Team was not able to assess any M&M reports while monitoring this provision of the MOA at HRYCI because there were no reports to review.

E. SCI

1. Assessment

The Monitoring Team found the State to be in substantial compliance with this provision of the MOA.

2. Findings

The Monitoring Team was unable to assess this provision of the MOA at SCI because there were no serious suicide attempts or inmate deaths that took place during the period being monitored, and for which an M&M report had been prepared and made available for review. The Monitoring Team is aware of an inmate death that occurred after that time, and reviewed the M&M report relating to that death at its most recent visit in August 2009, which is not covered in this report and will be covered in the Sixth Report.

F. Recommendations

At JTVCC, the State should reassign the responsibility for leadership of this critical program to a well-credentialed clinician.

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[78] that performs the following functions in a fashion that complements the requirements contained in this provision of the MOA in order to comply with generally accepted professional standards:

- establishes a multidisciplinary quality improvement committee[79] 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;

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[78] 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."

[79] 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.

- completes an annual review of the effectiveness of the CQI program by reviewing minutes of its committee meetings;
- performs at least one process quality improvement study[80] a year; and
- performs at least one outcome quality improvement study[81] a year.

J-A-06; P-A-06.

As reported in prior reports, 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 been conducting some 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. As has been expressed in prior reports, 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.

B. Baylor

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this MOA paragraph.

2. Findings

The Monitoring Team reviewed the minutes of the Quality Assurance Committee and found that there was a substantial amount of work going on. However, the minutes lacked analysis of causes for performance that was not meeting the required threshold. This was true with regard to sick call performance, referral to physicians by nurses, and health assessments being completed, as well as other important process-related issues. The process of analyzing the causes of less than optimal performance is critical to identifying an appropriately-designed improvement strategy that is likely to address the original problem. Thus, in reviewing the minutes, although deficiencies in performance were identified, at times improvement strategies did not appear to be effective in achieving the improvements that were sought.

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[80] "Process quality improvement studies" are studies that "examine the effectiveness of the health care delivery process." J-A-06; P-A-06.

[81] "Outcome quality improvement studies" are studies that "examine whether expected outcomes of patient care were achieved." J-A-06; P-A-06.

While the State has begun to conduct some self-observation of certain processes, the State has yet to demonstrate any well developed CQI processes.

C. JTVCC

1. Assessment

The Monitoring Team finds the State to be in partial compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the minutes of recent meetings of the QA Committee and found that there has been a substantial amount of activity by the QA Committee; however, it does not appear to be leading to the type of performance improvement one would anticipate. The Monitoring Team identified and discussed several contributing problems with the DON.

Some of the regularly performed reviews of a given process demonstrate findings that vary significantly from month-to-month. This variance is reflective of an unstable process and warrants a potential need to re-train and implement the QA process.

In addition, when performance in a stable process is not at an appropriate level, there is no analysis of causes that contribute to the less than adequate performance. Rather, a corrective action plan is implemented without such analysis. In such a case, it is not likely that the corrective action plan will result in the changes that are desired. The Monitoring Team discussed methods of analyzing "outliers" for patterns whose causes can be targeted by corrective action plans, and thus heighten the probability that the corrective action plans will lead to better performance.

The Monitoring Team also talked about the need to write the minutes so that people who did not attend the meeting can understand them, and learn from them what problems were found and how they are going to be mitigated. The Monitoring Team also talked about the need to focus the Quality Improvement Program both on process measures, as is currently happening, and also on professional performance, including nursing and physician performance. When performing a process review, such as timeliness of nurse sick call, one can have a clinician perform the review using the medical records and review the timeliness of the process and the professional performance of the nurse performing the sick call at the same time. It is important for this program to be seen by all staff as a source of energy to facilitate overall program improvement.

The mental health experts note that CQI meetings are held once a week at JTVCC. While the Monitoring Team observed some improvements in the QI process, too many issues have not been reviewed by the QI process.

D. HRYCI

1. Assessment

The Monitoring Team found HRYCI to be in partial compliance with this provision of the MOA.

2. Findings

There is a CQI committee, chaired by the HSA, which has met monthly since October 2008 with the exception of February; thus since October there have been five meetings. There is also now a quarterly report, and there are task teams which meet monthly, looking at specific MOA provisions. All of these things reflect an improvement and progress towards substantial compliance. There is a weekly mental health CQI phone conference, as well as a medical weekly CQI phone conference, in which all of the facilities participate by telephone. The program is beginning to address many of the areas that the Monitoring Team has consistently identified as falling short. Some attention still needs to be directed to the methodology of both performing studies and analyzing the data.

The Monitoring Team offered technical assistance to the state and local leadership staff with regard to the most efficient way to design studies, collect data and analyze factors that may contribute to less than satisfactory performance. In many of the studies the Monitoring Team reviewed, data was collected and where performance was inadequate, there was no analysis of the causes of less than adequate performance from which targeted improvement strategies could be developed. This is probably the biggest gap that remains.

The Monitoring Team discussed study design which would allow for the collection of relevant data, particularly with regard to records or instances of outliers, because it is well known in the quality improvement literature that understanding the outliers can lead to developing more effective and targeted improvement strategies. Areas that were being studied at the time of the Monitoring Team's visit included nurse sick call, medical records processing, bridge medications, medication administration, PPD planting, drug and alcohol withdrawal process, mental health treatment plans and physical assessment timeliness.

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 the quality assurance activities at the site, as well as documents generated by the BCHS. The quality assurance documents reflect a significant amount of activity by the local staff. However, the minutes of the meetings are written in a manner that can only be comprehended by people who attended the meetings. As in most sites,

the number of attendees compared with staff is relatively small. Thus, the information learned at these meetings is not easily communicated to the line staff. In addition, there were studies looking at medication management performance which showed strikingly high performance levels in areas that the Monitoring Team's review identified as having serious deficiencies. As a result, the Monitoring Team has concerns about the methodology utilized to obtain this data. In addition, certain parameters, such as quality of health assessment/first chronic care visit, in which the Monitoring Team found poor performance, were not addressed. Thus, the emphasis was primarily on process elements, such as timeliness, which is important, but quality of performance was not addressed in the documents that the Monitoring Team reviewed.

The Monitoring Team offered technical assistance to the HSA and the DOC medical director about how the quality assurance program could be improved. Possible improvements include the development of studies that include qualitative measures, requiring the participation of the site medical director or other advanced level clinicians, as well as the development of methodologies that parallel methods used in the Monitoring Team's audits. The Monitoring Team also discussed the need for the meeting minutes to summarize findings and plans in a way that facilitates learning by the line staff. The Monitoring Team expects that, with the assistance of BCHS professional staff and CMS regional staff, this program can be made more effective prior to the Monitoring Team's next visit.

The mental health experts also specifically reviewed this provision of the MOA. They found that, since January 2009, a monthly CQI meeting has occurred. The mental health experts reviewed a CQI audit notebook, which summarized relevant mental health QA studies. Similar to prior reports, the audits provided the raw data results, but lacked the format recommended during previous site visits. An adequate format includes listing the methodology employed, the results, and an assessment of those results. The Monitoring Team has offered this information on prior site visits.

F. Recommendations

At JTVCC, the Monitoring Team recommends that the State does the following:

- Performing CQI studies in a way that facilitates the identification of causes of less than optimal performance. This includes collecting sufficient data at the time of the study. This will allow for discussion and then a determination as to the cause of the less than optimal performance and a much more targeted improvement strategy, which is likely to achieve the desired outcome.
- Implement the changes the Monitoring Team discussed as detailed above.

At HRYCI, the Monitoring Team recommends that the State:

- Utilize the technical assistance offered by the Monitoring Team during this visit to focus areas to be studied that reflect problems the Monitoring Team have identified with regard to MOA provisions.

- Perform its study design in a way that allows it to develop information on outlier cases. This will enable the State to understand the causes of less than satisfactory performance and target the corrective action plans.

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 quality assurance. 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.

B. <u>Baylor</u>

1. <u>Assessment</u>

The Monitoring Team found Baylor to be in partial compliance with this provision of the MOA.

2. <u>Findings</u>

Now that the State has begun to make its CQI process more robust, it has started producing corrective action plans. As noted in the findings related to provision 54, a disconnect remains between collecting data and analyzing that data to form effective strategies to eliminate the problems identified.

C. <u>JTVCC</u>

1. <u>Assessment</u>

The Monitoring Team found the State to be in partial compliance with this provision of the MOA.

2. Findings

Now that the State has begun to make its CQI process more robust, it has started producing corrective action plans. As noted in the findings related to provision 54, a disconnect remains between collecting data and analyzing that data to form effective strategies to eliminate the problems identified.

D. HRYCI

1. Assessment

The Monitoring Team found HRYCI to be in partial compliance with this provision of the MOA.

2. Findings

As noted for Baylor and HRYCI, now that the State has begun to make its CQI process more robust, it has started producing corrective action plans. As noted in the findings related to provision 54, a disconnect remains between collecting data and analyzing that data to form effective strategies to eliminate the problems identified.

E. SCI

1. Assessment

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

2. Findings

The State has seen some success with corrective action plans at SCI. For instance, as the result of a study of the timeliness of intake screening, the State implemented a corrective action plan that resulted in substantial improvement. However, there remain a significant number of areas in which improvements have not been made in part because study methodology has resulted in inappropriate conclusions or there has not been sufficient analysis as to the cause of inadequate performance so that an appropriate improvement strategy has not been selected. In the Monitoring Team's discussion, the Monitoring Team has encouraged the QA leadership staff to gather data on the outlier records which could then lead to an understanding of the causes for the outliers and thus lead to what will likely be a more effective improvement strategy. These discussions on methodology should serve as the recommendations for future QA activities.

CONCLUSION

As has been the case in previous reports, it is clear the State is making progress towards substantial compliance with the provisions of the MOA. As shown in this report, this progress is highlighted by the fact that in three of the four facilities, the State received no "non-compliance" ratings. Despite this progress, the State continues to have a great deal more to achieve before it comes into substantial compliance with all provisions of the MOA. As noted in the Executive Summary, 147 of the 217 compliance assessments contained in this report are partial compliance.[82] As noted previously, 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.

The Monitoring Team has already begun monitoring at the facilities for the sixth and final monitoring cycle required by the MOA. While it is anticipated that the Monitoring Team will issue a Sixth Report sometime in January 2010, the parties to the MOA have not determined what form that report will be in. Also unclear is what will transpire after December 29, 2009, the date of expiration of the MOA. That is a decision subject to discussions between the State and the U.S. Department of Justice.

[82] There are 217 compliance assessments in this report because for JTVCC, HRYCI, and SCI, there are 54 provisions being rated, and, for BWCI, there are 55 provisions being rated.

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.

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[i] Staff used Temp Dots to measure the patient's temperature but reported that they did not work properly during the summer when the humidity was high.