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August 9, 2010
Honorable Robert J. Bryan
Honorable J. Kelley Arnold
United States Courthouse
1717 Pacific Avenue, Room 3100
Tacoma, WA 98402-3200

Re: Court Monitors Report: Herrera vs. Pierce County

Dear Judge Bryan and Judge Arnold:

Enclosed is our report on the ten remaining issues in Herrera vs. Pierce County .

We have sent our report to the medical and mental health administration at the Detention Center. We have incorporated some their comments. However we are still in disagreement regarding four areas: Medical Health Care Requests(Kites), Refusal of Care, Privacy of Nursing Interviews at Reception and Management of Alcohol withdrawal.

We have made recommendations to resolve our disagreements. We feel they could be in place in a short timeframe if all parties agree.

They have requested the names of the patients associated with our chart reviews . We will send this information to them.

There is also a question regarding the Court's intent for Quality Improvement. They are making a great progress in this area and have implemented the requirements of the initial Court Order. However they have not sufficiently demonstrated one of the most essential components of quality Improvement, the corrective action process. This was not specified in the court order but it is a community standard for quality improvement

Please contact me if you have any questions

Sincerely,
Judith F. Cox

95-CV-05025-RPT

Pierce County Detention and Corrections Services

Sandra Herrera, et al v. Pierce County, et al
United States District Court Western District of Washington

Report Findings
Submitted by Judith F. Cox, MA, CCHP and Kathleen E. Page, MS, RN, CCHP
August 10, 2010

August 2010 Report re: Sandra Herrera, et al v. Pierce County, et al
United States District Court Western District of Washington

This report contains the findings of the Court Monitor Judith F. Cox, MA, CCHP and Kathleen E. Page, MS, RN, CCHP on the status of Pierce County Correctional Facility in addressing the 10 remaining health care areas in Herrera vs. Pierce County.

The report is not a comprehensive review of the health care at the Pierce County Correctional Facility (PCCF). In compliance with the direction of the Court, the report examines facility practices in ten health care areas. It provides our professional opinions as to rather these practices are within the context of minimal standards of constitutionally adequate health care. Our opinions are not based on a particular standard of care. However they are guided by our respect for existing professional practices guidelines and national standards of care. These documents guide practitioner in meeting constitutional requirements of health care impacting on the right to access to care, the right to care that is ordered and the right to professional medical judgment.

The ten areas addressed in the report are as follows:

1. Segregation Rounds
2. Response to Medical Kites
3. Response to Mental Health Kites
4. Refusal of Care
5. Training of Custody staff performing reception screening
6. Privacy of nursing interviews at reception
7. Management of Alcohol withdrawal
8. Chronic Disease Program
9. Continuous Quality Improvement Program
10. Mental Health Referrals from Booking

This report is based on information assembled through telephone meetings conducted three to four times a month between 2/10 and 6/10 by the Court Monitor with facility clinical administrators (Dr. Miguel B, Mary Scott, Nursing Supervisor, Judy Snow, Director of Mental Health and Vince Goldsmith, Health Service Administrator), an onsite audit (July 11- July 14th.) and review of data and polices submitted by the facility administration and health care staff.

Judith Cox and Kathleen Page conducted the onsite audit on July 12-14, 2010. The audit included: direct observations of screening at booking and other health care practices and a review of patient clinical records, intake screens, inmate kites and facility reports, data and policies. Interviews were conducted with 13 inmates representing disciplinary segregation, mental health housings, the women housing and a sample of inmates awaiting clinic services. Brief fact-finding interviews were conducted with over 20 officers, medical and mental health staff.

At the time of the audit the population count was at 1360 inmates (14% female n=190) and 86% males N=1190). Inmates were housed in the *Main* (Old Jail) and in the *New* jail. Health care

providers were operating clinic services in temporary settings at both locations. The primary health care unit (located in the *Main* jail) was under construction with an anticipated completion date of September 2010.

Inmates in the *New* jail received clinic visits in the clinic located at the *New* jail while inmates in the *Main* jail received services in both clinics. High security inmates were housed in the *Main* jail and generally received services at the clinic in the *Main* jail. Most other inmates housed in the old jail are transported to the *New* jail for clinic visits. This has presented scheduling and transportation challenges for both security and health care staff.

The staffing at the facility during the audit is illustrated in Table 1.

Table 1

Pierce County Correctional Facility: Health Care Staff on 7/2010*

Current staffing	FTE
Medical Staffing	
Health services administrator	1
Responsible Physician	1
Nursing supervisor	1
PA	3
RN	15
LPN	14
Pharmacist	.4
Administrative	3
Mental Health Staffing	
Mental Health Manager	1
Direct Service Supervisor	1
Care manager	1
MH Evaluators	5
ARNP	2 (.5 each)
Psychiatrist	6 hrs/week
Office assistant	1

* All filled except 1 RN who is on military leave

Findings

Introduction

This section of our report addresses each of the ten required areas by providing a summary of the facility's policy governing each area, the audit methods employed and our findings.

We have found the staff at the PCCF very motivated to provide a high quality health service. We were especially impressed with clinical leadership and skills of the responsible physician, Dr Miguel Balderrama and with the full cooperation we received from the correctional administration.

Vincent Goldsmith, health services manager, Mary Scott, nursing supervisor and Judith Snow, mental health manager worked very hard during the audit to provide us with needed documents.

We understand that PCCF has a long history with this Court Order, much progress has been made and we are now looking at remaining outstanding issues.

Summary

We have reviewed each of the 10 areas. It is our opinion that three of these areas are complete or require some finish up work, which can be accomplished in a very short timeframe. They are: Segregation Rounds, Response to Mental Health Kites, Training of Custody Staff Performing Reception Screening and Mental Health Referrals From Booking

It is our opinion that four of these areas have access to care concerns, which need to be addressed. They are: Medical Health Care Requests(Kites), Refusal of Care, Privacy of Nursing Interviews at Reception and Management of Alcohol withdrawal.

We find the chronic disease program is good once an inmate is referred to the doctor/practitioner. However, the nursing intake –screening practices are rushed and fragmented resulting in some chronic diseases not being identified. Similarly, this intake screening process results in some mental health issues not being identified or referred by nurses at booking.

In regard to Continuous Quality Improvement, we find that the facility has established an external review committee consistent with the membership and meetings requirements imposed in the Court order. However, if the intent of the court is to have a CQI processes that meets community standard than PCCF has not yet achieve this. To evaluate its progress against community standard you must look at the internal CQI committee as well. Combined these efforts are close to meeting the community standard but lack a critical CQI component known as the corrective action and monitoring process.

What follows is a detailed description of our findings in each of the ten areas .

Detailed Description

Segregation Rounds

Policy: The Segregation Policy requires that individual cell rounds be made by trained health care staff three times per week in the two segregation units (3 South and 3 North B). Two of these rounds may be made by nurses and one by a mental health program (MHP) staff. Tracking of these rounds are done via the staff conducting the rounds by entering their signature next to the name of each inmate on the unit roster they visit. If clinical concerns are identified the finding are noted in the inmate's chart. All staff conducting rounds is to receive segregation training by nursing and by mental health staff

Audit Process: This area was audited through: 1) A review of unit logs for the period 5/1/10-6/30/10 to confirm health care rounds in segregation were made per policy, 2) Interviews with five randomly selected inmates housed in segregation,3) Interview with two officers assigned to segregation, and 4) Interview and shadowing one nurse while she made segregation rounds

Findings: Health services in segregation will meet minimal constitution requirements pending nurses receiving the mental health training required by policy

As documented on the health logs, during May and June 2010 nurses conducted rounds on all inmates in segregation three times per week. The nursing supervisor trained all nurses assigned to segregation rounds. A sign-in sheet documented the training had occurred.

Inmate interviews were conducted to determine if the inmates saw the nurse making rounds and if they had access to medical services while in segregation. Both concerns were confirmed by all five inmates interviewed and by the officer. Noted is the especially positive attitude and professional demur of the nurse making segregation rounds. She was excellent and it was clear that she knew the medical needs of the inmates in segregation and that they knew and even appreciated her.

The facility is in compliance with all sections of the policy with the exception of the mental health training for nurses, which reportedly is being scheduled in August 2010.

Recommendations:

1. Nurses assigned to segregation are provided mental health training per facility policy. A curriculum of the training and a sign in sheet documenting that all nurses assigned to segregation rounds received this training is sent to the Court Monitor.

Response to Medical and Mental Health Kites

Policy: The Non-Emergent Health Care Request and Services Policy requires that on a daily basis nurses passing medications collect inmate health/mental health requests (kites) from a locked box in the inmate housing units.

Policy requires that the health care requests (kites) be reviewed daily. There is a three-step process. First a night nurse screens, date stamps, sorts all kites and responds to emergent needs. Second, designated nurse triages the kites not handled by the night nurse (Monday –Friday excluding holiday). Third Mental health kites are picked up daily seven days per week from the medical nurses by mental health staff, these kites are also stamped by MH staff to denote the date received by mental health staff. They are then triaged by a mental health evaluator.

Triage nurses are to receive orientation, quarterly training by the responsible physician and annual training by mental health staff.

Audit Process: The audit process consisted of six steps including: 1) Review of the medical records assistant analysis of 150 health care requests (kites) selected by the monitor to determine if they were date stamped, 2) Review of a Pierce County(PC) mental health report which looked at 158 health care requests (kites) triaged by medical to mental health on 6/8, 6/10, 6/14, 6/17, 6/21, 6/24 & 6/28, 2010 to determine timeliness of mental health staff receiving and reviewing kites, 4) Review of a PC mental health analysis that looked at a sample of 300 mental health care requests (kites) received for June 2010, 5) Review of ten charts to determine if entries in the charts verified completion of referrals per nursing triage, and 6) Review of health care requests(kites) contained in 17 patient records

Findings: Response to Medical health requests (Kites): Our primary concern is the facility's practice of a *reversed kite response* to medical health care requests(kites) presents problems with an inmate's access to health care.

We also identified other areas where we recommend improvements. We observed that health care requests are not consistently stamped by nurses to denote when they were received and health care requests are not readily available to doctors/practitioners.

We did find that when nurses referred inmates to practitioners. This occurred frequently and they were seen on a timely basis.

Reversed kites: We looked at the practice of reversed kites and if it presented concerns regarding the nature and timing of medical care. Reversed kites are when the nurse writes a response to the inmate and sends the inmate back the kite without a face-to-face visit. The concern was rather this method of responding to kites prohibits and or delays access to care. For example: inmates that submit kites where a sensitive health care issue is identified e.g. sexually transmitted disease, HIV or where symptoms are described, e.g. diabetic patients with

complaints of foot problems such as sores, pain, or complaints of not being able to keep food down. Also if an inmate is unable to communicate in writing, sending them a reverse kite saying we don't understand what you are trying to say is not appropriate. In matters where only general information is requested reversed kites can be an effective strategy.

Charts were reviewed where there was a reversed kite. They were as follows:

Patient (16) submits kite 3/30 stating I am stroke victim, can't rest wants mattress or May I speak to the Doctor. Kite reviewed on 4/2 nurse writes "well written well spelled not seen any hand writing deficits I might expect with a CVA patient. Patient was not seen but reversed kite "you have an appointment, jail does not have pillows, ask provider next visit." Submit kite dated 4/5 stating, "I am stroke patient and my symptoms are getting worse...arms and legs getting stiffer. Patient not seen but reversed kite 4/9 "stay active." Additional note comes to clinic 2 times per day for blood sugar checks.

Patient (18) asked for reading glasses on 7/9 (*I can't see w/out them*) and on 7/11 to be seen more often for his diabetes The reversed kite was used to tell him he had an appointment with his provider, what snacks diabetics can receive, to inform him that only prescription glasses may be brought in and that reading glasses are available on commissary. A provider saw the patient the next day. The clinic visit shown documentation of labs being ordered in relation to the diabetes, but there was no mention of the request for reading glasses

Patient (19) submits kite on 6/28 stating I'm concern that I may have a STD. Please check me out. The reverse kite was used to ask for more information and for the patient to tell medical what STD she had. As of 7/14/10, the inmate had not been seen and there was no documentation that she responded to the nurse's reversed kite.

Patient (2) submits kite (NO DATE) asking for the treatment for a yeast infection. She knows that it is a yeast infection as she gets them frequently. The reverse kite dated 5/7 stated that treatment is with a cream for 7 days, choice of this or first up list. Await reply.

Patient (9) sent emergency kite via CO, which was delivered directly to the clinic stating, "when ever I take a breath it feels as if I'm being punched in the side." The nurse noted recent ultrasound and spleen was very oversized. The reversed kite "you have a scheduled appointment." No follow-up clinic visit noted. Patient transferred to Washington State Hospital on 7/02/10. The lack of follow-up for the patient was unacceptable.

Stamping of Kites / Timeliness: We looked at two sets of data from June 2010 in examining nurse timeliness in review of kites. The first set of data showed that nurses did not stamp 7 percent of 150 kites and the second set showed nurses did not stamp 75 % of 158 kites. In the sample of 150 kites, approximately 64% had been reviewed within 24 hours, 15% within two days, and 15% within three days.

We also looked at nurse's documentation in a smaller sample of ten charts. This showed the following findings:

- For Six charts timelines were consistent with policy
- For 1 chart there was a four-day span between when the kite was written & reviewed by nurse
- For 2 charts the patients were referred by officer s (no kite was written)
- For 1 chart there was no documentation that the kite was reviewed by the nurse, but there was documentation of treatment for the problems stated in the kite.

In this sample of ten charts we looked at rather the reasons for the kite or officer referral had been addressed. Seven charts had documentation that the concern was addressed, 1 had documentation that it was being address (inmate was scheduled for clinic on the next day) and 2 charts did not document that the concern was addressed. In both charts where documentation was not adequate, the concern was addressed via a revered kite.

Clinician access to kites: Kites are not scanned into the record; therefore the provider only sees a summary written by the nurse not the actual kite. If the nurse does not enter a complete descriptive note, or if the interpretation of the kite is wrong due perhaps to cultural differences, the provider does not know the inmate's concern. This process deters access to care as the record of health symptoms reported by the client is easily buried in piles of paper which nurses and providers do not have the time to sort.
Kites are kept in alphabetical order by month in the medical records office in the New Jail. Therefore if a provider wanted to see a particular kite or all of the kites the inmate has submitted for a certain period the provider would have to contact the medical record assistance and ask for the health request. The kites are filed in boxes in alphabetical order by month. So if the provider wanted to see health care requests for the past 6 months, a the medical record assistant or another staff would have to go through six boxes of records for six months searching for the health care requests. This burdensome method really prohibits reasonable access to these health care requests. Additionally it places more clerical work on an already very busy nursing and medical record staff. It should be noted that there were two medical assistants in medical records and reportedly one was just cut. These positions are critical to the maintenance of a usable electronic record

Findings: Mental Health Response: There is a timely response of mental health staff to inmate mental health requests (kites).

We requested the PC Mental health Department to conduct an analysis of inmate mental health requests (kite) received by mental health to compare the date they were received by mental health with the date the inmate request was written. The analysis looked at a sample of 300 kites received in June 2010. The analysis showed that of those 300 kites 80% were received by mental health and stamped by mental health within 24 hours (same day or by next day) of date the inmate indicated he/she wrote the kite. 15% were within 2 days and 5% were within 3 days.

Recommendations:

1. The Non-emergent Health Care Request and Services policy is modified to require that reversed kites are not used when clinical symptoms or sensitive health issues are described in the kites. The CQI committee should audit this practice to confirm implementation of the policy and professional agreement as to what constitutes clinical symptoms and sensitive matters. It should also look at the staffing implications, specifically are nurses using nurse kites in place of face-to-face visits because nursing or PA staffing is not adequate.

2. A system is developed to scan health care requests (kites) into the record within a reasonable timeframe from the date they prepared. Apparently this was attempted a year ago and the small size of the kite resulted in the jamming of the scanner. Reportedly a larger size paper would address this problem, e.g. half a page size.

Refusal of Care

Policy: The medical refusal policy recognizes the right of inmates to refuse health care. Inmates who refuse a scheduled practitioner visit are to have their name given to the practitioner for review of their medical record. If the inmate has an emergent problem the inmate is to be seen by provider to discuss the importance of being seen. If they continue to refuse, a refusal of care is to be offered. Inmates with non-emergent problems are to be offered two more clinics visits and brought to the attention of the practitioner. The practitioner documents the information provided, interactions and other information regarding the refusal.

Reportedly, since 2009 when mental health changed their practice, the only refusals are for injectable mental health medications for which there is a separate policy. In 2009 mental health prescribers and other mental health clinicians started going to the housing units. By policy the clinic nurse notifies mental health staff when inmates refuse injectables and mental health staff responds immediately by discussing the importance of the medication with the inmate.

Audit Process: During the audit we reviewed the clinic lists for July 9, 2010. We looked at 81 inmates who were scheduled for one of six categories of clinic visits at the *Main Jail*: 1) Urgent call outs for the new jail, 2) Urgent call outs for the old jail, 3) Doctor or Practitioner follow up for the main jail, 4) First up for the Main jail, and 5) Nurse call AM/PM & HS for the Main jail and 6) Nurse call AM for the New jail. Prior to our review nurses marked the lists to indicate if inmate was seen for the scheduled visit, refused to come to the visit, was out to court and if a signed refusal was obtained.

Findings: The refusal of care practice is not adequate. The number of inmate refusals for scheduled clinic visits is too high, signed refusals are obtained for only a minority of inmates who refuse clinic services and for many inmates who refuse clinic services the decision to delay the assessment or treatment does not appear to rest with the doctor/practitioner.

Corrective action is now being taken to reduce refusals of inmates on a drug withdrawal protocol. However other problems causing the high number of refusals also need to be identified and addressed to ensure the PCCF is making a reasonable effort to remove barriers, which may hinder access to care

Our findings show a high rate of refusals for clinic visits scheduled as urgent or for doctor/practitioner follow-up. In total there were 81 inmates on the clinic list for July 9th scheduled for these reasons. Twenty-five (31%) refused care, forty-eight were seen and eight were out to court. This large rate of refusals of scheduled clinic visits suggests systemic problems that interfere with access to care. We were told that this refusal rate is typical. We also found that signed refusals were only documented for 3 of the 25 inmates who had refused their clinic visit . The signed refusals were obtained for three of the five inmates who had been scheduled for an urgent clinic visit. Our findings on the number of signed refusals are consistent with the average reported for the facility. Reportedly there is an average of only 3-signed refusals per day. The rate of nurse call refusal was very low (approximately 2%).

We reviewed the health conditions listed on the clinic call out lists for the 25 inmates who had refused service(Table 2)

Table 2
Health Conditions Associated with 25 Inmates who had Refused a Clinic Visit

- Opiate withdrawal - eight inmates
- Heroin withdrawal-one inmate,
- Hypertension - four inmates
- Gastric Esophageal Reflux Disease (GERD) - two inmates
- Start medication for hypothyroid - one inmate,
- Left arm cellulites - one inmate,
- Arthritis-one inmate,
- Elbow pain - one inmate
- Dog bite - one inmate,
- Follow-up post St. Joe's ER - one inmate
- Lab draw - one inmate
- Earwax - one inmate,
- Stitches removal - one inmate, and
- Seizure - one inmate.

Our opinion is that these health conditions do warrant a signed refusal and that the practitioner should be responsible for determining if a delayed in access to the clinic service is appropriate.

In our audit we also looked at the reasons for the clinic refusals at the facility. First we asked several officers as it is the officer that usually tells the nurse that the inmate has refused. They reported that many inmates just want to play cards or sleep or they had a court date . Second, we interviewed three inmates who had refused care. All inmates lived in the main Jail. The reasons for their refusals were as follows:

> The first inmate stated that he had problems with Gastro Esophageal Reflux Disease (GERD), which had been treated, in the clinic. He was called to the clinic and did not go because his problem had cleared up. He did not know until he was called to go that he had a clinic appointment.
>
> The second inmate stated he was receiving treatment for an acute infection (MRSA). He was called to the clinic for a bandage change. He stated that if he went to the clinic he would miss his medication. He elected to miss the clinic appointment so he could get his antibiotic.
>
> The third inmate indicated that he had been roughed up by police during the arrest and injured his shoulder and back. He stated he was scared to go to the clinic and thought he might get beaten up again. He also said he thought he was going to be bailed out. This inmate was receiving mental heath treatment. The reason for the clinic visit was to address shoulder pain.

This concern regarding missing medication was also identified by other inmates. Specifically it appears that when inmates are not in their housing unit when medications are passed they often do not receive their meds. The MAR shows the patient "Refused" or a "No show" due to being in court, clinic or attorney visits etc. Provisions can be planned ahead by security and medical staff for inmates who go to court. Many other jails have systems in place to assure that the inmates receive their medications even when out to court.

Third , we looked at the inmate's housing, *Main Jail vs. New Jail* as a reason for refusals. We found the majority of refusals in our sample of 25 were for inmates who live in the Old jail, but had appointments in the New Jail. Inmates are not informed of the either the date or time of their clinic appointments and therefore are not empowered to notify the clinic when they are aware of conflicting appointments or visits. In other facilities clinic lists are posted in the housing area the night before or inmates are given specific appointment cards with the time of the next visit. This high percentage of inmate refusals may decrease when construction on the health care clinic is complete.

Fourth we looked at the number of patient who refused to have their blood sugar drawn. We found that there were 151 scheduled blood draws; 108 were completed, 19 no shows, 8 refused, 2 canceled, 2 in court, 1 not seen and 11 no documentation available. Documentation was not available as to if the inmate had been informed of the potential consequences of h/her refusal.

The times the blood sugars were drawn was reviewed to determine the reasons for the "no shows" and the "refusals." The "no show" rate at 0400 was 22%, 0900 was 14%, 1500 was 3%. The "refusal" rate at 0400 was 8%, 0900 was 14%, 1500 was 1%. Inmates must have their blood sugar checks prior to breakfast (4-5 AM) in order to get an accurate reading. This early hour may be the reason for the nearly 30% no show and refusal numbers.

Recommendations:

1. The refusal policy is modified to ensure signed refusals are obtained on all missed clinic visits and the Doctor/Practitioner reviews the inmate's signed refusal & specifies the plan of action. The nurse or the officer can witness the inmate's refusal. However what is essential is that a Doctor/Practitioner reviews the refusal and chart's h/her direction on the same day as the scheduled appointment.

2. The PCDCC policy on charting medication refusals and notifying practitioners of patterns of medication refusal should be reinforced and monitored. Corrective action should be implemented & monitored to address patterns of medication refusals.

3. A CQI study(s) is conducted to examine the reasons for the clinic refusals, develop and implement solutions for reducing the large volume of refusals and to demonstrate improvement. Correctional administration needs to be part of this study as we anticipate that many of the resolutions will require their cooperation and active involvement

Training Custody Staff Performing Reception Screening
Policy: Pierce County Detention and Corrections Center provides training for custodial staff to support the provision of health care within the facility and to recognize when the need to refer an inmate to medical or mental health care staff. All training is approved and reviewed periodically by Health Services Manager, Medical Director, and appropriate custody staff. Recently, July 2010 training for Booking officers was added to the list of trainings available to officers at this facility

Audit Process: The audit process reviewed the list of health and mental health training available to officers, the curricula used for the booking training and documentation to determine if all booking officers had received this training
Findings: The facility will meet minimal standards for training booking officer once the booking training is completed for all officers assigned to booking.

The facility has designed a training program for all staff that fills out booking forms and is currently in its implementation phase. As of the July 2010 audit, 69% of all officers and

supervisors who work in booking have received the training. The remaining 31 percent still need to be trained. Additionally the policy needs to be modified to denote that only officers who receive booking training approved by the responsible physician will be assigned to perform reception screening

This facility provides a wide range of health related training for officers. Health related training is provided at the Washington State Criminal justice Center, Corrections Officer academy and at the facility (Field training Officer program) for all new correctional offices. Annual training is provided to all staff which includes medical, mental health, biohazard safety etc. The intake medical screening will now be provided to a limited number of designated officers who are assigned to the Booking area.

Table 2 provides a list of topic area typically included in these training

Table 2 Health training for Corrections Officers

Academy Training	Annual Training
MH	MH
CPR	Infection Control
First Aid	MRSA, TB, HEP
Field Officer Training (FTO)	Substantial Exposure
Med Pass	Biohazard
Sick Call	HIPAA
MH	Mental Health Training
Booking	Behavior Indicators
Kites System	Suicide
Clinic Escort	Safety Officer Training
Booking Screening Form	Same as Annual – more in-depth
	Booking/Intake Screening

The Curricula for Booking/Intake training is illustrated in Table 3 below.

Table 3 Outline of the PCDCC Booking Deputy Training
Medical, Mental Health and Correctional Staff

Section I: Correctional Deputy Rob Scollick: Introduction to enhancing booking screening procedures

A. Introduction to the importance of maintaining confidentiality and privacy during the medical and mental health screening process

B. Assure confidentiality of arrestee's medical and mental health screening

Section II: Importance of receiving screening

A. Dr. Balderrama presents medical perspective that includes:
   1. timely medical care for both injury and illness related condition
   2. liability – case study

B. Judy Snow presents mental health perspective that includes:
   1. bridging the gap between corrections and health care team
   2. Suicide Prevention Program begins at booking and all staff are responsible for the identification and for providing appropriate care

Section III: General principles of effective screening Mary Scott

Section IV: Observation and identification of medical and mental health concerns(Dr. Balderrama, Mary Scott & Judy Snow)

Section V: Referral process following observation and identification(Dr. Balderrama and Mary Scott & Judy Snow)

Recommendations

1. The health and mental training for booking is completed for the remaining 31 percent of the booking officers who have not yet received this training.

2. A joint agreement or policy approved by correctional administration, mental health and health services as to how booking training will be continued for new officers assigned to booking . We recommend a CQI subcommittee be formed with correctional administration representation, which reports twice a year to the CQI committee and the Chief of Corrections on the status and plans for health training for officers including booking training.

Privacy of Nursing Interviews At Reception

Policy: At the Pierce County Correctional Facility, trained correctional officers provide medical and mental health screening utilizing a structured form for all inmates. Those with positive findings are then screened by the nurse located in the booking areas and pending the outcome the booking nurse verifies and consults with a provider who orders the medications, places the inmate on a monitoring protocol and /or refers the inmate to a provider. When there are mental health concerns the booking nurse administers a mental health screening form, as necessary follows additional procedures for suicidal inmates and forwards the mental health screening form and the officer's booking sheet to mental health services. Booking Officers also notify mental health regarding inmates with positive mental health findings.

(Recent Changes in practice and Policy): In 2010 three new changes were introduced. First the booking officer now calls the nurse on a designated phone to notify the nurse an inmate has been flagged on the booking sheet as needing a more in-depth screening. This is a good practice. Second, a privacy area has been drawn on the floor in the booking areas to denote where officers must stand when an inmate is being screened. This line was drawn in attempt to facilitate privacy. In addition to these changes PCDCC built a new medical exam room located in the booking areas. This was designated as a room to be used when the booking nurse needs to examine arrestee/inmate in private.

Audit Process: The audit process involved: 1) observation of 10 booking interviews and interviews with two nurse and six officers and 2) review of completed booking forms.

Findings: Nursing and officer interviews are not being conducted in an environment that affords privacy. The current privacy area identified by tape on the floor does not provide a sufficient sound barrier and is in a high officer/other staff traffic location.

Privacy: Protecting confidentiality is especially challenging in correctional facilities because of the tension that exists between maintaining optimal security and safety and maintaining confidentiality of inmate medical information. It is essential that health services and custody staff must work as a team to achieve these dual goals

During this audit we observed 10 booking. First the officer using a structured intake screening form asked the inmate a series of medical and mental health questions. When the officer identified an inmate with health care problems the officer picked up a red phone and called the booking nurse. The booking nurse then took the intake screening form completed by the officer and made additional medical and mental health inquiries on the same form.

For the officer intake screenings we observed that three of these screenings afforded privacy and seven did not afford privacy. The arresting officers were frequently too close when the booking officer was conducting the medical screening of the inmate. One of the interviews that did not afford privacy was an interview conducted using a telephone interpreter line. It involved use of a loudspeaker phone with the arresting officers standing close enough to hear the inmate.

The interpreter's questions could be heard throughout the booking area. The inmate refused to answer the medical questions probably due a lack of privacy.

Eight of these inmates were subsequently referred via the red phone to the nurse. Seven of the nurse screenings did not afford the inmate privacy. We observed nurse screenings being conducted in an open, non-private setting and in a rushed and fragmented manner. Most screenings we observed lasted only a few minutes. The nurse did not even ask the inmate h/her name and it was not written on the screening form. The nurse documented on the screening form her findings and it was not until later that the booking officer placed the patients name on the form.

The red taped privacy area did not provide a sufficient sound barrier and in two cases officers crossed the privacy line. Additionally during most screening conducted by the booking nurse, the booking officer remained at his/her station while the nurse was conducting the medical screening. This resulted in the booking officer hearing all of the conversation and in some cases participating in the screening interview. We did not observe any utilization of the new exam room. In fact we observed the nurse, office and an inmate going into the "change out room," so the nurse could exam the patient. The reason given by the nurse was that it was closer than walking down to the other end.

Discussion throughout our audit with security and nursing staff confirmed the concern that both nursing and officer intake interviews were not conducted in private manner especially in regard to the police officer presence. Custody suggested moving the booking screening to the far end of the booking area near the nurse's office and providing the booking officer and booking nurse each with their own screening areas behind the main desk. This would require some minor modification to the width of the desk to enable a private conversation between the nurse and inmate. Another solution mentioned was to have the nurses actually utilize the new exam room.

Other observations on nursing Interviews at Reception: We also observed that there is confusion as to the nurses doing a "brief medical clearance" that would allow the inmate to be accepted in the jail versus the "in-depth screening to begin the development of a "plan of care" that sets the system in motion to assure continuity of medical and mental health care.

We observed there was uncertainty regarding when the nurse is to complete a mental health screen. On eight of the 10 booking forms, officers had documented positive mental health finding. The positive findings were:

- 4 inmates -depression and anxiety
- 1 inmate - post partum depression
- 1 inmate- schizophrenia paranoid type
- 1 inmate - MH medication to treat psychosis and 1 inmate - depression

Of these 8 inmates only one inmate had the mental health screening form completed by the nurse.

Another observation, which we made, was that on several occasions the nurses placed themselves between the officer and inmate in unsafe proximity before the search was completed. At that point the nurse had no prior knowledge of the inmate's potential for risk. Even the booking officer who sits at a desk above the inmates is afforded this separation.

The nursing intake screening process in booking is especially critical. It is the only structured screening provided by trained health care professionals that most inmates entering the Pierce County facility will receive. Once assigned to their housing units, inmates will receive additional screening at their request for health services or when symptoms are observed. In correctional institutions certified by the American Correctional Association or the National Commission on Correctional Health care, all inmates are screened at intake and then within 14 days, they receive a physical assessment usually by a practitioner or Doctor. A mental health screening by a mental health or trained health care professional is also completed during that time.

Because of the importance of the early identification of health problems at booking, it is critical that custody and health services work together to provide a quality intake screening. A critical component of this screening is for medical information to be collected in a manner which respects the confidentially of medical information while ensuring staff safety.

Recommendations:

1. Officers and nurses conduct the medical /mental health intake screening in a manner which respects the confidentially of medical information while ensuring staff safety. Either of the suggestions identified above by facility staff would meet this requirement.

2. Inmates for whom the officer identifies a health care concern, but not a "medical clearance" are returned to the holding tank following the officer screen and remain in the tank until called out by the nurse for the medical screen. It may be more beneficial to have the officer separate those inmates with medical clearance issues from those with health care concerns. This would cut down on the "need to rush," which seems to permeate the screening process and help facilitate a more focused and private screening process.

Mental Health Referrals From Booking

Policy: At the Peirce County Correctional Facility, trained officers provide medical and mental health screening utilizing a structured form on all inmates. Per Receiving Screening Policy, those with positive findings are then screened by the nurse located in the booking area. Pending the outcome, the booking nurse verifies and orders medications, places the inmate on a monitoring protocol and /or refers the inmate to a provider. When there are mental health concerns the booking nurse is to administer a mental health screening form, as necessary follows additional procedures for suicidal inmates and forwards the mental health screening form and the officer's

booking sheet to mental health services. The booking officers also notify mental health regarding inmates with positive mental health findings via an electronic report .

Audit Process: The audit process involved:1) review of booking forms to determine if the nurse administered the mental health screening on inmates with symptoms or history of mental disorder and also forward information required by policy to mental health, 2) review of booking forms on clients who went to the emergency room and 3) comparison of nursing referrals to mental health with officer referrals(reports) to mental health.

Findings: Our concern is the facility's policy to identify inmates with mental illness is not fully implemented. Booking Officer referrals to the mental health department are adequate and they will improve with the new training . However the policy requires that a professional level of screening is administer by nursing to inmates screened by the booking officer with mental health problem. Our findings are nurses appear to be conducting these screening for only inmates identified as potentially suicidal and are missing many inmates with other serious illness like schizophrenia . Our opinion is that the facility meets minimal standards for referral from booking because of the officer screening process. However we did not see documentation that the facility meets requirements for a mental health screening. Standards around the mental health screening require the screening to be administered by a health care professional and it must be provide to all inmates within 14 days of admission.

A review of the booking forms of 10 inmates booked on 7/12/10 indicates that the current policy is not being followed. On eight of the 10 forms, officers had documented positive mental health finding. The positive findings were:

- 4 inmates -depression and anxiety,
- 1 inmate - post partum depression,
- 1 inmate- schizophrenia paranoid type, 1 inmate - MH medication to treat psychosis
- 1 inmate - depression.

In regard to nurse screening , only 1 of the 8 inmates had a mental health screening form completed and the booking form was faxed by the nurse on three inmates.

A review of the booking forms on seven inmates who were sent to the hospital ER indicates that inmates requiring more in-depth mental health screening at booking are not receiving them. As illustrated below in Table 4 officers had documented on the booking form positive mental health signs on at least five of these inmates. However none of these five inmates had a mental health screen in booking by the nurse and only one had their booking from faxed by the nurse to mental health. The mental health indicators identified by the officers were: 1) Prior suicide attempt (5 yrs ago) and daily alcohol, 2) According to police inmate had a loaded gun and threaten to kill self and girlfriend, has panic attacks, 3) Prior suicide attempt via drinking anti freeze, 4) Bipolar, AD/HD, schizo, medications lithium, 5) Hospitalized in military, stress, stomach problems.

Table 4: Sample of inmates who were sent to the ER May-June 2010

Patient A: ER for seizures X2 on 5/21/10 -Booked on 3/30/10 Booking form indicated a prior suicide attempt (5yrs ago) and daily alcohol use, seizures, taken meds last night –no documentation that the completed a mental health screen or faxed booking form to mental health. Patient given an F/u of 5/4/10

Patient B: ER ELOH w/d on 5/23/10-Booked on 5/22/10 booking from indicated that according to police inmate had a loaded gun and threaten to kill self and girlfriend, has panic attacks, has high BP. There was no documentation that the completed a mental health screen but booking form was faxed to mental health

Patient C: ER for suicide attempt, hanging on 6/13-Booked on 6/11/10. Booking form documented prior suicide attempt via drinking anti freeze, no nurse signature on form and no documentation that the completed a mental health screen or that nurse faxed booking form to mental health.

Patient D: ER for attempted hanging on 6/14/10-Booked 6/11/10. Booking form documents bipolar, AD/HD, schizo, medications lithium. There is no documentation of a completed mental health screen by the nurse or if the booking form was faxed to mental health. Patient was referred (urgent) to doctor for eye problem

Patient E; ER visit 6/20 head injury acute psychosis. Booked 6/11/10. Booking form documents hospitalized in military, stress, stomach problems and there is a check that inmate was uncooperative. There is no documentation of a completed mental health screen by the nurse or if the booking form was faxed to mental health.

Patient F: ER visit 6/23/10 Methadone W/D –Booked on 6/22/10. Booking form documents last drug methadone or heroin w/d. There is no nurse signature and no documentation of a completed mental health screen by the nurse or if the booking form was faxed to mental health.

Patient G: ER visit 6/23 drug o/d kntubated -Booked on 6/10 /10 .Booking form documents motor cycle accident, takes oxicotin, took this morning, lower back F/u with Ken 7/27/10

A comparison of nursing mental health screenings at booking with mental health reports prepared by booking officers was conducted by the Facility's Mental Heath Department. In June 2010 there were 2000 booking of which booking officers submitted mental health reports on 168 inmates (8% of all booking). Booking nurses completed 24 mental health screens on the same inmates (1%). This suggests a very low rate of mental health case finding by nurses at booking.

We are concerned with this low number of mental health screenings by booking nurses. We understand that the nursing supervisor and the mental heath manager are already working on these concerns. We would like to see implementation of a plan to resolve them and a report

on its effectiveness. As part of this process we would like data on the volume of inmates referred by booking nurses to primary care for mental health medications. Perhaps we are undercounting mental health referrals from booking nursing. In the community as well as in corrections inmates also receive mental health care from primary care providers.

As a point of reference we have provide a national study on prevalence of mental illness in jails. In 2009 the Justice Center issued a report (Illustration 1) on a comprehensive study of five local jails of more than 20,000 inmates. The findings in this study suggest that 16.9 percent of inmates in jails have a serious mental illness. If we compare the prevalence rates in this study with those found by the booking officers it suggests that only 50% of inmates with a serious mental health disorder are being identified at booking.

Illustration 1: Summary of Justice Center release June 2009

In a study of more than 20,000 adults entering five local jails, researchers documented serious mental illnesses in 14.5 percent of the men and 31 percent of the women, which taken together, comprises 16.9 percent of those studied—rates in excess of three to six times those found in the general population.1

"Serious mental illness" for this study refers to the presence of one or more of the following diagnoses: bipolar disorder, schizophrenia spectrum disorders, and major depression. Estimates do not include other less serious mental illnesses, such as anxiety disorders (including post- traumatic stress disorder), adjustment disorders, or acute reactive psychiatric conditions, such as suicidal thinking, which also represent significant jail management concerns.2 Although there are many adults in jail with mental health needs, the study highlights the population with the most significant disabilities and the greatest need for comprehensive and continuous treatment, both inside the jail and after release.

The prevalence estimates for women with mental illnesses are double those for men. This gender difference is particularly important given the rising number of women in U.S. jails.

These findings represent the most reliable estimates of rates of serious mental illness for adults entering jails in the last 20 years.

If these estimates are applied to the 13 million jail admissions reported in 2007 study, findings suggest that more than 2 million bookings of a person with a serious mental illness occur annually.

Recommendations:

1. The nursing screening process for chronic mental illness is reinforced to provide a more aggressive and effective identification of inmates with serious mental health concerns.

2. A corrective action plan is developed, implemented & studied to improve the quality and volume of mental health screening provided by booking nurses

Management of Alcohol Withdrawal

Policy: Inmates with alcohol and other drug problems are to be identified at booking and then placed on a withdrawal protocol in a general housing unit or in the *Main Jail* on 4 East. By policy nurses are to use a nursing screening tool for withdrawal monitoring, inmates on alcohol withdrawal are to be **monitored 3 times/day** and those on other drugs, twice a day or more frequently if required.

Audit Process: The audit process included: 1) Observation of ten inmates during their booking process to review early detection of inmates at risk of withdrawal and 2) Chart reviews for twenty-eight inmates receiving withdrawal monitoring on July 9, 2010 and July 12, 2010.

Findings: The facility has not adequately documented that nurses are consistently monitoring inmates on withdrawal protocols per the physicians order.

Of the twenty-six charts reviewed (Table 5), fourteen were alcohol related and 12 were other drug problems (1 methadone &11opiate). In 34 % of the charts reviewed (9 charts), nurses did not monitor patients as was ordered by physician approved protocol.

Table 5: Chart Review: Inmates on Withdrawal Protocol 7/9 & 7/12 2010

Alcohol/other drug Problem	7/9 & 7/12 Total on Withdrawal protocol	Monitoring not consistent w /Policy	Monitoring Consistent w/ Policy	Started in Booking
Alcohol	14	7	7	14 Y
Other Drug	12	3	9	7 Y 5 n
Total	26	9 (34%)	17	22 Y 5 N

Seven of these charts were on inmates with alcohol problems. Documentation showed, monitoring visits were between one and two visits per day in contrast to Doctor orders that required three visits per day. Three charts were for inmates with other drug problems. In these cases usually only one of the two required visits was documented.

It is critical that the monitoring visits for inmates on withdrawal are not missed. Many correctional facilities require monitoring at more frequent time periods. This is because the condition of a patient who is in active withdrawal, can change within hours, let alone in 8, 16 or

even 24 hours. The delay in assessment and treatment can lead to emotional and physical withdrawal. The most serious problem is seizures, heart attacks, strokes, delirium tremens (DTs) , hallucinations, and even death. A consistent problem in reviewing these charts was that the start and especially the stop date for the withdrawal protocol was not entered.

It is also noted that in five of the other drug related cases, the need for withdrawal monitoring was not identified until one to three days after booking. This may be partially related to the way questions are asked, the lack of privacy, the limited time the nurse spends with the inmate in booking, a need for staff training and/or the inmates reluctance to admit alcohol or drug use.

Recommendations:

1. The CQI committee implements a process to determine the reasons for the inconsistent monitoring. develop strategies to fix the problem(s), implement the strategies and then monitor their impact. A report of this CQI effort is sent to the Court Monitor.

Chronic Disease Program

Policy: The policy of the Pierce County Correctional health clinic is to provide a chronic disease program that identifies inmates with chronic diseases with a goal of decreasing the frequency and severity of symptoms as well as to prevent disease progression and deterioration. Clinical protocols consistent with NCCHC clinical practice guidelines and community standards are used to provide and monitor services for inmates with chronic conditions including but not limited to: Asthma, Chronic Obstructive Pulmonary Disease (COPD) Congestive Heart Failure (CHF), Diabetes, Epilepsy, Hepatitis C, HIV/AIDS, Hyperlipidemia, Hypertension, pain management, Tuberculosis.

Audit Process: The audit process included: 1) A review of the chronic care list for July 14, 2010 (medical only) to identify categories of chronic diseases & prevalence rates 2) A review of the clinic records of a random sample of patients from the chronic care list to determine if care was consistent with clinical practice guidelines and 3) Comparison of PCCF prevalence rates for chronic disease on select categories with national correctional rates for these diseases.

Findings: The chronic care program is good once a patient has been identified and seen by a provider. Documentation gave evidence of frequent clinic visits, assessments and timely follow-up by the providers based on the individual patients identified problems. We did have some concerns that are described in detail below on problem list documentation, medication, prevalence and identification of chronic illness at booking

The facility has also just implemented a tracking system using their electronic record to print out lists of patients with chronic illnesses. The first list of these patients was produced for this audit. It showed that there were 143 patients (Table 6) being served at the facility with one or more chronic illnesses.

Table 6 Chronic Care Categories tracked on 7/14/2010

Chronic Care category tracked on 7/14/2010	# Of inmates W/ illness
Hypertension	92
Diabetes	26
Hyperlipidemia	24
Chronic pain	15
Asthma	13
COPD	11
Seizure disorder	9
Hepatitis C	5
HIV	4
Hypothyroidism	1
hyperacidity	1
Total Patients with chronic illness	142 (patients had multiple chronic illnesses)

A review of 17 clinical records of patients with 43 chronic care concerns showed that the care they received was consistent with national clinical guidelines. Documentation confirmed providers are following chronic care clinical guidelines (Table 7). Patients are monitored by frequent clinic visits, repeat lab work, monitoring of blood sugars, blood pressures, with appropriate referrals and consultations between the physician and the other providers. Patients that required specialty referrals not available in the jail were sent out into the community, for example: ophthalmology, neurology and oral surgery etc. The specialist recommendation were followed or in the process of being arranged. In fact one patient with uncontrolled seizure disorder is scheduled for an implant that should diminish the severity and frequency of his seizures.

A review of the 17 chronic care charts found that when the patient was identified in booking, 47% were seen within one day, 29% were seen within 2 days, 18% were seen within 3 days. Patient will either see an MD or PA/NP depending on the complexity and severity of their health care needs. The PA/NP manages most of the stable patients and consults with the MD as needed for unstable patients. The MD monitors approximately 10% of PA/NPs patients for quality and appropriateness of care. The 17 patient's records documented frequent visits by type (MD and PA/NP) provider. (Table 7) Illustrated MD & PA/NP visits reviewed for the months of April, May, June and half of July 2010.

Table 7: MD and PA/NP visits for 17 Chronic Patients (April- July 14, 2010)

Patient	BK date	April		May		June		July	
		MD	PA/NP	MD	PA/NP	MD	PA/NP	MD	PA/NP
1	4/5		1		2	1	4		3
2	4/18		3	1	3		2		
3	6/16						1		
4	6/6					2	5		1
5	6/9					1	5		
6	9/08	3	2	WSH		3	1	1	
7	6/11					1	2		
8	1/24	2	4					1	
9	5/17			3		2		2	2
10	5/25					1	3	2	
11	6/26						3	1	
12	6/27						2		
13	6/05						6		
14	6/08	1	3		2		1		
15	1/27	3			1				
16	3/22		2		1			1	
17	6/1						3		

Documentation indicated that Chronic Care patients are followed closely. Disease specific required lab test are ordered at specific intervals and results shared with the patient. Medication management, diet, blood pressures, weight control, patient education, and monitoring of acute episodes are also included in the follow-up of patient returning to clinic. Patients with hypertension have their BP monitor closely, frequent follow-up visits and patient teaching regarding their disease.

The key of managing diabetes is "patient education, self-management about the disease process, lifestyle modifications and blood sugar monitoring" (NCCHC). We reviewed the patients schedule for patients who needed to have their blood sugars drawn on 6/30, 7/9 and 7/12 (Table 8).

Table 8: Review of blood Sugar Monitoring for 6/30, 7/9 and 7/12

Blood Sugars		Percent
Scheduled	151	100
Seen	108	72
No Shows	19	13
Refusals	8	5
Canceled	2	1
Court	2	1
Not Seen	1	.06
No Doc	11	7

The "No shows (13%), "Refusals" (5%) and the patient with No documentation (7%) represent 25% of all patient scheduled. The time of day the blood sugars were scheduled was also reviewed to determine "No Show" and "Refusals" rates. Also may refer to "Refusal of Care section."

Time	0400	0900	1500
No Shows	22%	14%	3%

The compliance rate for having their blood sugar drawn needs to be improved to better manage patient with diabetes. The patient teaching regarding the disease, importance of lifestyle changes and patient responsibility and where to go for follow-up care after release was excellent and well documented in the physicians' notes. However, the documentation of patient teaching for the PA/NPs and nursing was limited.

Documentation on problem list: We looked at documentation on the problem list . Each patient has a "Problem List" available on the EMR that can be used as a quick reference of past and current diagnosis. A review of the several problem lists found they were incomplete and did not document the patient's total number of chronic illnesses. However, a review of the patient's records had the information available in the "assessment section" as determined by the provider during a clinic visit, or chart review.

Medication: We found some concerns regarding medication(s). First, we saw charts where inmates did not receive their medications until 1-3 days after they were booked. This is a common problem in all Jails as the nurses must verify with the community pharmacy the inmate's current medications. Inmates usually have several pharmacies that they use and their memories may not be as good at booking (Pt # 7). Second, is renewal of maintenance medications/prescriptions to insure they are timely e.g. inhalers for Asthma, Hypertension medications (Pt # 2). Thirdly, patient's not receiving their medication because of being out to court, (Pt # 5)

The following examples were selected from the 17 Chronic Care patients.

Patient # 2	
Booked:	4/18/10 History of Hypertension, Asthma, foot surgery
Booking Meds:	Blood pressure, inhaler for Asthma and pain medication. Unable to confirm that medication was verified or continued.
Clinic Visit:	4/20 – Asthma exacerbation, only able to speak a few words, minimal airflow. Blood pressure and Asthma medication ordered.

	4/22 – Re-evaluation of high blood pressure. Patient did not get blood pressure medication last pm. Suppose to be on Lisinopril 20 mg QD but expired. Current BP 146/102.
Patient # 7	
Booked:	6/11/10 History of Asthma, MVA in 2005
Booking Meds:	Pain Medication, told needs Asthma meds
Kites:	6/14 gives name of another pharmacy 6/15 asking for something for Asthma 6/15/ Dr. B ordered inhaler
Grievance:	6/22/10 States no medication since 6/11/10. Response to grievance dated 6/25. Good research on current medication after patient filed grievance. Medication information received 6/23.

Prevalence rates: We compared the volume of chronic patients being served at the facility with national data. In a report to Congress on *The health Status of Soon-To-Be-Released Inmates,* released in the late 1990's the prevalence rates for chronic illness in correctional settings. Table 9 shows the distribution of chronic illnesses at the Pierce County correctional facility across selected categories and compares the rates for these illness in the Pierce County Correctional Facility (based on the current Chronic care list) with the findings in the above national report to Congress

Table 9: Select Chronic Care illnesses for Pierce County Inmates on 7/14/2010 Compared with National Prevalence Rates for Correctional Facilities(Jails & Prisons)

Chronic Care category	Pierce Co # /% Of inmates	National Estimated Prevalence rates in the Corrections
Hypertension	92 6.7%	18.3%
Diabetes	26 1.9%	4.8 %**
Asthma	13 .09%	8.5%

This comparison illustrates the high the numbers of inmates with chronic illness that may be housed at Pierce County Correctional Facility. It underscores the importance of having excellent screening at booking as previously discussed and a full health assessment within 14 days of an inmate's admission.

Review of the booking sheets: We looked at chronic diseases among our sample of 17 patients to determine if they were identified at booking. In total the 17 patients had 43 chronic illnesses. Eighteen of these illnesses were not documented as being identified in booking. Among the 18 illnesses not identified were Hyperlipidemia, Asthma, Hypertension and Diabetes.

We also looked at six inmates to compare medical issues identified on their booking forms with and what was identified in a subsequent health care follow-up. (Illustration 2). This review also suggests that chronic and acute health problems are being missed in booking or there is

failure to chart the information either on the booking form or in the EMR. For example the first patient had no identified health problems in booking, yet one month later was diagnosed with asthma. For other patients their mental illness was not identified on the booking sheet, yet within a few days after booking their mental illness was documented. Clearly this speaks to the good assessment skills of nurses and providers after booking but it again suggests a weak-screening system at booking . We believe this is directly related to the poor screening conditions including lack of privacy for officers and nurses.

Illustration 2

Patient: Booked 4/06/10 Negative screen – Nothing Identified 5/07/10 DX of Asthma, (Records 4/06-4/27 missing

Patient: Booked 4/18/10 Booking Screening: Hypertension, Asthma, and foot surgery 2 weeks ago. No medications started. Clinic visit 4/20/10 Urgent visit due to respiratory distress. Clinic visit 4/22/10 Diagnosed with GERD Clinic visit 5/13/10 Diagnosed with Depression

Patient: Booked 9/20/08 Booking Screening: COPD, Asthma, Dementia, chronic pain . Clinic visit Diagnosed with of Depression Clinic visit 10/28/08 10/28/0 Gives history of HX of Aortic valve replacement

Patient: Booked 6/26/10 Booking Screening: HTN, Alcohol and Drug use daily. Patient states only problem withdrawing is BP goes up. Question W/D protocol. Clinics visit 6/28/10 Diagnosed with HTN, Polysubstance abuse. Hospital-ER 6/28/10 HTN and unusual blood work.

Patient: Booked 6/05/10 Booking Screening: Stroke, Bipolar, Clinics visit 6/08/10 diagnosed with HTN, Hyperlipidemia, Migraines, Depression, GERD, and CVA.

Patient: Booked 6/01/10 Booking Screening: Diabetes, HTN, Depression, (Area on Mental Health, Substance abuse, and Medications area not completed.)Clinic visit 6/03/10 diagnosed with history of hypelipidemia, Depression and HX of alcohol abuse X 5 years

Another concern impacting chronic care, monitoring of alcohol and other drug withdrawal and mental health referrals is the fact that the booking sheet is scanned into the computer on an average of 3 days after booking. Therefore the information documented on the booking sheet is not available to the provider, clinic nurse and/or mental health team. This time frame is even longer when the office assistant assigned to medical records is pulled to cover another position for a person on leave. Reportedly one position was recently cut from medical records section. On the day of the audit there was a man booked on 7/10. He was assessed as suicidal on 7/14 as of 7/27 his booking sheet is still not in the electronic record.

Recommendations

1. The screening process for chronic illness is modified to provide a more aggressive and effective identification of chronic health problems inmates. We recommend that the facility follow the NCCHC 2008 standards for receiving screening and initial health assessments. This is actually not a large change from the current practice but it focuses the initial screening on a comprehensive in-dept screening and then the referral of only inmates with clinically significant findings for an initial health assessment.

2. A system is developed that renews chronic care medications automatically, consistent with community standards and does not depend on the inmate submitting a kite to restart the medications.

Continuous Quality Improvement Program

Policy: The facility has two CQI committees in place, an External Committee and a Internal Committee. The committee was formed to meet the requirements of the Herrera vs. Pierce County described in NO-C95-5025-FDB stipulated order and final judgment . This committee includes participation of physicians who are well qualified and familiar with accepted practices and community standards in the Tacoma/Pierce County medical community. Dr. Anthony Chen (Tacoma-Pierce County Health Department, Dr. Jeffery Smith (Tacoma County Community Health & Dr. Miguel Ballerina (responsible physician at the Pierce County Correctional Facility.

The facility policy governing the external committee describes their purpose & procedures as follows:

> *The committee will review all mortality cases as well as medical cases identified by medical staff for evaluation of quality and appropriateness of the diagnostic and treatment procedures, adequacy of treatment plans and appropriateness of outside consults and follow up care.*
> *The committee will advise the internal CQI program as requested on clinical situations and findings.*
> *The committee will meet at a minimum 3 times per year or more frequent as deemed necessary.*
> *In the event that one of the committee members is unable to attend the meeting, the member will be provided the documentation discussed at that particular meeting for his or her review and comments.*

The Internal Committee includes the Medical Director, one Physicians Assistant, the Health Services Administrator, the Nursing Supervisor and the Mental Health Director. The policy on this committee is currently under revision.

Progress of the External and Internal QI committees to date
(External Committee)
We saw documentation that the external committee has convened twice 12/21/09 & 3/22/10 and heard that they had also met in July 2010. Minutes were kept of the first two meetings and we have requested copies of the third meeting. All members were present at the first two meetings except Dr. Smith. However, email communication on 6/16/10 and 4/14/10 verifies his subsequent input to these meetings. We spoke with Dr. Smith and he confirms his participation in the this committee.

Topics at the 12/21 meeting included: 1) Alcohol withdrawal screening forms, 2) Two patient case reviews (one death review and one patient with a major mental disorder, substance abuse and seizures during withdrawal.

Recommendations/Actions included: 1) Agreement on the need to use a standardized tool for better monitoring of patients with alcohol withdrawal scale integrated on nursing from , 2) A standardized protocol to have the AD unit checked on a regular basis as well as having medical staff attend in-service to keep technique current (advised already done), 3) Patients on medications for W/D syndrome need close f/u by medical clinician, e.g. mental health patients on W/D protocol and 4) Medical staff could benefit from training to increase the awareness of usual course of alcohol withdrawal and usual timeframe that withdrawal symptoms may appear (advised already done).

Topics at the 3/22 meeting included: 1) Three patient case reviews (1 mortality review, 1 person with end-stage liver disease and 1 person with a major mental illness and multiple medical complications).
Recommendations/Actions included: 1) Patient #2 be reviewed by a pharmacological consultant & perhaps refer to pain management if pain continues to be a clinical concern & the jail should look into the possibility of hospice care for this patient. 2) Suggested the jail medical provider speak directly to the ER doctor when sending acute cases to ER so that all concerns are addressed (e.g. sepsis in a inmate with acute mental illness), 3) Staff need to look into forced/involuntary protocol so that treatment can be administered to mentally challenged or mentally incapacitated inmates.

(Internal Committee)
The Internal committee met on 3/6/10 and 7/08/10 as documented by minutes of both meetings. Present at both meetings were Vince Goldsmith (HSA), Mary Scott (Nursing Supervisor), Dr. Miguel Balderrama (Medical Director), Judy Snow (MHD)and Lana Dao (medical records assistant).

The topics discussed at the 3/16/10 meeting were: 1) A recent suicide 2) Policy revisions for Access to Care, Non-emergent Health Care Requests and Services and Inmates with Alcohol and other Drug Problems 3) The results of a random chart Audit on nursing assessments for patients on ETOH withdrawal. The audit found that 70% of 1st nursing assessments on EOTH W/D patients were done in a span of greater than 10 hours. Discussion was that they were in court, moved or simply refused.

Recommendations/actions made by the committee included: 1) Copies of new policies will be finalized and put in manual, 2) Agreement to randomly audit why inmates refuse sick call and to present at next meeting and 3) Alcohol w/d screening questionnaire and sample nursing triage check list were provided to be incorporated into this audit.

The topics discussed at the 7/8/10 meeting included: 1) Implementation of a chronic care pop up window in the EMR that is available to clinic providers 2) The results of chart reviews on patients with chronic illnesses. There was discussion on concerns regarding evaluation of diabetic retinopathy & lipid control where scores were low due to factors like length of stay at the jail and compliance with medical management. Also discussed was recent implementation and use of peak flow as tool for asthma/COPD management assessment, 2) The results of nursing audits on grievances, segregation rounds, kite training and alcohol withdrawal screening :

Access to Care: all grievances were reviewed & none had substantial reason to support the claim.

Segregation Rounds: the results were very impressive; the charting was good in all cases. We have a very good core group of nurses who are assigned to this task.

Kite Triaging: in reviewing the charts, Mary found that there were some inmates whose problems were not addressed timely. This discrepancy mainly resulted from our being in two different sites, inmate moved and kites were not moved to the new location promptly. Vince suggested that it can be made into a directive to have the kite nurses in both jails to communicate when there is a medically reasonable reason to have a particular inmate seen in the new location. The kites can also be faxed over.

Alcohol Withdrawal Screening: currently it takes the nurses time in screening these inmates due to there scattered housing. It would be much easier to have these inmates centralized in one unit this is an idea that will continue to explore. The scores are still not optimal on nursing monitoring but are improving now that we have more cooperation with custody staff. We explained the importance of reducing refusals and no shows to the clinic for VS monitoring. Unfortunately there are still factors out of our control like when the patient goes to court.. Mary continues to monitor very closely this process

3) The result of audits on the timeliness of mental health kites in June: In June, there were 19 kites received more than one day later and 119 kites were not date-stamped by the clinic. It was also requested the booking nurses to also make a notation in the behavior tab in LINX when there is a suicidal arrestee at booking.

Recommendations /Actions included: 1) Dr. Balderrama will work with group on the use of the peak flow assessment in this clinical setting, 2) New directive / procedures were recommended

for kite management (see kite triaging above), 3) Nursing Supervisor continue to audit nursing monitoring of inmates on withdrawal protocol, 3) Nurses make a notation on behavior tab in LINK denoting that a suicidal arrestee is in booking.

Audit Process: The audit process included a review of the activities of both committees against standards of quality assurance in corrections. Essentially we looked at the minutes and polices of these committees to determine if the facility had established a continuous system for review of the health care system from booking to release that employs quality assurance practices consistent with current standards of care in corrections. Among them are: 1) Multidisciplinary teams that meet at least 4 times a year to design quality improvement monitoring activities, discuss results and implement corrective actions for each discipline 2) Use of data for problem analysis, 3) Involvement of responsible physician re; identifying problems and thresholds and interpretation data and solving problems ,4) A corrective action process that includes identification of problem effecting health & mental health care, a plan to address the problem, and a process to monitor results and demonstration of improvement .

Findings: An essential component of Quality Improvement, the corrective action process, is not adequate .

The facility is making progress with their quality assurance efforts and has implemented both an external and an internal committee. They have a multidisciplinary approach, which includes leadership from the responsible physician and involvement of outside physicians. They meet regularly and keep minutes. They have also use audits and chart reviews to collect data for health care problem analysis. However the corrective action process in which their recommendations are implemented and studied to ensure effective resolutions is in the early stages of implementation . For example the CQI committee has identified ETOH monitoring when an inmate goes to court as a problem. The next step is to identify solutions followed by implementation and study of their effectiveness. Another example of a problem for this committee to develop a corrective action plan is on inmate refusals of clinic services.

Recommendations:

1. The CQI committee will develop and implement a corrective action plan that addresses a problem identified by the CQI committee and monitors its effective resolution of the problem (the studies identified in the recommendations in this report will be sufficient for this recommendation).

2. The Health Services Administrator is to submit a report to the Court Monitor by December 1, 2010 describing how each of the recommendations in this report was implemented and their outcome.

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August 9, 2010
Honorable Robert J. Bryan
Honorable J. Kelley Arnold
United States Courthouse
1717 Pacific Avenue, Room 3100
Tacoma, WA 98402-3200

Re: Court Monitors Report: Herrera vs. Pierce County

Dear Judge Bryan and Judge Arnold:

Enclosed is our report on the ten remaining issues in Herrera vs. Pierce County .

We have sent our report to the medical and mental health administration at the Detention Center. We have incorporated some their comments. However we are still in disagreement regarding four areas: Medical Health Care Requests(Kites), Refusal of Care, Privacy of Nursing Interviews at Reception and Management of Alcohol withdrawal.

We have made recommendations to resolve our disagreements. We feel they could be in place in a short timeframe if all parties agree.

They have requested the names of the patients associated with our chart reviews . We will send this information to them.

There is also a question regarding the Court's intent for Quality Improvement. They are making a great progress in this area and have implemented the requirements of the initial Court Order. However they have not sufficiently demonstrated one of the most essential components of quality Improvement, the corrective action process. This was not specified in the court order but it is a community standard for quality improvement

Please contact me if you have any questions

Sincerely,
Judith F. Cox