ARIZONA DEPARTMENT OF CORRECTIONS
HEALTH SERVICES CONTRACT MONITORING BUREAU
MEMORANDUM

TO: Arthur Gross

THROUGH: Richard Pratt

FROM: Vanessa Headstream

DATE: March 2013

SUBJECT: ASPC-Perryville status update

March 4, 2013 –

- reviewed charts @ ASPC Perryville IPC unit
    - MAR review demonstrates:
        - missing documentation of medication delivery (#[redacted] 03/02/13 @ 2100, #[redacted] 03/01/13 @ 0800, #[redacted] 03/03/13 @ 1800)
        - medication documented as "refused" has no refusal forms found in I/M medical record (#[redacted] on 03/01/13, 03/02/13, 03/03/13, 03/04/13)
        - start &/or stop dates are not documented for medications (#[redacted], #[redacted], #[redacted], #[redacted])
        - ordering Provider is not documented (#[redacted], #[redacted], #[redacted], #[redacted])
        - medications ordered 02/28/13 documented as "not available" (#[redacted]), ordered 01/22/13 documented as "not available" (#[redacted]
    - Tool/Sharp/Narcotics Inventory -
        - Controlled substance counts are not consistently conducted beginning/end of shift (02/24/13 has no end of shift count)
        - Tool/sharp counts are not consistently conducted beginning/end of shift (02/14/13, 02/21/13, 02/26/13, 02/27/13, 02/28/13). Count times are documented several hours after shift changes occur.
        - A controlled substance sign-out sheet was found in the narcotic book, I/M is no longer housed in IPC (#[redacted] 12/28/12)
    - Medical Records –
        - Charts are in disarray, paperwork is misfiled in all 6 medical files in the IPC; consults and lab results are with SOAPE notes, SOAPE notes are not in chronological date order, missing admit/discharge form (#[redacted]), no fall risk assessment forms completed in any of the IPC files, #[redacted]'s hospital d/c form filed in #[redacted] medical file
        - SOAPE notes are not signed by the nurse providing care (#[redacted] 03/03/13 @ 1940, #[redacted] 03/03/13 @ 0800, #[redacted] 02/26/13 @ 0800, #[redacted] 02/26/13 @ 0900, #[redacted] 02/21/13 @ 0700)
        - Vital signs not documented on SOAPE assessment (#[redacted] 02/28/13 @ no time shown, and 02/22/13 @ 0810)
        - Care plans are not utilized in patient treatment

        - Provider orders not noted (#[redacted] 02/28/13, #[redacted] 02/26/13)
        - #[redacted] – a high-risk twin pregnancy; provider order written 02/21/13 for fetal heart tones every 6 hours on each baby, no documentation of FHT monitoring was found in the medical file, OB pregnancy information sheet has not been updated since 02/11/13
        - #[redacted] – provider order written 02/26/13 for urine dip testing twice a week; one result completed on the date of the order was found in the medical file
- Reviewed charts @ ASPC-Perryville Complex
    - #[redacted] – HNR dated 02/21/13 date/time stamped 02/26/13, has not been responded to by nursing
    - #[redacted] – presented to medical for dressing changes on 03/02/13 & 03/03/13, no vital signs documented by nursing
    - #[redacted] – ICS response for seizure activity 03/02/13, no NAP/ERO utilized
    - #[redacted] – response to self harm with injury 03/02/13, no NAP/ERO utilized; placed on continuous suicide watch & allowed to keep an ace wrap on person
    - #[redacted] – response to sports injury 03/02/13, no NAP/ERO utilized; SNO & medications issued without orders
    - 26 HNRs dated 02/21/13 to 02/26/13 date/time stamped 03/01/13 still in Santa Cruz unit mailbox

March 6, 2013

- Reviewed Complex treatment room –
    - Tool/sharp counts are not consistently completed, or are not documented as completed, on a daily basis. Inventory counts are not done at beginning/end of shift per policy
    - QA checks were well documented as completed, i.e. refrigerator logs, glucometer checks
    - RDSA storage is neat and well organized
    - No oxygen available (canisters in hallway are all empty)
- Reviewed San Pedro –
    - Chronic care patient review of charts
        - 13 charts were reviewed, 4 are past their chronic visit date (#[redacted], #[redacted], #[redacted], #[redacted])
    - Provider review charts – 26 pending review of lab results, consult reports, nurse line referrals and nurse line appointment sign-offs dating back to 01/30/13
    - Medical Records -
        - #[redacted] – had a PL appointment 03/05/13, documents "awaiting xray report of hand", upon review of previous entries could not find an order for xray, contacted xray tech and he had no requisition to do an xray
        - HNRs do not consistently have a triage date/time stamp on them (#[redacted], #[redacted])
        - HNRs are not consistently scheduled for evaluation within the allowed timeframe (#[redacted] triage 03/01/13, scheduled PL 03/07/13; #[redacted] triage not signed, scheduled PL 03/13/13; #[redacted] triage 02/28/13, scheduled NL 03/01/13 & 03/04/13)
        - #[redacted] – NL evaluation 03/03/13 for minor sprain, NAP #26 utilized, an ace bandage was given to the inmate per NAP, no medical device accountability form completed, SNO provided was incorrectly signed by nurse, NAP #26 should be documented as Provider with the nurse co-signing
        - #[redacted] – NL evaluation 02/07/13 for wound, NAP #5 utilized, medical ice was issued by nurse for 3 days. SNO issued for medical ice, not authorized under NAP given
        - #[redacted] – NL evaluation 03/01/13 for wound, NAP #5 utilized, medical ice was issued by nurse for 3 days. SNO issued for medical ice and non-duty; not authorized under NAP

given. Follow up visit 03/04/13 demonstrates inmate was given another SNO for medical ice x 3 days; not authorized by NAP or provider order
    - #[redacted] – NL evaluation for knee swelling, no NAP utilized, SNO given for medical ice, not authorized by NAP or provider order
    - #[redacted] – incomplete refusal form, no consequences of refusal documented
    - #[redacted] – ICS response for unresponsive, no NAP/ERO utilized; SOAP documentation states "inmate says she can remember looking out the window, then my vision went dark, and I passed out", "c/o back pain and pain on back of head"; no C-spine cautions utilized, SNO for medical ice given, not authorized by NAP or provider order
    - #[redacted] – HNR dated 02/28/13 with triage date/time of 03/01/13 c/o "chest pressure, and real nauseated" scheduled for NL appointment 03/04/13, EKG demonstrated PACs and PVCs, patient has past cardiac history
  - Medication room –
    - Tools/sharps inventory are not consistently completed beginning/end of shift per policy and several entries do not have co-signature entered
    - RDSA inventory is not consistently completed daily
    - Refrigerator temperature log not completed daily, February is still on the refrigerator door
    - Insulin opened and not dated, Lantus and 70/30
    - 26 outdated medications (stop dates of 10/2012 through 02/28/13) found in filing cabinet used for DOT delivery
    - Multiple MARs with med errors noted, 25 copied demonstrate:
      - "no show" documented
      - Missing initials/blank dates (doses not administered)
      - Dose circled with no explanation why not administered
      - "not available" (medication not administered)
      - No start/stop date shown on MAR ([redacted], #[redacted], #[redacted])
      - No diagnosis or allergies shown on MAR (#[redacted], #[redacted])
      - Nurse initials on MAR do not have corresponding signature

March 7, 2013

- Complex nursing station – 0840
  - 35 HNRs are in the Santa Cruz mailbox with triage date of 03/06/13
- Reviewed San Carlos -
  - Chronic care patient review of charts
    - 16 charts were reviewed, 8 are past their chronic visit date (#[redacted], #[redacted], #[redacted], #[redacted], #[redacted], #[redacted], #[redacted], #[redacted])
  - Provider review charts – 141 pending review of lab results, consult reports, nurse line referrals and nurse line appointment sign-offs dating back to 01/2013
  - Medical Records –
    - Multiple charts with misfiled paperwork, i.e. HNR/consult report/wound care flow sheet/SNO filed in Progress Note section, minor surgery consents filed in consults, nurse SOAPE notes not filed and placed on top of right inside cover
    - #[redacted] – NL evaluation 02/19/13 for c/o knee pain, no NAP/ERO utilized, referral to PL, no f/u evaluation documented; SNO for light duty issued without provider or NAP authorization
    - #[redacted] – NL evaluation 02/28/13 for eye exam with visual acuity >20/40, no referral to optometry documented (provider signed off nurse note 03/01/13)

        - #[redacted] – NL evaluation 01/28/13 for eye exam with visual acuity >20/40, no referral to optometry documented (provider signed off nurse note 03/01/13)
        - #[redacted] – ICS response "passed out" 02/13/13, documents inmate "hit head", no C-spine precautions utilized (provider signed off nurse note 03/01/13)
        - #[redacted] – NL evaluation 02/06/13 for c/o back pain, no NAP utilized
    - Medication Room –
        - Tools/sharps inventory log not consistently completed beginning/end of shift
        - Refrigerator temperature log not completed daily
        - Insulin opened and not dated (Humulin R, Lantus, Novolin R)
        - 21 outdated medications found in KOP bins, #[redacted] Doxycycline (antibiotic)
        - 1 outdated medication found in DOT bin currently being administered by nursing
        - Multiple MARs found with med errors noted, 3 copied demonstrate:
            - Missing initials/blank dates (doses not administered)
            - Nurse initials on MAR do not have corresponding signature

March 19, 2013 –

- Reviewed charts @ ASPC Perryville Brent Lumley unit
    - Chronic Care –
        - 16 charts were reviewed, 7 were found to be non-compliant with f/u appointments (#[redacted], #[redacted], #[redacted], #[redacted], #[redacted], #[redacted], #[redacted])
- Staffing –
    - No desk nurse onsite, the scheduled nurse was pulled to San Carlos and not replaced
    - One med nurse onsite, the am med pass had not been started at 1100 hours
    - The assigned supervisor picks up the unit mail at Complex each morning for delivery to the unit, at 1130 the paperwork had not been received on the unit
- Medication Room –
    - Temperature log not documented daily
    - 5 cards of outdated meds found, med nurse notified
    - MARs incomplete as follows:
        - missing diagnosis (#[redacted], #[redacted], #[redacted], #[redacted], #[redacted], #[redacted])
        - 9 MARs from 28 yd documented "N/A" for medications ordered
            - #[redacted] – 03/06/13, 03/07/13, 03/08/13
            - #[redacted] – 03/17/13, 03/18/13
            - #[redacted] – 03/14/13 thru 03/19/13
            - #[redacted] – 03/14/13 thru 03/19/13
            - #[redacted] – 03/18/13, 03/19/13
            - #[redacted] – 03/11/13, 03/12/13
            - #[redacted] – 03/12/13 thru 03/18/13
            - #[redacted] – 03/14/13 thru 03/18/13
            - #[redacted] – 03/14/13, 03/15/13
        - No doses documented since ordered 03/15/13 - #[redacted]
        - 1 MAR documented "No show" (#[redacted]) 03/07/13
        - 15 MARs from 30 yd documented "N/A" for medications ordered
        - 2 MARs from 30 yd missing documentation of medications delivered (#[redacted], #[redacted])
- QA & Inventory –
    - OB Bag inventory check has not been documented since February 14, 2013; documentation prior

to that date was inconsistent
    - Mandown Bag inventory check has not been documented since February 28, 2013; documentation prior to that date was inconsistent
    - Daily glucometer calibration/check has not been documented since February 13, 2013
    - Daily tool/sharps counts are not conducted or documented per policy

March 22, 2013 –

- Reviewed Santa Maria unit –
- Medication Room –
    - 9 outdated medications found in currently used DOT med bins/drawers, unit supervisor notified of findings
    - MARs –
        - 35 noted with incomplete information, i.e. missing dates of administration, no diagnosis, no allergies, no start/stop date given, "no show" for administration, nurse initials do not have correlating signature on the MAR
- QA & Inventory –
    - Log indicates compliance with inventory and QA checks

- Reviewed charts @ Santa Cruz unit –
    - Chronic care –
        - 17 charts were reviewed, 8 were found to be non-compliant with f/u appointments (#[inmate], #[inmate], #[inmate], #[inmate], #[inmate], #[inmate], #[inmate], #[inmate])
    - Many of the charts reviewed contain misfiled paperwork, i.e. SNO, diet orders, and consult reports filed with SOAPE notes
    - 45 charts are on a shelf pending provider review
- Medication Room –
    - 22 outdated medications found in currently used DOT med bins/drawers, unit supervisor notified of findings
    - No refrigerator temperature log available for review, unit supervisor instructed the med nurse to begin monitoring the refrigerator temperature today
- MARs –
    - Books not available for review, the med nurse was signing the am med pass MARs around 1130, when I checked back at 1340, the med nurse was conducting another med pass
- QA & Inventory –
    - Daily glucometer calibration/checks are not being conducted or documented consistently
    - Mandown/OB bag lock checks are not being conducted or documented consistently

- Reviewed Insulin MARs from San Carlos unit –
    - 9 MARs reviewed with the following found;
        - #[inmate] – no nurse initials or dose written for Reg s/s coverage 03/13/13 pm or 03/21/13 pm
        - #[inmate] – no injection site written on 03/05/13, 03/14/13, 03/19/13 for Reg insulin given; no nurse initials or dose written for Reg s/s coverage 03/21/13 pm; no injection site written on 03/13/13, 03/14/13, 03/20/13 for Levemir insulin given; no documentation of Levemir administration on 03/20/13, 03/21/13 pm
        - #[inmate] – incomplete administration information for Levemir 03/18/13, 03/21/13 pm
        - #[inmate] – no documentation of Reg insulin administration 03/11/13, 03/14/13 pm

- #[redacted] – no documentation of Humulin N administration 03/02/13 pm
- #[redacted] - Regular insulin sliding scale coverage is documented as Humulin N 03/06/13, 03/21/13 am; 03/03/13, 03/05/13, 03/07/13 pm

March 26, 2013 –

IPC unit – At approximately 0945 am the IPC nursing station door was propped open, the nurse and aide were in other rooms of the unit not visible from the nurse's station, the officer was in the control room behind a closed door. The accucheck machine and lancets were laying on the bookcase in front of the open door, inmate medications were lying on a stack of charts to the right just inside the door, 7 large boxes of unsecured medications are stacked on the floor of the nurse's station and 1 large box of unsecured medications is sitting on the refrigerator.

- Reviewed charts @ IPC unit –
  - #[redacted] – nursing assessment SOAPE note not dated or time noted, no vital signs documented; 03/25/13 2000-0300 nursing SOAPE notes not signed by nurse; SOAPE note from 03/20/13 filed in "Flow Sheet" section of chart, flow sheets filed in "Progress Note" section of chart
  - #[redacted] – nursing assessment SOAPE note 03/22/13 @ 1008 & 03/23/13 @ 1045 no vital signs documented; 03/25/13 1900-0500 nursing SOAPE notes not signed by nurse; flow sheets filed in "Progress Notes" section of chart
  - #[redacted] – nursing assessment SOAPE note 03/22/13 @ 1015 & 2000 no vital signs documented; 03/24/13 @ 1000 no vital signs documented; 03/25/13 2000-0300 nursing SOAPE notes not signed by nurse; flow sheets/NFDR filed in "Progress Notes" section of chart; I/M has a PICC line in her (R) upper chest, nursing assessment documentation indicates placement in "RUE" (right upper extremity) – 03/17/13, 03/22/13, & 03/25/13
  - Care plans not utilized for patient treatment, a notebook with pre-printed care plans is available in the nursing station
- Medication Room –
  - Temperature log not documented daily
  - 26 cards of outdated meds currently being utilized found in med cabinet, med nurse notified
  - A MDV of Hydroxyzine was open in the med cabinet, not dated
  - MARs incomplete as follows:
    - missing dates of administration (#[redacted], #[redacted], #[redacted], #[redacted])
    - no start/stop date for prescription documented (#[redacted], #[redacted], #[redacted], #[redacted])
    - no diagnosis documented (#[redacted])
    - labs/tests not documented as completed (#[redacted], #[redacted], #[redacted], #[redacted])
    - **03/20/13 - Lasix 60 mg IV ordered once not given (#[redacted])**
    - Furosemide 20mg documented "N/A" 03/16/13 & 03/17/13 (#[redacted])
    - Loratidine 10mg documented "N/A" 03/01/13 to 03/12/13 (#[redacted])
    - Magnesium Oxide 250mg documented "N/A" 03/01/13 to 03/20/13 (#[redacted])
- QA & Inventory –
  - Daily glucometer calibration/check has not been documented
  - Daily refrigerator temperature log not conducted or documented
  - Daily tool/sharps counts are not conducted or documented per policy

- Reviewed @ Complex
- Consults/Reports
  - 4 Urgent offsite consults submitted 03/21/13 have no response documented –

        - #[redacted] – high-risk pregnancy, I/M sent out to hospital 03/26/13
        - #[redacted] – c/s cervix, Ca in-situ of cervix
        - #[redacted] – C-section @ 39 wks, previous C-section hx, at time of consult 36 wk IUP
        - #[redacted] – targeted OB u/s for marginal placentia previa, transverse/breech presentation, at time of consult 30 wk IUP
    - Optometry form dated 11/23/12 has a sticky note "need referral" (#[redacted])
    - U/S report received 02/20/12 signed off by provider 03/21/13 (#[redacted])
    - 2 consult reports received 03/06/13 not signed off by provider (#[redacted], #[redacted])
    - 5 xray reports received 03/19/13 not signed off by provider (#[redacted], #[redacted], #[redacted], #[redacted], #[redacted])
    - 4 mammography reports dated 11/23/12 (#[redacted]) & 02/15/13 (#[redacted], #[redacted], #[redacted]) not signed off by provider
    - 2 mammography referrals dated 03/11/13 returned to the provider for re-submission on a new form remain in the provider box unprocessed (#[redacted], #[redacted])
    - #[redacted] – H & P report from TSL dated 03/07/13, received 03/15/13 requesting surgical consult, labs, etc. has not been signed off by a provider
- Reviewed @ San Carlos –
    - +/- 106 medical charts remain on the shelves for provider review of labs, nurse line appointments, consult reports, etc.

March 27, 2013 –
- Reviewed Complex Tools/Sharps log
    - Tools inventory log missing pages from book with dates from 03/11/13 after 0845 through 03/17/13 @ 1930
    - Sharps/needles inventory log missing pages from book with dates from 03/08/13 after 1700 through 03/22/13 @ 0825
    - Locked (blue tag) cabinet lock log missing pages from 03/01/13 through 03/27/13 – one page with today's date is the only page currently in the book. I made copies on 03/05/13 of previous entries that are now not located in the inventory book
- Reviewed San Carlos unit –
    - Medication Room –
        - 28 outdated med cards, both DOT and KOP, were found in the bins; med nurses notified
    - Tool/Sharps Inventory
        - The only log page in the inventory book starts 03/21/13 @ 1640, documentation indicates counts are not consistently completed at the beginning/end of shift as per policy:
            - 03/23/13 – missing beginning shift count
            - 03/24/13 – missing beginning shift count

March 29, 2013 –
- Reviewed Complex Medical –
    - An opened envelope labeled "medical records" was in the San Carlos chart bin, inside were copies of MARs, dental xrays, and lab results. After review of the papers, only the lab results were relative to Perryville, the other papers were male inmates. The paperwork was given to DON Jasinsky for forwarding to the proper locations.
- Medical Records -
    - 4 charts were in the Santa Maria/Piestewa/Santa Rosa chart bin with provider orders written 03/28/13 not noted by nursing. The orders include referral to outside specialist (#[redacted]), 6 month f/u (#[redacted]), 3 month f/u (#[redacted]), medications & SNO, 3 month f/u (#[redacted]).

- #[redacted] - a note written by the provider indicates he prescribed medication last week but the inmate has not received the medication

- HNRs –
  - #[redacted] – HNR triage date 03/28/13; c/o being out of medications – pharmacy profile indicates meds refilled 03/25/13
  - #[redacted] – HNR triage date 03/28/13; c/o being out of medications – pharmacy profile indicates meds have not been refilled, submitted for refill 03/29/13
  - #[redacted] – HNR triage date 03/28/13; c/o being out of medications – pharmacy profile indicates one was filled 03/23/13, remaining medications submitted for refills 03/29/13
  - #[redacted] – HNR triage date 03/26/13; c/o being out of medications – pharmacy profile indicates some filled 03/08/13, 03/23/13, & 03/25/13. Remaining 3 medications submitted for refill 03/27/13