



**THIRD SEMI-ANNUAL REPORT OF THE
INDEPENDENT MONITOR OF THE MEMORANDUM
OF AGREEMENT BETWEEN THE UNITED STATES
DEPARTMENT OF JUSTICE AND THE STATE OF
DELAWARE REGARDING THE DELORES J. BAYLOR
WOMEN'S CORRECTIONAL INSTITUTION, THE
DELAWARE CORRECTIONAL CENTER, THE
HOWARD R. YOUNG CORRECTIONAL INSTITUTION
AND THE SUSSEX CORRECTIONAL INSTITUTION**

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EXECUTIVE SUMMARY

This is the Third Report submitted pursuant to the MOA³ and the Monitoring Agreement,⁴ covering the period from January 1, 2008 through June 30, 2008. During this monitoring period, the Monitoring Team⁵ has visited each of the Facilities⁶ on multiple occasions in order to provide technical assistance and conduct monitoring. In order to monitor the State's compliance with the provisions of the MOA, the Monitoring Team conducted interviews of leadership and staff of Delaware Department of Correction ("DOC") and Correctional Medical Services ("CMS"),⁷ and inmates housed in the Facilities.⁸ In addition, the Monitoring Team has reviewed numerous medical records at each facility. All of these materials, in connection with the observations that the Monitoring Team made while on site at the Facilities, form the basis of the compliance assessments⁹ contained in this Report.

The compliance assessments made in this report regarding the State's compliance with the provisions of the MOA are made by consensus of the Monitoring Team, which means that the Monitoring Team reviews the evidence and determines whether the evidence shows substantial, partial or noncompliance with a provision of the MOA. The State and the DOJ continue to discuss the approach to be used in the future with regard to measuring the State's

³ The "MOA" refers to the Memorandum of Agreement between the United States Department of Justice ("DOJ") and the State of Delaware (the "State") regarding the Delores J. Baylor Women's Correctional Institution, the Delaware Correctional Center, the Howard R. Young Correctional Institution, and the Sussex Correctional Institution, which was entered into on December 29, 2006. The MOA is available at http://www.deprisonmonitor.org/pdf/delaware_prisons_moa_12-29-06.pdf.

⁴ The "Monitor Agreement" refers to the Agreement between Joshua W. Martin III (the "Monitor") Individually and on Behalf of Potter Anderson & Corroon LLP and the State of Delaware, which was entered into on May 14, 2007 (the "Monitor Agreement").

⁵ The Monitor has retained a team of medical and mental health experts. The Monitor, together with the medical and mental health experts and other attorneys, are hereinafter referred to as the "Monitoring Team."

⁶ The term "Facilities" refers to the Delores J. Baylor Women's Correctional Institution ("Baylor"), the Delaware Correctional Center ("DCC"), the Howard R. Young Correctional Institution ("HRYCI"), and the Sussex Correctional Institution ("SCI").

⁷ CMS is a private contractor that has been providing medical and mental health care services at the Facilities since it took over the prior vendor's contract on July 1, 2005. The CMS website is available at <http://www.cmsstl.com>.

⁸ The Monitoring Team also has received unsolicited information from inmates, their families, advocates, community groups and other external sources, which has been taken into consideration.

⁹ For those provisions of the MOA for which the Monitoring Team made an assessment, there are three different compliance assessments possible: substantial compliance, partial compliance, and non-compliance. These compliance assessments will be explained at greater length in the introduction to the report.

compliance with the provisions of the MOA. Specifically, during this monitoring cycle, the parties agreed to sampling techniques to be used by the Monitoring Team with regard to several medical health provisions. These techniques will be implemented and used during the next reporting cycle. The parties are still working to develop techniques with respect to certain mental health provisions, and expect to resolve this issue prior to the recommencement of monitoring in August 2008. Furthermore, the parties have worked to identify with greater precision the relevant universe of documents to be reviewed. Prior to the Monitoring Team's visit to a site, it serves upon DOC an explicit list of documents that it anticipates reviewing during its visit. The DOC will then take steps to have these documents ready for review upon the Monitoring Team's arrival, if not prior to that date.

Summary of Findings

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

As will be seen throughout this report, while CMS has made efforts and has had some success in filling leadership positions, there has continued to be significant turnover in those positions. For the most part, those individuals filling the leadership positions have not yet had enough time in those positions for their influence to be seen in results of this report because consistent and effective leadership is necessary to implement the processes required by the MOA.

The Monitoring Team also has found that many of the Facilities have improved with respect to the timeliness of certain intake processes. That progress is noted in the Monitoring Team's findings. Now that the State has begun to have greater success in this area, the Monitoring Team believes that the State can make even more progress toward ensuring the accuracy and adequacy of these functions.

The Monitoring Team finds that the State has made some improvement with respect to sanitation. These improvements are found primarily at HRYCI and Baylor. Sanitation at DCC and SCI still needs improvement.

Summary of State's Compliance

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

- The Monitoring Team found that Baylor is in substantial compliance with thirteen of the provisions; in partial compliance with thirty-five of the provisions; and in non-

compliance with six provisions. The Monitoring Team did not assess Baylor with respect to one of the provisions because there was nothing to assess for that provision.

- The Monitoring Team found that DCC is in substantial compliance with seven of the provisions; in partial compliance with thirty-eight of the provisions; and in non-compliance with seven provisions. The Monitoring Team did not assess DCC with respect to two of the provisions because there was nothing to assess for those provisions.
- The Monitoring Team found that HRYCI is in substantial compliance with seven of the provisions; in partial compliance with forty-two of the provisions; and in non-compliance with three provisions. The Monitoring Team did not assess HRYCI with respect to two of the provisions because there was nothing to assess for those provisions.
- The Monitoring Team found that SCI is in substantial compliance with ten of provisions; in partial compliance with thirty-six of the provisions; and in non-compliance with six provisions. The Monitoring Team did not assess SCI with respect to two of the provisions because there was nothing to assess for those provisions.

While the number of provisions for which the State has reached substantial compliance has increased only slightly, this should not be taken as an indication that the State has not made any progress since the Second Semi-Annual Report (the “Second Report”). In this report, approximately seventy provisions which were not assessed for various reasons in the Second Report have now been assessed. For almost all of these provisions, the State is in partial compliance. As is discussed in the Introduction, a partial compliance rating covers a wide range of performance. Although for some provisions the State has received a partial compliance rating in both this and the Second Report, this does not mean that the State has not made any improvements. To the contrary, in many situations, the State has made progress, but still has some work to do before achieving a substantial compliance rating. In order to gain a complete understanding of the progress made by the State, the reader must look past the assessment itself and review the findings made for each provision by the Monitoring Team.

Additionally, there were some recommendations made in the Second Report, which the State has been unable to implement due to budgetary issues. As the State moves into a new budget cycle, the Monitoring Team hopes that the State will now be able to implement some of these recommendations. Similarly, the State has developed plans to address certain problems raised in the Second Report concerning privacy and clinic space issues, and has begun to implement those plans. The Monitoring Team looks forward to seeing the results of the State’s work in these areas during the next reporting cycle.

While the State needs to continue improving, the Monitoring Team notes that during the time period between the first report and this report, the State has completed a number of tasks, which are relevant to its obligations under the MOA, including the following:

- Released the second of its semi-annual Compliance Reports on January 30, 2008, and the third of these reports on June 23, 2008;¹⁰
- Drafted new and/or revised policies after consulting with the Monitoring Team, and submitted those policies to the DOJ;
- Started, in cooperation with CMS, drafting local operating procedures in order to fully implement the policies; and
- Has received approval for some plans to ameliorate the privacy and clinic space concerns highlighted in the report.

The Monitoring Team

During this monitoring period, the Monitoring Team added two new members. The following is a collection of brief biographies for each of the experts, including the two new members:

Ronald Shansky, M.D.

Dr. Shansky has over three decades of experience auditing or investigating health care facilities in correctional facilities. He has experience in jails and prisons and in both the federal system, state systems, local jails and in the District of Columbia system.

Dr. Shansky has worked with the DOJ in reviewing programs in such states as Alabama, Mississippi, and Georgia. He has also monitored programs for the courts in other jurisdictions such as New Jersey, Wisconsin, and Ohio

Dr. Shansky graduated from the University of Wisconsin with a Bachelor of Science and received his Doctor of Medicine from the Medical College of Wisconsin. Additionally, Dr. Shansky received a Master of Public Health from the University of Illinois School of Public Health. He has a special focus on improving the quality of correctional health services and is an expert on chronic care diseases.

Dr. Shansky currently resides in Illinois.

Lynn Sander, M.D., FACP, FSCP, CCHP

Dr. Sander, a board certified internist, joined the Monitoring Team in the third reporting cycle. Dr. Sander has over two decades of experience with health care in correctional

¹⁰ The State is required to report its progress toward implementing its Action Plan, which was issued on April 5, 2007. See MOA ¶¶ 65, 66. The State issued its latest compliance report on June 23, 2008. The State's next semi-annual Compliance Report is scheduled to be issued on or about December 29, 2008. These Compliance Reports can be found at:

<http://doc.delaware.gov/information/Prison%20Health%20Care.shtml>

facilities. Her experience includes nineteen years caring for inmates of the Denver Sherriff Department first as Director of Medical Services and then as Departmental Medical Director. She spent three years working as the Corporate Medical Director for Correctional Healthcare Management. Dr. Sander is also a member of several professional organizations and is a Fellow of both the Society of Correctional Physicians and the American College of Physicians. She served as the President of the Society of Correctional Physicians from 2005-2007 and is currently serving as Immediate Past-President and Editor of Corrdocs.

Dr. Sander graduated from the University of Vermont with a Bachelor of Arts, and received her Doctor of Medicine from Boston University School of Medicine. She currently resides in Colorado.

Madeleine LaMarre, MN, FPN-BC

Ms. LaMarre is a board certified family nurse practitioner, and has over twenty years of experience working in the Georgia Department of Corrections. She was the Nursing Director of the Georgia Department of Corrections for over a decade, and was the Statewide Clinical Services Manager for an additional nine years. Ms. LaMarre also has been appointed a medical expert in the states of California and Ohio.

Ms. LaMarre has authored numerous publications on health care related issues in correctional facilities. She received her Master of Nursing from Emory University, and her Bachelor of Science in Nursing from Russell Sage College. Ms. LaMarre currently resides in Georgia.

Mary Ellen Lane, BSN, MBA

Ms. Lane, along with Dr. Sander, joined the team during this third reporting cycle. She is a registered nurse, and has over twenty years of experience in the health care industry. She was employed as a Clinical Services Consultant in the Georgia Department of Corrections, and also was the Health Service Administrator at Walpole State Prison in Massachusetts.

Ms. Lane received a Master of Business Administration from Bryant College, and her Bachelor of Science in Nursing from Boston College. She currently resides in Georgia.

Jeffrey Metzner, M.D.

Dr. Metzner is a board certified forensic psychiatrist with extensive experience over the last twenty five years, much of which has included working for the courts monitoring mental health programs in prisons and jails. Specifically, he has served as a monitor in some capacity in facilities in New York, Puerto Rico, Kansas, Ohio, California, Illinois, Georgia, Montana, Washington, Florida, and New Mexico.

Dr. Metzner has written numerous articles and portions of books covering mental health services in the correctional facility setting. He received his Bachelor of Science from the

University of Maryland, and received his Doctor of Medicine from the University of Maryland Medical School. Dr. Metzner currently resides in Colorado.

Roberta Stellman, M.D., DABPN, CCHP, DFAPA

Dr. Stellman is also a board certified psychiatrist with previous experience in the correctional facility setting. Dr. Stellman also serves as Compliance Monitor for Behavioral Health Services for a facility in Albuquerque, New Mexico. She has also spent over 17 years working in facilities in New Mexico as a Clinical Psychiatrist. She has also monitored and reviewed correctional systems in Arizona, Florida, Texas, and Massachusetts.

Dr. Stellman received her Doctor of Medicine from the State University of New York. She completed her residency at the University of New Mexico and currently resides in New Mexico.

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INTRODUCTION

The First Semi-Annual Report of the Independent Monitor for the State of Delaware Department of Correction was published on June 29, 2007, and represented a preliminary overview of the Monitor's duties, and summaries of the Monitor's first observations regarding the State's compliance with the MOA.¹¹ The Second Semi-Annual Report (the "Second Report") was published on January 31, 2008. This report represented the Monitoring Team's first opportunity to conduct and report on monitoring of the Facilities and was designed to serve as a baseline against which the State's future improvement will be compared.

In this Third Semi-Annual Report (the "Third Report"), the Monitoring Team continues to report on its monitoring of the Facilities. Specifically, this Report takes note of improvements made by the State since the Second Report. However, it will also describe the many significant hurdles the State must overcome to come into full compliance with the MOA.

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

During this monitoring period, the Monitoring Team's visits to the Facilities occurred between February and May 2008. The Monitoring Team visited each Facility at least twice during that time; the medical and nursing experts would visit a given Facility once to monitor the provision of medical and nursing services, and the mental health experts would visit a given Facility once to monitor the provision of mental health services at the Facility. Each visit lasted three to five days.

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

¹¹ Previous reports can be found on the Monitor's website, at the following address: www.deprisonmonitor.org. The website contains an overview of the Monitor's role, and links to press releases and reports. All future reports will be posted on the website.

Definition of Assessment Ratings

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

- The term “substantial compliance” shall mean that the State has satisfied the requirements of all components of the assessed MOA provision. If the State has sustained substantial compliance with all provisions of the MOA for a period of one year, then the State may submit a written request to the DOJ for early termination of the MOA. *See* MOA ¶ 60. The DOJ will determine whether the State has, in fact, maintained substantial compliance for the one year period. *Id.* Otherwise, the MOA is designed to terminate after three years from December 29, 2006. *See* MOA ¶¶ 59 and 60. Non-compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance will not constitute failure to maintain substantial compliance. *See* MOA ¶ 60. At the same time, temporary compliance during a period of sustained non-compliance shall not constitute substantial compliance. *Id.*
- The term “partial compliance” shall mean that the State has achieved less than substantial compliance with all of the components of a rated provision of the MOA, but has made some progress toward substantial compliance on most of the key components of the rated provision. A partial compliance rating encompasses a wide range of performance by the State. Specifically, a partial compliance rating can signify that that the State is nearly in substantial compliance, or it can mean that the State is only slightly above a non-compliance rating.
- The term “non-compliance” shall mean that the State has made negligible or no progress toward compliance with all of the components of the MOA provisions being assessed.

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

Overview of Third Report

The Third Report, like the Second Report, generally follows the format of the MOA, which is organized into three distinct substantive areas: (1) Medical and Mental Health; (2) Suicide Prevention; and (3) Quality Assurance.¹² The Third Report mirrors that format, and

¹² *See* MOA ¶ 65 (defining Sections III through V as the “Substantive Provisions” of the MOA).

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

- a summary of the particular MOA requirements;
- discussion, as appropriate, of any applicable generally accepted professional standards which relate to the MOA provision;¹³
- key findings made by the Monitoring Team;
- an assessment of the State's compliance with the relevant provision;
- recommendations, if any, to assist the State in achieving substantial compliance with the provision.¹⁴

¹³ In this report, the monitor has cited to both NCCHC standards (or other appropriate standards). For informational purposes, this report cites to the NCCHC standards that were in effect at the time the parties entered into the MOA. The NCCHC published a revised version of its standards in 2008. For information about the 2008 Revisions, including summaries of the major changes to the NCCHC Standards please see http://www.ncchc.org/resources/2008_standards/intro.html. The 2008 Revisions do include some substantive changes. For instance, P-E-04 now permits certain facilities to not conduct an initial health assessment on all new intakes, and instead provides an alternative. However, this revision does not comport with provision 12 of the MOA, which requires all newly admitted inmates to receive health assessments within one or two weeks of intake, depending upon whether they have a chronic illness.

¹⁴ Recommendations included in this Report are in the nature of technical assistance and do not represent an obligation of the DOC pursuant to the MOA. The Monitoring Team believes, however, that if the State is able to enact its recommendations, the State's success in achieving substantial compliance with the MOA will be enhanced.

MEDICAL AND MENTAL HEALTH CARE

1. Standard

A. Relevant MOA Provision

Paragraph 1 of the MOA provides:

The State shall ensure that services to address the serious medical and mental health needs of all inmates meet generally accepted professional standards.¹⁵

This provision of the MOA requires that the State provide services in all of the areas set forth in the MOA according to generally accepted professional standards, including but not limited to, the standards promulgated by the National Commission on Correctional Health Care (“NCCHC”) for prisons and for jails. The Facilities are all used both as jails¹⁶ and as prisons.¹⁷ For the most part, the NCCHC standards for jails and prisons are the same; however, there are some notable differences based upon the different functions served by a jail versus a prison, especially with regard to intake procedures. (*See e.g.*, discussion of provision 10) As the

¹⁵ According to section II.C. of the MOA, “generally accepted professional standards” means:

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

¹⁶ A “jail” is, “a detention facility where accused persons are detained until their alleged crime is adjudicated before a jury or judge.” Joseph E. Paris, Ph.D., M.D., CCHP, FSCP, *Interaction Between Correctional Staff and Health Care Providers in the Delivery of Medical Care, in Clinical Practice in Correctional Medicine* (Michael Puisis, D.O. ed., 2006). Thus, “[f]or the most part, persons in jails are not yet convicted of a crime, although some jails also house those serving misdemeanor terms (1 year or less) as well as those serving county jail time as condition of felony probation.” *Id.*

¹⁷ A “prison” is a “facilit[y] where persons are incarcerated as punishment for crimes for which they have been convicted.” Joseph E. Paris, Ph.D., M.D., CCHP, FSCP, *Interaction Between Correctional Staff and Health Care Providers in the Delivery of Medical Care, in Clinical Practice in Correctional Medicine* (Michael Puisis, D.O. ed., 2006).

DOJ has acknowledged in the MOA, the NCCHC has adopted separate standards for prisons and for jails.¹⁸

B. Assessment

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

C. Findings

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

2. Policies and Procedures

A. Relevant MOA Provision

Paragraph 2 of the MOA provides:

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

This provision of the MOA requires that the State have policies¹⁹ and procedures²⁰ in place to address vital procedural steps in providing appropriate medical and mental health care for inmates, and is meant to ensure that these policies and procedures are readily available to relevant staff. According to NCCHC standards, policies and procedures should be facility-specific. J-A-05; P-A-05.

¹⁸ Unless otherwise noted, all references in the format of “J-__-__” shall refer to standards from the *Standards for Health Services in Jails*, National Commission on Correctional Health Care (2003). Likewise, unless otherwise noted, all references in the format of “P-__-__” shall refer to standards from the *Standards for Health Services in Prisons*, National Commission on Correctional Health Care (2003).

¹⁹ A “policy” is defined by the NCCHC as “a facility’s official position on a particular issue related to an organization’s operations.” J-A-05; P-A-05.

²⁰ A “procedure” is defined by the NCCHC as “describ[ing] in detail, sometimes in sequence, how a policy is to be carried out.” J-A-05; P-A-05.

B. Assessment

The Monitoring Team found that the State is in partial compliance with this provision of the MOA due to the lack of Facility-specific procedures.

C. Findings

As described in the Second Report, the State had a substantially complete set of policies which had been approved by the DOJ as of November 6, 2007. The State still needed to draft or revise a number of mental health related policies, and has submitted a number of draft mental health policies to the Monitoring Team for comment. The Monitoring Team has provided some feedback. These policies relate to such topics as telepsychiatry, inmates placed in isolation, and suicide prevention. The Monitoring Team anticipates that once its comments are implemented, the State will submit these draft policies to the DOJ for approval.

The Monitoring Team believes that the absence of local operating procedures in the Facilities contributes to continued systemic problems, such as substantial delays in inmate access to advanced level providers,²¹ and the processing of medications. The Monitoring Team has received a rough draft of Facility-specific operating procedures that are going to be used to implement the State's policies at each of the Facilities. Those procedures require a great deal of revision, however. The State and CMS are working towards a good working draft of these procedures, which will be submitted to the Monitoring Team and the DOJ for review, comment, and approval.

D. Recommendations

The Monitoring Team recommends that CMS leadership at the facility-level and the State Office of Health Services ("OHS") complete the process of drafting local operating procedures, and submit them to the Monitoring Team for review and comment after the parties have agreed to the Local Operating Procedures ("LOP").

The Monitoring Team further recommends that the State establish a policy and procedure template that will enable the health care leadership at each of the Facilities to provide sufficient and uniform direction to staff as to how they are to implement policies and procedures. The template should combine the procedure with the policy.

In addition, each policy and procedure manual should have a current table of contents and health care leadership signature page that indicates the date of effectiveness of the policies and annual revision date.

As the policies are those of the Delaware Department of Correction ("DOC"), they should be published under the letterhead of the DOC and not CMS.

²¹ The term "advanced level providers" refers to physicians, physicians' assistants, and nurse practitioners.

When finalized, health care leadership should provide training to staff and make policy and procedure manuals readily available to staff.

3. Record-Keeping

A. Relevant MOA Provision

Paragraph 3 of the MOA provides:

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

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

- identifying information (*e.g.*, name, identification number, date of birth, gender);
- problem list containing medical and mental health diagnoses and treatment as well as known allergies;
- receiving screening and health assessment forms (*see* discussion of provisions 10 and 12 of the MOA);
- progress notes of all significant findings, diagnoses, treatments, and dispositions;
- provider orders for prescribed medication;
- medication administration records ("MARs");

- reports of laboratory, x-ray, and diagnostic studies;
- flow sheets;
- consent and refusal forms;
- release of information forms;
- results of specialty consultations and off-site referrals;
- discharge summaries of hospitalizations and other inpatient stays;
- special needs treatment plan, if applicable;
- immunization records, if applicable;
- place, date, and time of each clinical encounter; and
- signature and title of each documenter.

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

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

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

The DOC uses a paper medical records system, rather than electronic medical records. However, some information generated for the paper record is initially recorded in the Delaware Automated Correctional System (“DACS”).²² DACS contains multiple “modules,”

²² The State began working with the DACS software vendor in April 2006 to improve 178 medical module functions. (See DOC Action Plan, Section II.3a). The DOC implemented these upgrades on

and is used by the DOC for many non-medical tasks. Although DACS contains a medical module, the DOC reports that it was not designed to be (and has not been) used as an electronic medical record. Until recently, the DACS medical module was used mostly for certain intake and scheduling tasks.

In the Second Report, the Monitoring Team made the following recommendations for each of the Facilities with regard to medical record-keeping: (i) hire a professional medical records staff to provide leadership, supervision, and standardization to medical records policies and procedures; (ii) hire medical records staff dedicated only to that task in order to relieve the nursing staff from that clerical function; (iii) provide standardized inpatient binders sufficient for each bed in the infirmary; (iv) ensure timely, consistent and standardized filing of all documents; (v) ensure that the creation of additional binder volumes for a given inmate results in all necessary documents being moved to the active file; and (vi) self-monitor for timeliness and standardization of filing.

During its visit in April 2008, the Monitoring Team found that the recommendations described above had not been implemented. Of particular note, the Monitoring Team found that the State has not yet hired a credentialed Medical Records Supervisor for the Central Office to supervise and oversee medical records services at the institutions. The Monitoring Team believes that this has a negative impact on the State's ability to be in substantial compliance with this provision of the MOA, because a Medical Records Supervisor at the Central Office can ensure that the Facilities are training medical records personnel appropriately, and that these employees are receiving appropriate supervision and guidance. The State has, however, hired appropriate facility-level medical records staff. As noted later in this report, the State has made some recent progress toward hiring a Medical Record Supervisor for the Central Office.

Although the State is not required to implement the recommendations offered by the Monitoring Team, the Monitoring Team believes that the recommendations regarding this provision of the MOA are especially important for the State to follow in order to ensure compliance with this provision of the MOA. Accordingly, the Monitoring Team reiterates the previous recommendations it made in the Second Report.

October 8, 2007, and reports that training on the upgrades is ongoing. In the Second Report, the Monitoring Team concluded that the DACS upgrades had the potential to assist the state in obtaining more complete health information for inmates' medical records; however, the State should ensure that information collected and maintained in DACS is printed and incorporated in the paper medical record promptly and properly. As will be discussed in this report, DACS has assisted the State somewhat with scheduling and timeliness of certain functions. In addition, the State can use DACS to generate reports for CQI audits. The State must be mindful, however, of the accuracy and reliability of the information that is put into DACS by staff, and ensure that staff is properly trained regarding the appropriate use of DACS.

B. Baylor

1. Assessment

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

2. Findings

Appropriateness of Format and Organization of Health Records

The Monitoring Team found that both in policy and practice there is a unified health record, which contains medical, dental and mental health information. With respect to the organization of the health record, the Monitoring Team found that a problem list was visible upon opening the second section of inmates' health records. The Monitoring Team also found that archived health records are bulky and should be purged in accordance with professional standards.

Timeliness of Health Record Filing

The Monitoring Team spoke with staff who estimated the backlog of filing for mental health notes to be approximately six weeks. However, the Monitoring Team toured the health records room, and found a stack of records awaiting filing which was several feet high, and which dated back to 2007. Overall, despite the reported backlogs, the Monitoring Team observed the records to be better organized than they were during visits conducted in the previous monitoring cycle.

Adequacy of Facility and Staff

The Health Records room contains two desks and is very cramped. There is a separate medical records archive room in another part of the institution that is used to store other records, including those that are "to be filed."

There are two staff members dedicated to filing of health records. One is scheduled for the day shift and one for the evening shift.²³ A 0.5 Full-Time Equivalent ("FTE") mental health clerk was hired recently. The Monitoring Team believes that this action will help reduce the backlog of the filing of these notes.

²³ In the Delaware Department of Correction Compliance Report published June 23, 2008 (the "Compliance Report"), DOC indicates that CMS reports that additional temporary staff has been hired to assist each Facility with medical records tasks. Specifically, temporary personnel reportedly provided 320 additional hours at Baylor to assist with the organization of the archive and active medical file rooms.

Adequacy of Tracking Systems

The laboratory and diagnostic test result tracking systems in place at Baylor document the date the test was completed, but not when the report was received. Thus, the facility is unable to determine the time between the receipt of test results and the review of test results.

C. DCC²⁴

1. Assessment

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

2. Findings

Appropriateness of Format and Organization of Health Records

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

Timeliness of Health Record Filing

Medical records staff make a concerted effort to maintain current filing, however, the Monitoring Team found that there are delays in the review²⁵ and filing of health records in a timely manner. Specifically, the Monitoring Team found 62 laboratory test reports dated from April 1 through April 23, 2008, which had not yet been reviewed by a clinician. In another stack of miscellaneous records, the Monitoring Team found documents dated as far back as December 2007 that had not yet been reviewed and filed.

Adequacy of Facility and Staff

The medical records area is poorly designed, cramped, and the floors are not

²⁴ On June 3, 2008, Delaware Governor Ruth Ann Minner signed a bill renaming DCC, the James T. Vaughn Correction Center. For purposes of these reports, the Monitoring Team will continue to refer to the facility as DCC to avoid any confusion for a reader comparing this report to past reports.

²⁵ Many health-related documents, such as laboratory tests results, must be reviewed by a clinician before they are filed. Thus, a clinician failing to review documents on a timely basis can delay filing. On the other hand, if documents are not maintained in a manner so that clinicians are aware of and can find such documents, clinicians cannot timely review such documents. There should be systems in place at each of the Facilities to ensure that clinicians are aware of the receipt of laboratory test results, and review them in a timely fashion. (See discussion of provision 4 of the MOA.)

clean. The shelves where medical records are stored pending filing are not labeled. Therefore, staff members who bring records to be filed may not know where to place the records. For example, staff members were placing reports which had not yet been reviewed by a clinician in a bin marked “To be Filed.” This problem reflects lack of adequate systems and medical records leadership to ensure that all reports are reviewed and filed in a timely manner.

There appears to be adequate number of health records staff, but they are not distributed in the most efficient manner possible. Medical records staff are on duty from 3:30 a.m. to 4:30 p.m., and there are no medical records staff assigned to the evening shift when clinical and nursing staffs still see patients. The Monitoring Team recommends that medical records staff be scheduled to be on-site up until 10:00 p.m. each evening.

Adequacy of Health Record Retrieval Systems

There is an “out guide” system for health records that is actively used. An “out guide” is a system to account for the whereabouts of a health record that has been taken out of the files for use.

For the most part, mental health staff reported reasonable access to healthcare records within the facility.²⁶ The one reported exception was the Security Housing Unit (“SHU”) where staff reported frequent problems with gaining access to records. Staff was not able to identify the reasons these problems existed.

The Monitoring Team found that CMS meets periodically with security at the facility to have night shift nurses track inmate transfers, and move their health records and medications at the same time. However, this system is problematic because records and medications frequently are not following the transferred inmate in a timely manner. The Monitoring Team confirmed this problem through interviews with psychiatrists who practice at DCC.

The Monitoring Team was informed that a tracking system is being developed by DCC personnel. This system was scheduled to be set up as a tracking tool during the next Continuous Quality Improvement (“CQI”) Committee meeting which followed the Monitoring Team’s visit.²⁷

D. HRYCI

1. Assessment

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

²⁶ The Monitoring Team did not specifically interview medical clinicians at DCC about this same point.

²⁷ CQI is addressed more specifically in the discussion of MOA provision 54.

2. Findings

In general, the Monitoring Team found significant improvements in record keeping at HRYCI since the Second Report. For instance, current and archived health records have been relocated to other areas of the facility. Specifically, this change has resulted in increased access to these health records and better use of existing space. For example, archived health records have been moved from the administrative area to the booking area where they are more readily available when inmates return to the facility.

Appropriateness of Format and Organization of Health Records

With respect to the formatting of the health record, the Monitoring Team found that the facility maintains unified health records that contain medical, dental and mental health information. With respect to organization of the health record, the Monitoring Team found that a problem list was visible upon opening the second section of the health record, and it appears that efforts were being made to note the patient's active medical problems. However, the patient's mental health diagnoses were not consistently noted.

The Monitoring Team also found that documents containing similar information related to the patient's care were not filed in the same sections in chronological order. For example, nursing sick call notes and clinician progress notes relating to the same complaints were filed in different sections of the record, making it difficult to follow the patient's care chronologically. Chronic disease forms are also filed in their own section and not chronologically with other related information.

Timeliness of Health Record Filing

For the pretrial detainees held in the west side of the facility, medical records filing appeared to be up to date. For the sentenced inmates held in the east side of the facility, there was a loose filing stack which was approximately 2-1/2 inches thick, reflecting documents that were about four to six weeks old.

The Monitoring Team found an average delay of six to seven days from the time that laboratory reports were available until they were reviewed by a clinician. The Monitoring Team further found isolated cases in which laboratory or diagnostic reports were not initialed as having been reviewed by a clinician at all. This topic will be addressed at greater length in the discussion of provision 4 of the MOA.

Adequacy of Facility and Staff

The new Director of Nursing ("DON") has appointed a licensed practical nurse ("LPN") to be responsible for monitoring the transcription of physician orders, and tracking the completion of laboratory tests, diagnostic procedures (excluding consultations) and related reports. Another staff person is responsible for scheduling the consultations and specialty

appointments and related reports.

Adequacy of Tracking Systems

The Monitoring Team found that there is no system for tracking laboratory specimens that are sent out to a reference laboratory, nor is there a tracking system for the dates the facility receives laboratory reports. In addition, there is a tracking system for performing x-ray procedures; however, the log was not complete at the time of the Monitoring Team's visit. Specifically, the x-ray log is not maintained to show whether the ordered x-ray has been performed nor does it have a column to reflect the date the report is received. For example, on May 4, 2008, a chest x-ray designated as high priority was ordered for a patient who complained of coughing up blood. The column that showed the date the patient was seen was left blank, and, although a staff member informed the Monitoring Team that the chest x-ray was obtained, there was no space on the log to show when the report was received.

Adequacy of Health Record Retrieval Systems

The Monitoring Team believes that timely access to the medical records was reported to have improved significantly. Clinicians have access to records about 80% of the time according to the administrative and line staffs. Mental health staff does their own filing and records were reasonably organized. Any backlog in filing is no more than a few days unless the record is not available, in which case the unfiled notes are placed in an "out guide" sleeve. However, these unfiled notes are usually returned to the mental health office for filing rather than the medical records clerk entering them when the medical record is returned to their area. This process is problematic because it can result in lost entries, filing in incorrect sections of the record, and a significant delay in filing essential material.

E. SCI

1. Assessment

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

2. Findings

Appropriateness of Format and Organization of Health Records

The Monitoring Team found that the State has developed and implemented a unitary record-keeping system at SCI. The unitary record-keeping system does not yet ensure timely and adequate documentation of assessments and treatment, or adequate and timely access by medical and mental health care staff.

Timeliness of Health Record Filing

The Monitoring Team found that although there were only four inches of medical documents pending to be filed, many of those documents were dated from December 2007 through February 2008, indicating that these health records are not filed in a timely manner. The Monitoring Team also found that MARs for Keep on Person (“KOP”) medications²⁸ are kept in the medication room and may not be filed for up to a year.

Adequacy of Facility and Staff

At SCI, there are two medical records clerks, one of whom is assigned to the Maximum Security Building (“MSB”), and one of whom is assigned to the pretrial unit. The MSB medical records clerk has several responsibilities other than health record maintenance, which makes it difficult for her to keep up with filing.

The Monitoring Team also found that inmate medical records at SCI are not maintained in a sufficiently confidential manner. Specifically, in the MSB at SCI, the health records are stored in unlocked filing cabinets in the main clinic where inmates and officers circulate. There are also open desks in this area in which medical records await to be filed.

Adequacy of Tracking Systems

The State needs to implement more efficient medical records tracking systems. SCI has an “out guide”, but staff reported that it is not consistently and reliably used.

In addition to the “out guide”, there is a laboratory test log that is supposed to track laboratory tests sent out to the laboratory, but staff does not complete the section documenting receipt of laboratory reports. In order for the laboratory test log to be sufficient, it should document the date the clinician made the order for the laboratory test, the date staff drew the laboratory sample, the date the Facility received the laboratory report containing test results, and the date on which a clinician reviewed the laboratory report.

The Monitoring Team found that when laboratory and hospital reports arrive at the facility, staff insert the report in the health record and place the record in a cabinet for physician review. However, there were seven to ten day delays from the time a laboratory report was received until it was signed as being reviewed by a clinician. It is not clear whether this delay is because there was a delay in making the report available to the clinician or because clinicians did not review the reports timely, or both. The Monitoring Team found instances in which hospital and procedure reports sometimes were filed in the health record without having been reviewed by a clinician. This lack of review presents a risk that clinicians will be unaware of patients with abnormal diagnostic or laboratory findings, which can cause a delay in diagnosis and treatment.

²⁸ KOP medications are those that inmates are allowed to keep in their cells with them and administer as instructed.

Finally, SCI does not have an adequate system for tracking outside consultations, procedures or hospital reports. The consultation tracking log used to have a column for tracking reports, but it was eliminated.

F. Recommendations

In general, the Monitoring Team recommends that the State fill the regional office medical records director position with a person who has appropriate medical records credentials and who can oversee the medical records program at each institution. This is a vital step that the State and CMS can take to assist with the State's compliance with this provision of the MOA. It appears to the Monitoring Team that, in spite of the importance of this recommendation, there is very little urgency on the part of the State or CMS to hire such a medical records supervisor.²⁹

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

At DCC, the Monitoring Team recommends that the State clean and reorganize the medical records room in order to optimize the use of space and enable better tracking and filing of health records. The Monitoring Team also recommends that health care leadership establish and monitor systems to ensure the tracking, clinical review and filing of all health records (*e.g.*, laboratory and diagnostic reports) in a timely manner. Medical Records staff coverage should be provided for the day and evening shifts when health care staff see patients.

Furthermore at DCC, the Monitoring Team recommends that the State conduct a CQI study in order to address the issue described above concerning records not being transferred with inmates in a timely manner. Finally, the State should take steps to identify why mental health staff is having problems accessing records in the SHU and take steps to rectify this problem.

At HRYCI, the Monitoring Team recommends that health care leadership establish and monitor systems to ensure the tracking, clinical review and filing of all health records occur in a timely manner. The State should implement tracking systems (*e.g.*, laboratory, diagnostic and consultation) that document not only when the procedure was performed, but when the report of the results was received. Additionally, clinicians should continue to actively update problem lists. Furthermore, the Monitoring Team recommends that the State work to eliminate the east side population filing backlog of the east side inmates' health records and monitor the timeliness of filing for both populations. Finally, the State should address problems associated with the "out guide" system, so that the potential for delays and lost

²⁹ The State has informed the Monitoring Team that this position has been made a part of the contract amendment between CMS and the DOC, which was signed on July 1, 2008. The State and CMS are taking action to fill this position.

entries can be eliminated.

At SCI, the Monitoring Team recommends that the State hire a credentialed medical records supervisor in order to oversee site medical records services. Also, when the medical unit is renovated, the State should ensure that a sufficiently-sized and secure medical records room is dedicated or built, which can accommodate health records and staff associated with health record maintenance. The health care leadership (*i.e.*, Health Services Administrator (“HSA”), DON and Medical Director) should ensure that the health record tracking system is utilized by all staff. They should also develop and implement a system to ensure timely review and filing of laboratory, diagnostic and hospital reports. Furthermore, the clinicians must review laboratory, diagnostic and hospital reports in a timely manner and document appropriate action as clinically indicated. Additionally, MARs for nurse-administered medications should be filed monthly so they are available to clinicians for review. MARs for KOP medications should be filed at least quarterly. Finally, the Monitoring Team believes that the appropriate staffing allocation for health records maintenance is 3.0 FTE medical records staff.

Finally, at Baylor and SCI, the Monitoring Team recommends that the State implement the recommendations from the Second Report.

4. Medication and Laboratory Orders

A. Relevant MOA Provision

Paragraph 4 of the MOA provides:

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

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

As this provision impacts the provision of adequate medical and mental health care, the major focus is on laboratory orders used to monitor the level of various medications in inmates’ blood. For instance, lithium has serious side effects if the lithium levels in an inmate’s

blood become too high. As a result, regular testing of inmates on medications such as lithium is necessary as a safety precaution, and to ensure that a mental health professional is aware of the current medication levels before seeing an inmate, so that proper adjustments to the medication dosage can be made if necessary.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team evaluated compliance with this provision by reviewing: (a) policies and procedures related to this area; and (b) records selected from various service areas (e.g., sick call, chronic disease management, medications) to determine whether medications and laboratory orders were transcribed and implemented in a timely manner.

In only three out of thirteen health records containing medication orders did the nurse transcribe the order within four hours; the remaining ten orders were transcribed the following day.³⁰ In four out of the thirteen records, the Monitoring Team found transcription errors. These errors included failure to discontinue a medication, failure to transcribe new medications onto the MAR, and failure to transcribe start and stop dates. In another record, PharmaCor³¹ printed an incorrect medication dosage onto the MAR, which resulted in a patient not receiving the prescribed increased dosage of blood pressure medication for two weeks. The failure to accurately transcribe and implement medication and laboratory orders in a timely manner may lead to patient harm by failing to diagnose and treat conditions in a timely manner. Medication errors can result in serious adverse events; for example, giving too high a dose of blood thinner (warfarin) may lead to life-threatening bleeding.

In three of the ten sick call records reviewed (see *infra*), results for sexually transmitted infection tests and a chest x-ray were not contained in the patient's record. It is unclear whether the tests were obtained but not filed, or simply not obtained at all.³² In a fourth record, a nurse signed off on orders for antibiotics, but the medications were not ordered and the medication not begun for seven days.

³⁰ The Monitoring Team found in its review of HIV care that one patient's laboratory orders were not transcribed for 30 days.

³¹ PharmaCor is the pharmaceutical provider used by the State.

³² The Monitoring Team notes that the laboratory tracking systems at Baylor do not record the date that the report was received, which contributes to an inability to identify which point in the system is breaking down.

In four out of five HIV records reviewed, disease-specific laboratory test results (*i.e.*, CD4 count and viral load) were not performed and filed in the record at the time of the chronic care clinic.³³

In assessing this provision of the MOA for issues impacting the provision of adequate mental health services, the Monitoring Team reviewed twenty records of inmates on the mental health caseload who had been prescribed Depakene, lithium, carbamazepine, or Clozaril. The Monitoring Team observed that in two out of nineteen records (11%), it appeared that laboratory specimens were not drawn in a timely manner.³⁴ For instance, one inmate was prescribed lithium in October 2007. The only laboratory test for this inmate's lithium blood level was ordered two weeks after the prescription for lithium. Although it is customary practice to check lithium levels on a weekly basis until a therapeutic medication level is reached, the first recorded lithium level was over two weeks later and reported levels that were lower than the therapeutic level. In another example, laboratory orders for an inmate were written on March 18, 2008, but the laboratory specimen was not drawn until April 25, 2008.

In cases where abnormal reports occurred, they were examined by medical staff who recorded appropriate actions on the laboratory form itself.

The Monitoring Team found that problems with obtaining laboratory results have arisen due to a lack of availability of phlebotomists.³⁵ According to the DON at Baylor, who informed the Monitoring Team of this problem, a corrective action plan has been initiated to resolve this problem.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team found that the review and filing of laboratory reports is not occurring in a timely manner. The Monitoring Team found approximately 60 laboratory reports from April 2008, in which there was an average delay of six to seven days from the date of the

³³ In one case, the reason was that the physician ordered the wrong test.

³⁴ The Monitoring team did discern from the health records that laboratory studies were eventually performed, or at least there was a notation in the records when the laboratory specimen could not be or was not drawn.

³⁵ A phlebotomist is an individual trained to draw blood, either for laboratory tests or blood donations.

report until a clinician documented review of the report (*see* discussion of provision 3 of the MOA). The Monitoring Team attempted to determine the cause of this delay, and was informed by medical records staff that they do not receive laboratory and radiology reports on a daily basis, but did not know the reason.

With regard to the application of this provision of the MOA to mental health services, the Monitoring Team found that there has been significant improvement in the timeliness of laboratory tests being ordered and drawn, with over 90% of laboratory tests ordered being drawn in a timely fashion. Although there are still some problems with blood work ordered being drawn within one week, there has been significant improvement in this area as well.

The Monitoring Team observed problems with laboratory test results being filed in the health records in a timely manner. Additionally, the Monitoring Team's review of eleven records revealed several problems with laboratory orders not being conducted in a timely fashion. For instance, in one case a physician order had still not been carried out two months after the order was issued. In another case, an order for a transferred inmate, which had been written prior to the transfer to DCC, did not occur despite a written record note prompting DCC staff to do so.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed ten health records in order to evaluate this provision of the MOA. In three of ten cases, the physician orders were not transcribed in a timely manner (range from one to fourteen days), and one was not transcribed at all. Such delays or failures can result in clinical problems. For example, in one case, a patient continued to receive the same dose of a blood thinner even after his blood test showed that he was at risk for bleeding and the physician changed the dosage. Another patient with a wrist fracture did not receive a follow-up x-ray on time, and an x-ray performed two months later showed a displaced fracture.

The Monitoring Team also found that in four of the ten records, the physician's order either was not implemented, or was implemented but the results were not in the health record. Further, in four out of the ten records, the laboratory report was not reviewed by clinician on a timely basis. Specifically, three reports had been reviewed five to six days from date on which the report was available, and one report did not appear to have been reviewed at all. In two out of the ten records, the laboratory report showed abnormal test results in which the patient was neither notified nor provided treatment for the abnormal tests. Finally, in two records, the patients' medication order expired and was not renewed in a timely manner. In one

of those cases, a nurse continued to provide the patient prescription medication beyond the date the medication expired. Thus, the nurse was providing prescription medication to the patient without a valid order.

The new DON has appointed a nurse to oversee the transcription of physician orders. The Monitoring Team anticipates that this will improve both the timeliness and reliability of order transcription.

With regard to the application of this provision of the MOA to mental health services, the Monitoring Team noted a slight increase in the frequency of laboratory studies being ordered, but the specimens were not drawn in a timely fashion. When studies are ordered, they are often drawn several weeks after the request. For instance, one inmate was placed on Haldol, Depakene, Thorazine, Ativan, and Cogentin, but the only laboratory test ordered was a Depakene (valproic acid) level test two weeks later. Furthermore, there was no indication in this inmate's record that the laboratory specimen was drawn, nor were any laboratory test results listed in his record. There were also numerous health records where an inmate was placed on lithium but lithium levels were not checked with adequate frequency.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team found that SCI continues to have serious problems with the timely transcription and implementation of physician orders, such as those prescribing medications, or those requesting laboratory tests.

With respect to timeliness, SCI does not have a reliable system for the timely transcription of orders. The Monitoring Team found that in four out of ten MARs reviewed, the physician had dated but not timed the order. Only one of those ten records reflected that the physician's order had been transcribed on the same day it had been written. In the remaining nine records, the transcription delays ranged typically from one to four days, and in some cases longer.³⁶ This type of transcription delay results in systemic delays in obtaining medications and laboratory tests.³⁷ Specifically, four out of the ten records reviewed demonstrated that the

³⁶ In most cases, a four to eight hour period of time between the clinician giving the order and the order being transcribed is reasonable.

³⁷ The Monitoring Team notes that in some cases, the medication or laboratory test was never obtained.

medication ordered was not administered to the inmate within 24 hours³⁸ and, in one case, the medication was not administered to the inmate until five days after the order was written.

The Monitoring Team also found that nurses do not transcribe new orders onto the MAR for nurse administered medications on a consistent basis. Each MAR should contain for each order a notation of the date the physician ordered the medication, the date the inmate started taking the medication, and the date on which the medication order is to expire. The nursing staff frequently did not document the physician order date.

In addition, the Monitoring Team found that nurses also did not transcribe each medication order onto the MAR as a new order. For example, if a physician wrote a medication refill order, the nurse often crossed out the old dates on the MAR, and overwrote the new dates on the MAR. This defaces a previous order and should not be done. Further, this practice increases the risk of transcription error when the dosing or frequency of a medication may be changed.

The Monitoring Team found that there were problems with regard to the timeliness of drawing of blood for laboratory tests, particularly when the laboratory tests were not ordered on an emergency basis or with a scheduled time frame, such as prior to the next chronic care visit. In fact, the site Medical Director estimated that for routine non-specifically scheduled laboratory orders, the time frame was approximately 30 days. The blood draws are all performed at this point by the already overwhelmed nursing staff, which could be contributing to the delay.

With regard to mental health, the Monitoring Team reviewed a total of fifteen records of inmates who were on psychotropic medications requiring monitoring by laboratory testing. The Monitoring Team found that four of these records were deficient, in that the tests were not performed in a reasonable time frame of being ordered.

The Monitoring Team observed that while doctors are doing a better job noting laboratory results in their progress notes, psychiatrists need to increase their monitoring of thyroid functions for those inmates on lithium. Additionally, inmates placed on Depakene should have baseline liver function tests to rule out active liver disease, and those inmates with Hepatitis C should have follow up liver function tests (“LFTs”) when they are placed on Depakene.

F. Recommendations

At each of the Facilities, the Monitoring Team recommends that the State conduct CQI studies to address the untimely collection of laboratory test specimens, especially with regard to drawing blood.

At Baylor, the Monitoring Team recommends the following:

³⁸ The Monitoring Team believes that 24 hours is an acceptable time unless the order indicates sooner.

- The DON should implement a system to ensure timely transcription of physician orders and a mechanism to track the implementation of all physician orders;
- The DON should implement a CQI study with respect to improving the accuracy of medication order transcription (including the services provided by PharmaCor); and
- Clinicians should document briefly their plan to address abnormal laboratory test results in the progress notes to explain the rationale for treatment decisions.

At DCC, the Monitoring Team recommends the following:

- The health care leadership should implement a system to ensure timely transcription of physician orders and a mechanism to track the implementation of all physician orders; and
- The health care leadership should develop a system to ensure that physicians review all laboratory, diagnostic and consultation reports in a timely manner, and that appropriate clinical follow-up occurs.

At HRYCI, the Monitoring Team recommends the following:

- The DON should implement a system to ensure timely transcription of physician orders and a mechanism to track the implementation of all physician orders;
- The health care leadership should develop a system to ensure that physicians review all laboratory, diagnostic and consultation reports in a timely manner, and that appropriate clinical follow-up occurs;
- The health care leadership should develop a system to ensure that patients with chronic diseases receive continuity of their medications; and
- Nurses must refrain from providing KOP medications beyond the expiration date of the medication order.

At SCI, the Monitoring Team makes the following recommendations:

- The HSA, DON and Medical Director must develop a system to ensure that all clinician orders are transcribed in a timely manner according to their urgency.³⁹ Once the system is developed, training should be provided for staff and the system monitored on a daily basis until issues associated with order transcription are resolved. Nurses should transcribe each new order completely. A complete transcription should include the order,

³⁹ For a routine laboratory test order, the generally accepted standard is that four hours is a reasonable amount of time to lapse between the physician making an order and the nurse transcribing the order. In urgent cases, however, the lapse of time should be no more than one hour, and in “stat” cases, the transcription should occur immediately.

and start and stop dates for the order. Nurses should refrain from crossing out the start and stop dates on a previous order, and inserting the new dates, as this practice increases the risk of transcription error and defaces the patient's health record;

- Resources to perform phlebotomy should be reassessed and the possibility of hiring at least a part-time phlebotomist should be considered;
- Routine tests should be drawn within one week of the time of order; and
- Continue to improve on the scheduling of chronic care tests to take place before the chronic care visit so that the results are available for the clinician at the time of the visit.

STAFFING AND TRAINING

5. Job Descriptions and Licensure

A. Relevant MOA Provision

Paragraph 5 of the MOA provides:

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

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

During this monitoring period, the Monitoring Team identified two areas related to this MOA provision which require additional discussion.

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

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

30, 2008. Therefore, the State will be assessed in accordance with the old job descriptions. In the next report, the State will be assessed based upon the revised job descriptions.

Second, with respect to mental health, the Monitoring Team had been critical of the use of unlicensed mental health clinicians at the Facilities, and during its monitoring visits this cycle noted the same problems. Indeed, the Second Report had indicated that the State planned on ensuring that all mental health clinicians were appropriately licensed by December 2008. However, after the monitoring visits for this cycle had been completed, the State informed the Monitoring Team of its belief that mental health clinicians were not required to be licensed under Delaware law.⁴⁰ After a review of the applicable law, it appears the State is correct. Delaware law requires only those who hold themselves out as licensed mental health professionals to hold licenses. *See 24 Del. C. § 3030.* Thus, if one does not hold him or herself out as being licensed, no license is required, but he or she can still provide counseling services.⁴¹ However, the Monitoring Team believes that with respect to unlicensed mental health clinicians, some supervision is required of these individuals. While none of the parties dispute that supervision is required, the parties are currently attempting to work out what standard and levels of supervision are required.

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

6. Staffing

A. Relevant MOA Provision

Paragraph 6 of the MOA provides:

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

⁴⁰ There is no dispute that other mental health professionals, such as psychiatrists and psychologists, need to be licensed.

⁴¹ Although in the minority, Delaware is not the only state to allow unlicensed mental health clinicians to practice. A review of the national scene reveals that Delaware is among 10 states that do not require all mental health clinicians to be licensed. In addition, of the 40 states requiring licenses for mental health clinicians, 21 of those states exempt mental health clinicians employed by state or local governments from licensing requirements, which essentially provides for an outcome that is the same as the Delaware system.

One way to evaluate the adequacy and effectiveness of a Facility's staffing plan is the Facility's ability to meet the health needs of the inmate population. J-C-07; P-C-07. Various factors can be examined to determine the number and type of health care professionals required at a facility, such as the: (i) size of the facility; (ii) types and scope of health services delivered; (iii) needs of the inmate population at the particular facility, and (iv) organizational structure of the facility. *Id.* In addition, two other factors of significance in evaluating the sufficiency of staffing levels are whether a prescribing provider⁴² is available for a sufficient amount of time so as to avoid any unreasonable delay in patients receiving necessary care, and if physician time⁴³ is sufficient to meet both clinical⁴⁴ and administrative responsibilities.⁴⁵ *Id.*

B. Baylor

1. Assessment

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

2. Findings

With respect to nursing, the Monitoring Team found that the nurses are not appropriately assigned responsibilities in accordance with their level of education and training. For example, LPNs are performing sick call when the charge nurse is absent, conducting intake screening, and managing the chronic care clinic. These responsibilities involve nursing assessment and educational skills and are more appropriately assigned to a registered nurse. Moreover, the facility does not appear to have adequate relief coverage for nurse staffing. A more detailed discussion of staffing is included below.

⁴² A "prescribing provider" is defined as "a licensed individual, such as a medical doctor, doctor of osteopathy, nurse practitioner, or physician's assistant, authorized to write prescriptions. J-C-07; P-C-07.

⁴³ Typically, 3.5 hours of physician time per 100 inmates housed at a facility is regarded as the minimum acceptable physician time. J-C-07; P-C-07. Nurse practitioners or physician's assistants may substitute for a portion of the physician's time seeing patients, but must do so under the supervision of a physician. *Id.*; *see generally*, 24 Del. C. § 1772.

⁴⁴ Clinical responsibilities include conducting physical examinations, evaluating and managing parties in clinics, monitoring other providers by reviewing and co-signing records, reviewing laboratory and other diagnostic test results, and developing individual treatment plans. J-C-07; P-C-07.

⁴⁵ Administrative responsibilities include reviewing and approving policies, procedures, protocols, and guidelines, participating in staff meetings, conducting in-service training program, and participating in quality improvement and infection control programs. J-C-07; P-C-07.

Advanced-Level Provider Staffing

Currently, Baylor is allocated 2.0 clinical FTE positions. This includes a 1.0 FTE Medical Director and a 1.0 FTE nurse practitioner (“NP”). The Monitoring Team finds this allocation to be adequate. However, the Medical Director works approximately 0.65 FTEs. Thus, the facility is not receiving the full complement of clinical hours required.

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

Nurse Staffing

Excluding the DON, there are 5.2 FTE registered nurses to cover 24 hours per day, 7 days per week. There are two RNs on the day shift (a charge nurse and infection control nurse), one RN is assigned to cover the evening shift, and one RN is assigned to cover the night shift. The remaining 1.2 RNs are assigned to cover the weekends. This staffing pattern is not adequate because it does not provide for sufficient relief coverage. For example, the charge nurse performs sick call, but when she is absent, sick call may be performed by an LPN.

There are 6.2 LPN positions to cover 24 hours per day, 7 days per week. There are 2 LPNs assigned to the day shift. Their duties include managing the chronic care clinic, medications, intake screening, and other duties such as providing treatments (*e.g.*, blood pressure checks, administering insulin). There are 2 LPNs assigned to the evening shift, and 1 LPN assigned to the night shift. The remaining 1.2 LPNs provide weekend coverage. This staffing pattern is not adequate because it does not provide for sufficient relief coverage.

Other Staffing

There are 2.0 FTE medical assistant positions. One medical assistant provides support to the physician and NP on the day shift, and the other medical assistant is assigned to the night shift. The Monitoring Team finds this level of staffing to be sufficient.

There are 3 administrative support positions. One individual is designated as the consultation coordinator, the other is an administrative assistant. The Monitoring Team finds this level of staffing to be sufficient.

Mental Health Staffing

In April 2008, Baylor lost a 1.0 FTE mental health clinical position at Baylor after CMS moved this clinician to DCC. Additionally, the hours the psychiatrist worked were reduced from 22 hours per week to 16 hours per week. It is unclear what the long term impact of these decreases in mental health allocated positions and hours will be. The Monitoring Team

interviewed inmates in the Harbor House⁴⁶ unit, who complained that approximately one scheduled group counseling session was cancelled each week due to staffing issues. This is an indication that the decreased staffing will not be sufficient.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team evaluated this area by reviewing the staffing allocations assigned to DCC, and the overall adequacy of care provided.

Advanced-Level Provider Staffing

The clinical staffing for the facility is 5.0 FTE. This includes 3 physicians and 2 NPs. The Monitoring Team finds that this staffing allocation most likely is adequate.

Nurse Staffing

The facility clearly has insufficient numbers of both RNs to conduct sick call and intake assessments. The Facility also has insufficient numbers of LPNs to administer medications in a timely manner (see Medication Administration). Both RNs and LPNs perform sick call; however, sick call should be assigned to properly trained RNs.

Mental Health Staffing

With respect to mental health staffing, the Monitoring Team does not believe that the current staffing levels are sufficient to provide care for inmates' serious medical and mental health needs in a manner that meets generally accepted professional standards. Currently, the infirmary is regularly staffed by only two different psychiatrists on a two day per week basis. In other words, the infirmary has psychiatrist coverage on only two out of seven days per week. This coverage is not adequate.

⁴⁶ Harbor House is the housing area for inmates with special mental health needs. Harbor House is a housing unit for women with serious mental health illnesses and women who have been court ordered to this program for various reasons related to their mental health issues.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team evaluated this area by reviewing budgeted staff allocations assigned to the facility, vacancy rates, and the overall adequacy of care provided. The Monitoring Team found that the facility most likely has adequate clinical staffing, but has insufficient numbers of RNs to conduct sick call and intake assessments, and insufficient numbers of LPNs to administer medications in a timely manner.

Advanced-Level Provider Staffing

With respect to primary care clinical staffing, HRYCI currently has 4.6 clinical FTEs comprised of 1.0 FTE Medical Director, 1.6 FTE physician and 2.0 FTE NPs.

Although the total clinical hours may be a sufficient allocation for the facility as a whole, the Monitoring Team has concerns about how clinical staff is distributed and utilized.⁴⁷ For example, clinical staffing allocated for the east side of the Facility, which has approximately 700 sentenced inmates, is 1.0 FTE NP. When the NP is on personal or educational leave, routine clinical coverage is not provided; only in response to emergencies is coverage provided. The Monitoring Team found that not only did this result in significant problems with respect to access to care for sick call, but also with respect to chronic disease management because the NP also manages patients with chronic diseases. A related issue is that the NP is not permitted to manage any patient with more than one disease, regardless of severity of the patient's disease. This does not appear to be the best use of the NP's skills, as many patients may have more than one disease, which are mild enough in severity for an NP to provide adequate treatment. A more appropriate approach is to have the physician manage complicated patients and have the NP manage uncomplicated patients.

Nurse Staffing

With respect to RN staffing, currently there are a total of 9 FTE RN positions excluding the DON.⁴⁸ They are allocated as follows: 1.0 FTE RN supervisor on days and evenings 7 days per week, and a 1.0 RN FTE on each shift 7 days per week. There is no RN

⁴⁷ CMS policy is that the HSA is responsible for the allocation of clinical staffing, not the Medical Director.

⁴⁸ There are RN and LPN positions at HRYCI that are not filled. It is not clear at this time if the staffing levels would be adequate if all of those positions were filled.

assigned to the night shift. There is a RN designated as an infection control coordinator, and CQI/chronic care case manager. On the west side of the Facility, RNs did not conduct sick call or perform intake screening, except to triage the sick call request form. On the east side of the Facility, an NP conducts sick call, but when the NP is absent, the task is delegated to an LPN or not conducted at all.⁴⁹ LPNs are not appropriately qualified or licensed to perform these functions independently. In order for RNs to perform the activities that require independent assessments, more RN positions are required. After consultation with staff at the Facility, the Monitoring Team recommends that 4 more FTE RN positions be allocated and hired.

With respect to LPN staffing, there are a total of 12.2 FTE LPN positions. Although a significant portion of these nurses are assigned to administer medications, medication administration is not taking place on a timely or appropriate basis. The Monitoring Team attributes this problem in part to inadequate staff assigned to this function (*See* discussion of provision 24 of the MOA). Although redistribution of assignments may free up additional LPNs to perform medication administration, more LPNs are likely to be necessary. After consultation with staff at the Facility, the Monitoring Team recommends that 6 more FTE LPN positions be allocated and hired.

Other Staffing

Medical record staffing appears to be adequate at this time.

Mental Health Staffing

The mental health staff at HRYCI is comprised of a Mental Health Supervisor, five mental health professionals, one psychiatrist FTE, and a fulltime mental health clerk. There is mental health staff on site seven days a week, and the Mental Health Supervisor provides on-call coverage 24 hours a day, seven days a week.

At the time of the Second Report, HRYCI mental health personnel reported that the facility required at least three more FTE counselors beyond their current allocation. During the team's March 2008 visit, it was reported by the mental health supervisor that these additional positions were not needed to provide the services required by the MOA. This change was likely due to the fact that at the time of the Second Report many of these personnel had just been hired, but by the time of the March visit, they had been in their positions for enough time to better understand their capabilities and what was required. It is premature to know whether these additional positions are necessary. The Monitoring Team will have to see how the new management team progresses before making an assessment.

The Monitoring Team observed that, at the time of its visit, 38 out of the 40 allocated hours of psychiatrists' time were being provided. Previously, only 30 hours were being

⁴⁹ The State has informed the Monitoring Team that, since the time of the Monitoring Team's visit, the allocation of tasks among staff has been modified, and the Monitoring Team looks forward to reviewing this process again in Fall 2008.

provided, due to vacancies. Generally, one mental health clinician is present when the psychiatrist is working and that clinician usually sits in during interviews with inmates. While staff believes this process is useful from the perspective of increasing the consistency in the treatment given to inmates, it does negatively impact the counselors' availability to deliver individual counseling throughout the facility.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team evaluated this area by reviewing budgeted staff allocations assigned to the facility, vacancy rates, and compliance with the requirements of the MOA. In summary, the Monitoring Team found that the facility most likely has inadequate clinical staffing. Due to other identified issues related to access to care (*e.g.*, cooperation of custody to provide access to inmates, etc.),⁵⁰ however, the Monitoring Team is unable to make a final determination regarding the adequacy of clinical staffing. With respect to nurse staffing, the facility has insufficient numbers of RNs to conduct sick call and intake assessments and LPNs to administer medications in a timely manner.

Advanced-Level Provider Staffing

There are 3.0 clinical FTE positions for SCI and Sussex Violation of Parole ("SVOP").⁵¹ The Monitoring Team has determined that SCI is receiving approximately 1.5 FTEs, which, given the clinical issues there, is likely to be insufficient.

According to the Staffing Control Document ("SCD"), the Medical Director is a 1.0 FTE position; however, SCI is receiving approximately 0.60 FTEs of the Medical Director's time because he is responsible for providing medical care at the other Facilities. As a result, there has been fragmentation and lack of adequate clinical oversight at SCI. A 0.4 physician and 0.5 NP FTE are also assigned to the facility.

Nurse Staffing

⁵⁰ These issues include sending inmates back to their housing unit from the clinic for count before they are actually seen by a clinician, and then the inmate is not brought back to the clinic

⁵¹ SVOP is not covered by the MOA.

From a physical plant perspective, SCI is made up of two separate facilities, one for pretrial detainees and one for sentenced inmates. Each side has a separate medical clinic requiring dedicated nursing and ancillary staff. However, the institution is staffed as a single facility and duplication of coverage is not fully taken into account, resulting in inadequate nurse staffing.

With respect to RN staffing, there were a total of 10.2 RN positions including the DON. All but one weekend night position was filled at the time of the Monitoring Team's visit. Two RNs are dedicated to CQI, and infection control, respectively. A charge nurse position is allocated to provide coverage for the pretrial unit; however, the Monitoring Team notes that this nurse was located primarily in the MSB. Five RNs are available to provide coverage for all remaining weekday shifts on both sides of the facility (2 RNs on day shift, 1 on evening, and 2 RNs on night shift). On weekends, 1.2 FTEs provide 24-hour coverage.

RNs do not conduct sick call or perform intake screening. Instead, these responsibilities are assigned to LPNs, who are not appropriately qualified or licensed to independently perform these functions.

With respect to LPN staffing, there are a total of 10.8 FTE LPN positions. A significant portion of these nurses are assigned to pass medications; however, staff currently is unable to administer medications in a timely manner and in accordance with standards of nursing practice. The Monitoring Team attributes this problem to inadequate staff assigned to this function (*see* discussion of provision 24 of the MOA). Although redistribution of assignments might free up additional LPNs to perform medication administration, more LPNs are likely to be needed.

There are institutional practices that increase the demand for nursing staff. In pretrial, medication administration is centralized, which is relatively efficient. In the MSB, medication administration is primarily decentralized. Morning and Hour of Sleep ("HS") medications are delivered to the housing units. In order to accomplish this task, nurses spend hours transferring properly labeled medication into improperly labeled envelopes to take out to the housing units. This is extremely staff intensive, and violates standards of nursing practice by not ensuring that medications are administered one hour before or after a designated time.

Other Staffing

The medical records clerk is assigned multiple functions. It is unclear at present whether staffing for medical records is adequate.

Mental Health Staffing

There were 3.1 FTE vacancies for mental health clinicians at SCI (out of 5.0 FTE slots). Two FTE clinicians have been offered jobs but had not started at the time of the Monitoring Team's visit in April 2008. There have been at least 1.5 FTE line staff vacancies since January 2008.

These vacancies have resulted in a waitlist for inmates for routine mental health referrals, which is approximately 100 inmates long. In addition, routine 30-day visits for mental health caseload inmates are not occurring.

F. Recommendations

With respect to mental health staffing, the Monitoring Team recommends the state conduct a systemic analysis to adequately assess the necessary level of mental health staffing allocations.

At Baylor, the Monitoring Team recommends that:

- The Facility receives the full complement of clinical staffing; and
- The State and CMS reassess and adjust RN and LPN staffing to permit RNs to conduct sick call, intake screening, urgent/emergent evaluations, and any other responsibility that requires nursing assessment skills.

At DCC, the Monitoring Team recommends that:

- The State, in collaboration with CMS, conducts a staffing analysis at DCC;
- Health care leadership should assign RNs the responsibility for nurse sick call and intake screening, and provide RN coverage at night. This will require the addition of approximately four RN positions; and
- The State provides sufficient LPN staffing to enable staff to administer medications in a timely manner and in accordance with standards of nursing practice (see Medication Administration).

At HRYCI, the Monitoring Team recommends that:

- The Medical Director is given the responsibility for allocation of primary care clinician staffing, including ensuring adequate clinical coverage of both medical and mental health services;
- Health care leadership assigns RNs the responsibility for nurse sick call and intake screening, and provides RN coverage at night. This will require the addition of approximately four RN positions; and
- The State provides sufficient LPN staffing to enable staff to administer medications in a timely manner and in accordance with standards of nursing practice.

At SCI, the Monitoring Team recommends that the State:

- Reassess clinical and nurse staffing to ensure adequate coverage for both the pretrial and MSB areas;

- Assign RNs the responsibility for nurse sick call and intake screening and provide additional RNs to enable this to occur; and
- Provide sufficient LPN staffing to enable staff to administer medications in a timely manner and in accordance with standards of nursing practice.

7. Medical and Mental Health Staff Management

A. Relevant MOA Provision

Paragraph 7 of the MOA provides:

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

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

B. Baylor

1. Assessment

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

2. Findings

As at the other Facilities, the leadership team at Baylor has lacked stability over

the course of the monitoring period. Specifically, the Monitoring Team found that both the HSA and DON positions have been subject to frequent turnover. At the time of the Monitoring Team's visit, the HSA position was vacant. The Monitoring Team learned that a replacement had been hired and would be starting at Baylor the week of the Monitoring Team's site visit. Also, the DON at Baylor had been in that position for approximately four weeks prior to the Monitoring Team's visit. Finally, during the Monitoring team's visit, the Medical Director at Baylor submitted her resignation, and, since that time, has departed.

With regard to the staffing of mental health leadership positions, as discussed in the findings for provision 6 of the MOA, a 1.0 FTE mental health clinician position was reassigned to DCC. This reallocation has ramifications on the findings and assessment for this provision at Baylor. As a result of the staffing shortages, the mental health director has a full caseload, which results in significantly less time to perform his administrative duties.

C. DCC

1. Assessment

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

2. Findings

The HSA at DCC had been in place slightly more than six months prior to the Monitoring Team's visit. Since the Monitoring Team's April 2008 visit, the Monitoring Team has learned that the HSA resigned. The Medical Director had been working at DCC in another role for two years prior to the Monitoring Team's visit; however, she had only recently been assigned the title of Medical Director.

In addition, the DON position has turned over three times in the past year. The most recent DON had been in that role for approximately six weeks prior to the Monitoring Team's visit. Prior to being hired as the DON, she was an NP who practiced at the facility. As a primary care provider at the facility, the DON became aware of nursing issues that negatively impacted the delivery of quality medical services and took the DON position to effect positive change. She impressed the Monitoring Team as being very dedicated. However, since the April 2008 visit to DCC, the Monitoring Team has learned that the DON has been reassigned to her prior role as an NP.

With respect to the staffing of mental health leadership positions, at the time of the Monitoring Team's visit the Mental Health Director had recently resigned due to personal reasons. However, the Monitoring Team found that his performance prior to his departure was satisfactory, and found that the interim director was doing an effective job as well.

D. HRYCI

1. Assessment

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

2. Findings

The leadership team over the course of the monitoring period has lacked stability. Although the Monitoring Team is impressed with the individuals currently in leadership positions, they have not been in their positions collectively long enough in order to create sustained, effective processes to ensure the adequacy of care. The following list describes the duration of the staffing of leadership positions at the time of the Monitoring Team's visit:

- The HSA had been in his position a little more than a year.
- The DON had been in her position for two months.
- The site Medical Director had been in her position for two months.
- The supervising nurse had been in his position for approximately a year.

The site Medical Director does not have the authority to redeploy primary care provider staff in order to assure coverage at HRYCI. Thus, when the NP, who is the sole primary care provider for the sentenced population of approximately 700 inmates, went on vacation there was no coverage provided for a two-week period other than for emergencies. This lapse is not acceptable and clearly impacted access to care. The site Medical Director also does not oversee the distribution of clinical resources and does not have an active role in conducting peer review of other clinicians (which is performed by the Statewide Medical Director). The site Medical Director works 40 hours per week and is not permitted to work more hours even when the demands of the position require it. It is the Monitoring Team's view that a site medical director should have the authority and responsibility to redeploy to the extent possible to ensure all areas do not have a period of time in which there is no on-site coverage.

With regard to the staffing of mental health leadership positions, a new statewide mental health director started in late February 2008. At the time of the Monitoring Team's visit, he was not yet providing clinical supervision. Thus, none of the clinicians at HRYCI are receiving formal supervision by a licensed clinician.

E. SCI

1. Assessment

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

2. **Findings**

The Monitoring Team found that, as of the time of its visit to SCI, the SCI leadership team had been in place for a greater period of time than the other Facilities. Specifically, the HSA and the Medical Director had been in place for two years or more, and the DON had been in place for approximately a year and a half.

With respect to the staffing of mental health leadership positions, the Monitoring team found that mental health supervision at SCI is being provided by a licensed master's level counselor.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State hire properly credentialed health care professionals who can provide sustained leadership and implement the requirements of the MOA.

At DCC, the Monitoring Team recommends that the State stabilize the leadership team so that they have the opportunity to implement sustainable systems.

At HRYCI, the Monitoring Team recommends the following:

- The Medical Director's role should be redefined to reflect the duties of a true Medical Director;⁵² and
- The State should ensure sustained leadership so that processes can be put in place that effectively meets the needs of the patient population.

At SCI, the Monitoring Team recommends that the State:

- Draft and submit to the Monitoring Team the local operating procedures and begin to monitor performance to ensure that the operations conform to the procedures;
- Implement strategies, as part of the CQI program, designed to improve performance when performance is found to be less than required; and
- Hire a full time Medical Director at SCI, devoted to providing clinical and administrative leadership to the facility.

⁵² This includes allocation of clinical resources on a day-to-day basis and meaningful participation in quality improvement activities including peer review, CQI activities, etc.

8. Medical and Mental Health Staff Training

A. Relevant MOA Provision

Paragraph 8 of the MOA provides:

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

Adequate training for medical and mental health staff includes an immediate basic orientation⁵³ and all full-time staff must complete a formal in-depth orientation⁵⁴ to the health services program at a facility. J-C-09; P-C-09. In reviewing this provision of the MOA, the Monitoring Team also reviewed whether medical and mental health staff have received suicide prevention training, as required by provision 43 of the MOA.⁵⁵

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this

⁵³ A “basic orientation” is one that “is provided on the first day of employment, includes information necessary for the health staff member (*e.g.*, full-time, part-time, consultant, per diem) to function safely in the institution.” J-C-09-; P-C-09. At a minimum, the basic orientation should include relevant security and health services policies and procedures, response to facility emergency situations, the staff member’s functional position description, and inmate-staff relationships. *Id.*

⁵⁴ An “in-depth orientation” should occur within 90 days of employment, and includes “a full familiarization with the health services delivery system at the facility, and focuses on the similarities as well as the differences between providing health care in the in community and in a correctional setting.” J-C-09-; P-C-09. Specifically, at a minimum, the curriculum of the in-depth orientation should include all health services policies and procedures not addressed in the basic orientation, health and age-specific needs of the inmate population, infection control including use of standard precautions, and confidentiality of records and health information. *Id.* In addition to these essential topics, a formal orientation program could include the following topics: (i) security, including classification of inmates; (ii) health care needs of the inmate population; (iii) the inmate social system; (iv) the organization of health services at the facility; and (v) infection control. *Id.* For nursing staff, topics could also include: (i) assessment and sick-call triage; (ii) emergency triage and management; (iii) resource utilization outside the facility; (iv) procedures for release of information; (v) expected documentation practices; (vi) isolation procedures; and (vii) professional boundaries. *Id.*

⁵⁵ The required contents of suicide prevention training are contained in provision 42 of the MOA.

provision of the MOA.

2. Findings

The Monitoring Team reviewed the personnel records of all relevant medical and mental health staff members. All of the medical and mental health staff have received the training required by this provision of the MOA, with the exception of suicide prevention training. The only employees who have not completed suicide prevention training are the psychiatrists. Thus, the eight-hour initial training, and the two-hour annual refresher training should be provided to all psychiatrists.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team reviewed the personnel files of all relevant medical and mental health staff members. With regard to the mental health staff, the Monitoring Team found that the psychiatrists have not received the suicide training, and the other mental health staff may have attended suicide training, but there is not a complete set of documentation to verify that they have completed the training.

With regard to medical staff, the physicians have completed their required training. At the time of the Monitoring Team's most recent visit, the nursing staff had not fully completed the training. There were three nurses who had not completed either Orientation 1 or Orientation 2. There were seven nurses who had completed Orientation 1 but had not completed Orientation 2. The personnel records of thirteen out of fifteen nurses did not contain documentation of completion of suicide training.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed the personnel records of all relevant medical and mental health staff members. There were four nursing staff members who had not completed training pursuant to this provision of the MOA. Specifically, the nurses lacked either OSHA and

safety training, NEO1,⁵⁶ or NEO2.⁵⁷ Also, five mental health staff members had not completed training, and psychiatric staff has not received the suicide training.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed the personnel records of all relevant medical and mental health staff members in order to determine whether all staff had received the required initial and follow-up training. The required training included at least five program elements, including two health care orientation programs, a program regarding OSHA information, a program regarding suicide, and CPR training. All of the medical staff records documented completion of such training. As at the other Facilities, the psychiatrists had not received the suicide prevention training

F. Recommendations

In general, the Monitoring Team recommends that the State provide suicide prevention training to all psychiatrists as required under the MOA.

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

- Provide certificates or cards to people who attend the suicide prevention training, and require that attendees present this certificate or card to their supervisor or other appropriate person so that it can be included in their personnel files;
- Maintain a spreadsheet to track each staff member's completion of required training, and whether or not there is documentation of receipt of such training; and
- Provide suicide training to psychiatrists by providing a video or in-person training.

At HRYCI, the Monitoring Team recommends that the State complete the training for all staff, and continue to track and monitor compliance with training requirements.

⁵⁶ NEO1 is a non-clinical training program required of medical staff.

⁵⁷ NEO2 is a clinical training program required of medical staff.

9. Security Staff Training

A. Relevant MOA Provision

Paragraph 9 of the MOA provides:

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

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

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

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team reviewed ten personnel files of security staff working at the Baylor. In ten out of ten of the records, the security staff had received the required training.

C. DCC

1. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA.⁵⁸

2. Findings

The Monitoring Team reviewed 36 personnel files of security staff working at DCC. All of the security staff had completed all of the required training, except for one individual, whose attendance at the suicide training was not documented.

One of the two correctional officers assigned to the Special Needs Unit (“SNU”) during one of the Monitoring Team’s visits reported not having received the required mental health training. While officers who are regularly assigned to the SNU had completed the required training, situations have occurred in which officers who provide coverage for regularly assigned officers have not received or completed the required training. The Monitoring Team believes that both officers who are regularly assigned to the SNU as well as those who only provide coverage from time to time should have the necessary training in order for the State to be in substantial compliance with this provision.

D. HRYCI

1. Assessment

The Monitoring Team found that HRYCI is in partial compliance with this provision of the MOA.⁵⁹

2. Findings

The Monitoring Team reviewed the records of 32 of the approximately 330 security staff that work at HRYCI. The Monitoring Team found that all but two of the security staff had received the training required by this provision of the MOA.

With regard to the officers working on the mental health inpatient unit, the weekday officers had completed special training, but the weekend officers had not completed such training. The State is to submit documentation of the completion of this training.

⁵⁸ For informational purposes, the Monitoring Team finds that the DCC will be regarded as in substantial compliance with this provision of the MOA if the State can submit documentation that the coverage officers have received the required training.

⁵⁹ For informational purposes, as at DCC, the Monitoring Team finds that the HRYCI will be regarded as in substantial compliance with this provision of the MOA if the State can submit documentation that the coverage officers have received the required training.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed 30 personnel files of security staff working at SCI. Each file reflected that the employee had completed the required training within the past two years.

SCREENING AND TREATMENT

10. Medical Screening

A. Relevant MOA Provision

Paragraph 10 of the MOA provides:

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

According to NCCHC standards, timely receiving screening⁶⁰ means that the screening performed on inmates immediately⁶¹ upon arrival at the respective intake facility, and is performed by a qualified health care professional or a health-trained person. J-E-02; P-E-02. The policies adopted by the State provide that such receiving screening will be initiated within two hours of arrival into a facility and will be the responsibility of the nursing healthcare staff. *See* State Policy E-02. This policy is adequate. If a receiving screening is completed within three to four hours of arrival to a Facility, the Monitoring Team believes that is reasonable.

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

⁶⁰ A “receiving screening” is

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

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

⁶¹ NCCHC standards do not clarify what is meant by “immediately.” As stated above, the Monitoring Team believes that three to four hours is reasonable.

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

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

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

- appearance (*e.g.* sweating, tremors, anxious, disheveled);
- behavior (*e.g.*, disorderly, appropriate, insensible);
- state of consciousness (*e.g.*, alert, responsive, lethargic);⁶²

⁶² Persons who are unconscious, semi-conscious, bleeding, mentally unstable, or otherwise urgently in need of medical attention upon arriving at a Facility should be referred immediately for care. J-E-02; P-E-02. Such an immediate referral upon arrival at a Facility should be noted on the receiving screening form. *Id.* In addition, if the inmate is referred to a community hospital for care of the emergency condition and is returned to the Facility, the Facility should require a written medical clearance from the community hospital. *Id.*

- ease of movement (*e.g.* body deformities, gait);
- breathing (*e.g.* persistent cough, hyperventilation); and
- skin (*e.g.* lesions, jaundice, rashes, infestations, bruises, scars, tattoos, and needle marks or other indications of drug abuse).

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

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

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found that Baylor is in substantial compliance with respect to the timeliness of medical screenings, and in the high end of the partial compliance range for appropriateness of the medical screenings. The Monitoring Team also found Baylor is in substantial compliance with respect to mental health services.

2. Findings

Timeliness of Intake Screening

There were 188 intakes during the first quarter of 2008, of which 172 were screened within four hours of entry (91.5%). In addition, of the sixteen who were not screened within four hours, all but one of the patients were screened within five hours. There was one case in which the screening did not take place for 36 hours.⁶³

⁶³ The Monitoring Team found that in three of ten records sick call records reviewed, the date and time printed on the intake screening report was incorrect. This is a reflection on the potential lack of accuracy in information being used by the State to self-monitor, and being provided to the Monitoring Team.

Adequacy of Intake Screening

The Monitoring Team reviewed ten health records for the adequacy of the intake screening. In general, of the ten records reviewed, the history was complete, and the follow-up was timely and appropriate.⁶⁴

The DON reviews all intake screenings that are being performed, including those performed by LPNs, but this has not been documented in the medical record.

Mental Health Intake Screenings⁶⁵

With regard to mental health screenings, the Monitoring Team reviewed seventeen health records, which were selected from a DACS-generated report reflecting inmates that arrived at Baylor during the first quarter of 2008. Of the seventeen health records reviewed, fifteen reflected that the inmate had received a screening in a timely fashion. Only one of the two remaining health records reflected that the intake screening was not performed in a timely manner. The other remaining health record was not applicable to this provision of the MOA because it was for an inmate who had been transferred within the system, and who had been screened already at the initial facility.

C. DCC

1. Assessment

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

2. Findings

Timeliness of Intake Screening

The Monitoring Team reviewed a report generated by DACS, which listed all newly arrived inmates for a period of time. The report identified approximately twenty inmates whose medical screening was not completed within the required time frame. The Monitoring Team reviewed a sample of those inmates' health records, and found that most of those inmates had been transferred from the other Facilities, and had been viewed by the staff at DCC as intrasystem transfers. However, upon further review, the Monitoring Team found that these inmates had not been screened by the facility from which they had been transferred. Therefore,

⁶⁴ This assessment includes planting and reading the TB skin test. There was only one patient for whom an issue with the TB skin test was identified.

⁶⁵ See also discussion of provision 33 of the MOA.

these inmates had not received a medical screening.

In addition, the Monitoring Team selected twenty records of individuals who had entered DCC in the previous quarter as a new direct intake. Within that group, the Monitoring Team found that all but one had been screened within four hours, and that one inmate had been screened within four hours and nine minutes of intake.

Adequacy of Intake Screening

With regard to the intake TB screening program, the Monitoring Team found that six out of the twenty health records reflected that those inmates had not received their TB evaluation, either through a skin test or a chest x-ray, within the required time frame. Finally, of seven records of patients who indicated they were on medications, three individuals did not receive those medications within the first 48 hours.

Further, of the twenty health records reviewed, seven reflected that LPNs had performed the medical screenings, and there was no countersignature by an RN on a paper copy of that screen as is required. Notably, the cases in which the Monitoring Team found breakdowns in the appropriateness of the screening and continuity of care or medication, invariably were those in which an LPN had performed the intake screening rather than an RN.

Mental Health Intake Screening

With regard to mental health intake screening, the Monitoring Team reviewed health records for sixteen inmates. Those health records were selected from a DACS-generated report for intake screenings that took place during the first quarter of 2008. Of the records reviewed, fifteen of the sixteen reflected timely intake screenings.⁶⁶ Additionally, the Monitoring Team reviewed five health records of inmates admitted to DCC without having received intake screenings. These five records were selected from a DACS-generated report of inmate intakes to DCC during the first quarter of 2008. The Monitoring Team found that all five inmates were intrasystem transfers who had previously received intake screenings at the other Facilities.

D. HRYCI

1. Assessment

The Monitoring Team found HRYCI to be in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found HRYCI to be in substantial compliance with respect to the timeliness of medical screenings, partial compliance with respect to the appropriateness of the medical screenings, and not in compliance with respect to intrasystem transfers.

⁶⁶ The one remaining record was not applicable because the screening had occurred in 2006.

2. Findings

Timeliness of Intake Screenings

The Monitoring Team reviewed the health records of 26 newly arrived inmates. In each case, the inmate received a timely medical screening. In addition, the Monitoring Team reviewed DACS-generated reports, which listed medical screenings that did not take place in a timely manner. The DACS-generated report reflected that intake screenings were not performed in a timely manner less than 10% of intakes.

Appropriateness of Intake Screenings

The Monitoring Team found that LPNs performed all of the intake screenings reviewed. If an LPN performs the intake screening, an RN should review and countersign the intake screening because an LPN is not appropriately qualified or licensed to perform independent assessments. The Monitoring Team found that none of the 26 records reviewed had been reviewed or countersigned by an RN. Of the 26 records, only one did not have a documented TB screen result.

The Monitoring Team reviewed five records of inmates who had been transferred to HRYCI from the other Facilities. Only three out of the five records contained a completed intrasystem transfer form from the transferring facility. In four out of five records, HRYCI staff did not complete the portion of the intrasystem transfer form that is to be completed by the facility to which an inmate is transferred.

In two of the health records of inmates with medical problems, the Monitoring Team found that follow-up care was not provided in a timely manner. For instance, one inmate transferred into HRYCI with a lung abscess, and was admitted to the infirmary. Although a physician was on-site when the inmate arrived, he was not clinically evaluated until three days after his arrival at the facility. In another case, an inmate had an elevated blood pressure reading, which was not addressed by the nurse.

E. SCI

1. Assessment

The Monitoring Team found SCI to be in partial compliance with this provision. For informational purposes, the Monitoring Team found SCI to be in substantial compliance with this provision with respect to mental health services. Also, for informational purposes only, the Monitoring Team found that SCI is in substantial compliance with respect to the timeliness of receiving screenings, and in partial compliance with respect to the adequacy of the receiving screenings.

2. **Findings**

Timeliness of Intake Screening

The Monitoring Team reviewed health records that were selected from a DACS-generated list of newly arrived inmates from December 2007 through February 2008. During that period of time, there were 181 inmate intakes to SCI. The DACS-generated report reflected that only three of those new inmates received untimely intake screenings. One of the untimely medical screenings was only one minute late.

Appropriateness of Intake Screening

The Monitoring Team found instances in which patients with serious medical conditions were released to general population without a nurse contacting a physician, and patients with abnormal vital signs were sent to general population without ensuring that appropriate monitoring of these vital signs would take place. The Monitoring Team found that more than half of the intake screenings were negative, which means that they require no response other than release to the general population by the LPN performing the medical screening.

The Monitoring Team reviewed six records of inmates who had transferred to SCI from the other Facilities. The Monitoring Team found that in six of six records, the transferring facility completed an intrasystem transfer form prior to the transfer, and staff at SCI completed the intrasystem transfer form in a timely manner upon the inmate's arrival.

Two of the six cases involved inmates with pending consultations. In both cases, the receiving nurse failed to note that the pending consultation was present and refer the patient to a clinician. Medication continuity was provided for both patients on medications. A physician failed to review the record in each of the six cases.

*Mental Health Intake Screenings*⁶⁷

With regard to mental health intake screenings, the Monitoring Team reviewed medical records relevant to this issue and examined five records. Of the five health records reviewed, all five inmates received timely mental health intake screenings.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State:

- Review the sixteen cases in which intake screenings were late in order to determine the reasons for the tardiness, so that strategies may be implemented that will improve on the current performance;

⁶⁷ See also discussion of provision 32 of the MOA.

- Continue to timely screen and implement follow-up for patients in need; and
- Ensure that when intake screening is performed by an LPN, there is a documented review of this intake screening that is signed by a RN.

At DCC, the Monitoring Team recommends that the State:

- Continue to self-monitor with regard to the timeliness of the intake screening;
- Implement the procedure regarding intrasystem transfers in order to ensure that those inmates who had not received a screen prior to arriving will receive a screen;
- Monitor the timeliness of receipt of medications for those individuals who arrive at the Facility who report that they are on medications; and
- Ensure that an RN reviews and countersigns all medical screenings performed by an LPN.

At HRYCI, the Monitoring Team recommends that the State:

- Continue to monitor the timeliness of intake screening;
- Implement the process by which RNs review and countersign intake screenings on a timely basis; and
- Health care leadership should develop a system to ensure that nursing staff review and complete the intrasystem transfer form for newly arriving inmates and continuity of care is provided.

At SCI, the Monitoring Team recommends that:

- The State implement the procedure of all intake screenings being reviewed by an RN as soon as possible, or no less than 24 hours after the screen had been performed;
- The RN should intervene where indicated, and also provide feedback to the LPN so that LPN performance can improve;
- An ongoing process of reviewing the quality of performance regarding this provision of the MOA should be part of the CQI Program;
- The OHS should consider revising the intrasystem transfer review process to include recently completed or pending consultations; and
- Physicians should review records of all transferring patients to ensure that the patients' medical problems have been identified and an appropriate treatment plan has been developed.

11. Privacy

A. Relevant MOA Provision⁶⁸

Paragraph 11 of the MOA provides:

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

The MOA requires that the State make “reasonable efforts” to ensure inmate privacy when conducting medical and mental health screening, assessments, and treatment, subject to legitimate security concerns and emergency situations. This provision of the MOA differs somewhat from the NCCHC standards, which provide for clinical encounters⁶⁹ to be conducted in private, without being observed or overheard by security personnel unless the patient poses a probable risk to the safety of the health care provider or others. J-A-09; P-A-09.⁷⁰ The MOA does not require an individual correctional officer to make an independent assessment of the security risk of an individual inmate. Rather, the State can set the procedures for correctional officers to follow to ensure that privacy is afforded in accordance with this provision of the MOA.

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

⁶⁸ Additional, related observations regarding clinic space and equipment can be found in the discussion of provision 18 of the MOA below.

⁶⁹ “Clinical encounters” are defined as “interactions between inmates and health care providers that involve a treatment and/or an exchange of confidential information.” J-A-09; P-A-09.

⁷⁰ Further, NCCHC standards provide that, in cases in which it is necessary for security personnel to overhear clinical encounters, security personnel should be instructed regarding the maintenance of confidentiality of health information. *Id.* Such privacy is not feasible under all circumstances, such as instances in which health staff is dealing with an inmate’s health concern at the inmate’s cell, or in Facilities in which space issues do not allow for privacy as described above. Under such circumstances, if safety is a concern and full visual privacy cannot be afforded, the NCCHC recommends that alternative strategies for partial privacy, such as a privacy screen, be used. *Id.*

B. Baylor

1. Assessment

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

2. Findings

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

The staff at Baylor has made improvements with regard to the provision of privacy since the Second Report. Nursing sick call is now being conducted in a clinic room instead of the clinic hallway. However, because of insufficient clinic space, nurses continue to conduct clinical encounters (*e.g.*, chronic disease visits) in the main hallway, with other inmates circulating in the area. This arrangement does not represent a reasonable effort to maintain auditory privacy.

With regard to the State's efforts to maintain privacy during the provision of mental health care services, the Monitoring Team observed very little change in the State's efforts from their last visit to Baylor. Staff reported to the Monitoring Team that there are issues regarding the adequacy of available office space for use in assessing and treating inmates with mental health care needs. Whether adequate and available space can be found depends on the housing locations of the inmates and other variables such as whether the available spaces are being used by other disciplines.

C. DCC

1. Assessment

The Monitoring Team finds that DCC is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team finds that DCC is in partial compliance with respect mental health services, but is not in compliance with respect to medical issues.

2. Findings

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

The Monitoring team found that some efforts have been made to provide privacy. During the Monitoring Team's last site visit, the medical assistants obtained vital signs and interviewed inmates openly in the middle of the clinic, which provided no privacy. Since that time, the medical assistants have been moved to a back hallway; however, this is an area of frequent inmate and correctional officer traffic and the arrangement does not improve patient

privacy in a meaningful way.

Moreover, none of the three clinical examination rooms in use have doors, and privacy curtains are not utilized. A patient sitting on an exam table in one room can observe and hear a patient sitting on an examination table across the hall. The hallway also has frequent officer and inmate traffic. Moreover, the area is very noisy and the lack of examination room doors makes it difficult to perform examinations that require a quiet environment (*e.g.* listening to heart, lung and bowel sounds, etc.).

Finally, the Monitoring Team noted that in the main clinic area, there were several rooms that were not in use. The Monitoring Team recommends that if it is possible, the State use these rooms to provide clinic or office space to provide privacy (*see* discussion of provision 18 of the MOA).

In the Second Report, the Monitoring Team noted that the State had preliminary plans to address concerns over inadequate space in the infirmary area. Since that time, the State has requested and obtained an estimate for an additional examination room and interview room to service the infirmary area. The State is working on resolving security staffing for this new area before proceeding with construction. The Monitoring Team commends this effort.

Also, as discussed in the Second Report, the Monitoring Team described privacy concerns resulting from office doors being left open during clinician interviews with inmates. The doors were left open because the doors lock automatically upon closing, posing a safety concern. During this reporting cycle, the Monitoring Team observed that this practice continues, and no reasonable efforts have been made to change this practice. The Monitoring Team observed a psychiatrist interviewing an inmate in one of these offices. Based on their observations, the Monitoring Team concludes that there is inadequate privacy to facilitate a confidential visit in these offices due to periodic hallway traffic and noise levels, and that reasonable efforts have not been made to improve this condition.

During the Monitoring Team's April 2008 visit, staff reported to the team that they recently had been instructed that inmates housed in the main compound who were on the mental health caseload would now need to be seen in their housing units. The previous practice was to see these inmates in the "outpatient clinic." Apparently, this change was necessary due to custody restrictions regarding the number of inmates allowed in the clinic area at one time. Unfortunately, however, this change in practice has caused problems with regard to privacy. Specifically, there is a lack of adequate office space to see inmates in the housing units. Additionally, some clinical encounters with inmates housed in the main compound are taking place in a cafeteria which has been noted to be noisy, heavily trafficked, and not conducive to effective visits due to frequent physical distractions for both the clinician and inmate.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team evaluated compliance with this provision by touring clinic space, interviewing staff and observing clinical encounters.⁷¹ The Monitoring Team found that the State has made some efforts to improve the clinic space in general, which resulted in increased privacy.

In the booking area, medical screening has been relocated to a larger room. As noted in prior reports, inmates stand outside the room at a half-door where they are interviewed by a nurse sitting at a desk in the room. This arrangement does not permit adequate privacy, observation of the patient, and is not conducive to obtaining a thorough medical history or, if necessary, performing a nursing assessment.

In the west side medical clinic, a continued problem is that the room adjacent to the inmate waiting room is used simultaneously to draw laboratory specimens and to perform physical examinations. Although there is a partition in the room, it does not permit adequate auditory and visual privacy. Under the circumstances, the use of a partition in this room does not represent a reasonable effort by the State to maintain inmate privacy.

In the east side medical clinic which serves approximately 700 inmates, there is only one examination room. Staff advised the Monitoring Team that both the clinician and nurse conduct sick call in the clinic room at the same time, which does not permit adequate auditory privacy.

The Monitoring Team observed that there continues to be a problem at HRYCI regarding a lack of privacy during mental health encounters. This problem stems from the absence of an available interview rooms for seeing inmates on psychiatric close observation (“PCO”) status in the infirmary.

The State has informed the Monitoring Team that this issue was in the process of being remedied. Specifically, the State has plans to move the pharmacy to another area of the Facility, which will create space for interviews in the infirmary. This construction project was expected to commence in April 2008. At the time of the Monitoring Team’s visit to the Facility, mental health staff interviewed patients in the dayroom area while other inmates were away, or at the inmate’s cell front.

⁷¹ Observations regarding the components of this provision of the MOA are noted in the section of this report regarding clinic space and equipment.

Adequate office space is not available for mental health assessment and treatment purposes in the dormitory housing units either. The Monitoring Team is unaware of any plans by the State to remedy this situation.

E. SCI

1. Assessment

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

2. Findings

The clinical space limitations at SCI result in very little privacy for patient interviews and examinations. Specifically, the medical clinic space at SCI is completely inadequate for a facility of its size. There is only one room that is used for patient examinations. However, an administrative employee shares this space, and the staff bathroom is in this room. Thus, clinicians see patients with another staff person continuously in the room and staff trafficking to and from the bathroom. Often, two clinicians share this space even though there is only one examination table.

Moreover, two nurses conduct sick call at an open table side by side in the center of the clinic. These nurses do not have immediate access to an otoscope/ophthalmoscope to conduct health assessments. Inmates and officers are able to overhear conversations and observe any examinations that do take place.

Medical records are stored in unlocked cabinets and health record documents sit on desks in the clinic where inmates and officers circulate. This does not provide adequate privacy of health records.

The Monitoring Team found that lack of adequate office space remains a problem with regard to the provision of mental health care services. In the Second Report, the Monitoring Team noted that there were significant problems with housing units not having any private or confidential space for clinical encounters. In fact, the Team found that most clinical encounters occurred in public. These problems still existed during the Monitoring Team's April 2008 visit. These space and privacy issues are a significant problem at SCI. Some areas in the general population section have no office space available at all and clinical encounters occur in a dining area at picnic style tables between two dormitories. There is a loud ice machine in this room, there are fans in the summer, and this room is the main ingress/egress to the building.

As of the time of the Monitoring Team's visit, the efforts implemented as of the time of the Monitoring Team's visit were not reasonable although the State has plans that should

be implemented in Fall 2008, which most likely will be reasonable.⁷² Specifically, the State has shown the Monitoring Team architectural plans for a commercial trailer that will be erected on SCI grounds, which would be used for clinical encounters. The plans called for this project going out for bidding soon after the Monitoring Team's visit, with a prospective completion date sometime in Fall 2008. The use of this trailer should eliminate many of the problems discussed in the preceding paragraphs.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State ensure that all clinical and counseling encounters are provided in a setting that affords visual and auditory privacy.

At DCC, the Monitoring Team makes the following recommendations:

- Office doors should be re-tooled to manually lock rather than the current automatically locking doors;
- Adequate office space must be made available if clinicians are to meet with inmates in the housing units;
- The State should proceed with the construction of additional office space;
- Clinical examination rooms in the main clinic should be retrofitted with a door that has a Plexiglas window that provides a quiet environment to interview inmates and perform examinations, and permits correctional officers to monitor the safety of staff;
- A privacy curtain should be available in each examination room to provide the patient privacy during examinations; and
- The process of obtaining vital signs, finger stick blood sugars and interviewing inmates should be conducted in a room rather than a hallway.

At HRYCI, the Monitoring Team recommends the following:

- In the booking area, the nurse should perform the medical intake screening process with the patient in the room sitting in a chair;⁷³
- In the west side medical clinic, the State should consider establishing of an examination room in the infirmary (and potentially the radiology room); and

⁷² The Monitoring Team believes that some of the efforts that the State plans to implement, such as the construction of trailers on SCI grounds to be used for medical and mental health care, could be reasonable.

⁷³ Consideration should be given to installing cameras or a Plexiglas window enabling security to provide visual security.

- In the east side medical clinic, the State should consider creating an examination room where the medication room was located.

At SCI, the State should proceed with its building plans, which hopefully will address space and privacy issues. The Monitoring Team also recommends that clinicians and nurses examine patients in a setting that affords visual and auditory privacy and encourages thorough examinations (*see* recommendations following discussion of provision 18 of the MOA).

12. Health Assessments

A. Relevant MOA Provision

Paragraph 12 of the MOA provides:

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

The MOA provides for timely and adequate medical and mental health assessments⁷⁴ to occur. NCCHC standards differ with respect to timeliness of a health assessment (*compare* J-E-04 and P-E-04 (stating that health assessments in jails take place “[a]s soon as possible, but no later than 14 days...” and in prisons, “[a]s soon as possible, but no later than 7 days...”), but the MOA requires that the State adhere to the standard for jails, which is 14 days.⁷⁵ An adequate health assessment should include at least:

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

⁷⁴ A “health assessment” is defined as “the process whereby the health status of an individual is evaluated, including questioning the patient regarding symptoms.” J-E-04; P-E-04.

⁷⁵ The State’s policy adopts the 7-day standard applicable to prisons for timeliness of health assessments. *See* State Policy E-04.

- A recording of vital signs;
- A physical examination (an objective, hands-on evaluation of an individual, involving the inspection, palpation, auscultation, and percussion of a patient's body to determine the presence or absence of physical signs of disease);
- Laboratory and/or diagnostic tests for communicable diseases including sexually transmitted diseases;
- A test for TB; and
- Initiation of therapy and immunizations when appropriate.

Id. The hands-on portion of the health assessment should be performed by a physician, physician assistant, or NP, and the health history and vital signs should be collected by a qualified health care professional.⁷⁶ *Id.* When significant findings are present as the result of the hands-on portion of the health assessment, and it is done by a health professional other than a physician, the physician should document his or her review of the health professional's health assessment in the inmate's medical record.

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

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team reviewed for timeliness and appropriateness the health records of ten inmates who had received health assessments. In ten out of ten records, the

⁷⁶ The hands-on portion of the health assessment may be performed by a registered nurse when (i) the nurse completes appropriate training, approved or provided by the responsible physician; and (ii) the responsible physician documents his or her review of all health assessments. J-E-04; P-E-04.

inmates received an assessment within fourteen days of intake. In addition, the assessments in all ten instances were appropriate.⁷⁷

The Monitoring Team found that mental health staff is not reviewing the records of this subset of inmates, although nursing staff is conducting such a review. While mental health staff members have been involved in the assessment of these inmates upon referrals from the medical staff, the MOA states that mental health staff also should be reviewing the records of these inmates. If not for this lack of review by mental health staff, the State would be in substantial compliance with this provision.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team reviewed twenty records of inmates that had received health assessments. At the time of the Monitoring Team's review, two of the individuals had not received a health assessment at all, even though their records indicated that they had been at the Facility for a period of time greater than the seven or fourteen days allowed pursuant to this provision of the MOA. In addition, there were four individuals who had received a health assessment, but it was documented on the wrong form. There were three other individuals who received a health assessment after fourteen days, even though they should have had the assessment within seven days.

The Monitoring Team found that mental health staff is not reviewing the records of this subset of inmates, although nursing staff is conducting such a review. While mental health staff members have been involved in the assessment of these inmates upon referrals from the medical staff, the MOA states that mental health staff also should be reviewing the records of these inmates.

D. HRYCI

1. Assessment

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

⁷⁷ The Monitoring Team found that there was only one record in which there was a delay in laboratory results returning to the record, but that is not relevant to this provision of the MOA.

2. Findings

The Monitoring Team reviewed 26 records of inmates who were new admissions to HRYCI. Fifteen of these inmates had chronic diseases, and therefore, should have received a health assessment within the first seven days of entering the Facility. This health assessment should have been documented on the standard physical examination form, or the initial chronic disease database.

Seven of the 26 records reflected that the physical assessment had not been performed on a timely basis, and, in four of those cases, the health assessment performed was inadequate. The Monitoring Team learned that the NP who was performing the health assessments had not been trained in the use of the chronic disease forms or the chronic disease program, so when she used the chronic disease database form for a health assessment, she did not use it correctly. Specifically, the NP did not assess the degree of control of the patients' chronic diseases, nor did she ask the required disease-specific questions with regard to the patient's history.

The Monitoring Team also found duplication of effort. For instance, the Monitoring Team found records in which the NP would complete the data entry in both the chronic disease database and the standard history and physical form, and, in addition, would complete a progress note.

The Monitoring Team also reviewed the records of eleven juvenile offenders who entered the system. Two of the juvenile's records lacked the required physical assessment.

The Monitoring Team found that mental health staff is not reviewing the records of this subset of inmates, although nursing staff is conducting such a review. While mental health staff members have been involved in the assessment of these inmates upon referrals from the medical staff, the MOA states that mental health staff also should be reviewing the records of these inmates.

E. SCI

1. Assessment

The Monitoring Team found that SCI is in partial compliance with this provision of the MOA. For informational purposes, SCI is in substantial compliance with regard to the timeliness of the health assessments.

2. Findings

The Monitoring Team reviewed twenty records in order to assess SCI's compliance with this provision of the MOA. Of those twenty records reviewed, only one record reflected that a health assessment was not performed within the required time frame. In general, the physical exams were performed roughly within one week, but certainly no more than two weeks after the intake. There was one case in which a physical exam was not performed because

the patient had had a physical 11 ½ months before, when the patient had been incarcerated on a prior occasion. However, this was a returning patient with diabetes who should have been referred to the physician not only for the health assessment, but also for appropriate reassessment and follow-up regarding his chronic disease.

In eight out of the twenty records reviewed, the Monitoring Team found problems with the adequacy of the health assessment, and the follow-up from it. Specifically, there was a failure to develop an initial problem list with an initial plan for each problem as required within the NCCHC standards. Additionally, there was a delay in patients receiving critical medications, including, in one instance, a patient with HIV disease. There was another instance in which medications were ordered inappropriately for a patient who did not have a problem.

The Monitoring Team found that mental health staff is not reviewing the records of this subset of inmates, although nursing staff is conducting such a review. While mental health staff members have been involved in the assessment of these inmates upon referrals from the medical staff, the MOA states that mental health staff also should be reviewing the records of these inmates.

F. Recommendations

With regard to mental health assessments, the Monitoring Team believes that the State must change the current process it uses with respect to inmate transfers and inmates being readmitted so that mental health staff is reviewing the records of these inmates. If necessary, the State should implement a policy or set of procedures to ensure that mental health staff members are performing this task.

At DCC, the Monitoring Team recommends that the State:

- Finalize the operating procedures to ensure that individuals' health assessments are performed using the correct form;⁷⁸
- Perform CQI reviews of this process once it is implemented in order to provide feedback to staff;
- Perform regular reviews using DACS to determine whether assessments are being performed on a timely basis; and
- Have the Medical Director review the appropriateness of the assessments, for individuals with chronic or acute diseases.

At HRYCI, the Monitoring Team recommends that:

⁷⁸ For individuals with chronic diseases who are new to the system or have never had an initial chronic disease database performed for their chronic diseases, the assessment must be either on the general health assessment form or on the chronic disease initial database. If the general health assessment form is used then a complete initial chronic care database must be completed within the first 30 days of incarceration.

- For individuals with chronic diseases, when using the chronic disease database form, the State ensure that the clinician using the form has been appropriately trained in the chronic disease program and understands how to appropriately use the form; and
- The State monitor both the timeliness of the assessments and the appropriateness of the assessments.

At SCI, the Monitoring Team recommends that:

- The current physical examination form be replaced with a form that requires a specific history related to any positive findings found during the health assessment;⁷⁹ and
- The State implement a CQI review process of the health assessments of patients who have positive findings.

13. Referrals for Specialty Care

A. Relevant MOA Provision

Paragraph 13 of the MOA provides:

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

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

⁷⁹ After the collection of objective data, the development of the initial problem list and relevant diagnostic and therapeutic plans for each problem should be a required entry on the form.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team reviewed ten records of patients referred for specialty care or off-site services. In each of the records, the Monitoring Team found that the services were provided on a timely basis, and the follow-up to the care was appropriate. However, the Monitoring Team notes that this success is a direct result of extraordinary efforts by the on-site Medical Director to ensure that the tracking and follow-up occurred. The on-site Medical Director has, on her own, implemented a system in which she makes a copy of every off-site request made by her or by any other clinician, meets with the scheduler on a weekly basis, tracks and discusses every pending consultation until the report is back and the patient has been seen. Through this extraordinary effort, the Monitoring Team identified that services were provided timely and follow-up occurred as appropriate.

In addition, after the specialty or off-site services are provided, the Monitoring Team found that reports are filed in the inmate's health record, and the Medical Director has discussed the findings and plan with the patient. The Monitoring Team recommends that the HSA (a position which was vacant at the time of the Monitoring Team's visit) needs to implement a system that is independent of the extraordinary efforts of the site Medical Director. Scheduling and tracking must occur as part of a regular processes.

With regard to the provision of mental health specialty or off-site services, the Monitoring Team was unable to assess this provision because no mental health inmates have been referred by mental health staff for specialty care, such as a neurology clinic.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team reviewed eleven records of patients referred for specialty care. If the clinician referring the patient for an outside consult is an NP, policy mandates that the Medical Director review the request and see the patient prior to approving the referral. A consult that is authorized to go forward is then sent to the scheduler, who faxes the request to the utilization management group for approval. At the time of the Monitoring Team's visit, approval for urgent requests ordinarily took one to two days, and approval for routine requests ordinarily

took three to four days. After approval, the scheduler then calls the service for appointments. For most specialty services, outside appointments are available within 30 days. At the time of the Monitoring Team's visit, an exception was endocrinology, which took approximately 60 days.

DCC has a process in place for the patient to return to the medical area after the specialty referral, where a nurse would fill out a pink form called the "Off-site Return Progress Note." This form is designed to ensure adequate record-keeping and follow-up regarding off-site referrals. The form includes a number of sections requesting information such as the patient's name and number, the specialty service from which the person just returned, and recommendations from the specialty service provider.⁸⁰ The form also included a section requesting information such as vital signs, and a plan to contact the physician to ensure that orders were received, and the patient was scheduled for a provider visit on return. Finally, the last section of the form included a space to note the patient's disposition; in other words, whether the patient should be held for the provider to see immediately, or could return to the general population.

Despite the development of this helpful form, it has not been used appropriately. In fact, the Monitoring Team's review of the patient records revealed that none of the sections were used on a regular basis, except for the section of the form requiring the patient's name and the specialty service provided. The Monitoring Team believes that there has not been adequate training of staff regarding how to use the form properly.

For most of the patients whose records were reviewed, the Monitoring Team found that, at the time of the request, a majority of records did not contain a progress note on the day of the referral to explain why the clinician made the referral. In addition, when the patient returned to the Facility, the follow-up visit by the primary care provider did not occur. Finally, the Monitoring Team also identified significant delays in reports being reviewed and acted on by the responsible clinician.

The Monitoring Team observed that, with respect to referrals for mental health specialty services, improvements have occurred in connection with timely access to neurological consultations. During the Team's previous visit, referrals were completed in as many as sixty days. During the Monitoring Team's recent visit, the Monitoring Team reviewed three referrals, all of which had been completed within two to four weeks, which the Monitoring Team considers to be timely.

⁸⁰ In the event that there was no consultation report, this form is supposed to be forwarded to the scheduler, who is to call the specialty service provider in order to obtain such a report.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed twelve records of patients referred for specialty or off-site services. Usually, the Monitoring Team found that the record contained both an order and a progress note at the time of the initiation of a consult request. However, in six of the twelve records, the record did not contain a follow-up note to indicate that the clinician discussed the findings and plan with the patient after the patient returned to the Facility.

With regard to mental health specialty services, the Monitoring Team found only one relevant referral had occurred. In that case, the inmate was referred to a neurologist. This referral was completed in a timely basis.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed ten records of patients referred for specialty services or off-site tests, including CT scans and MRIs. In general, the Monitoring Team found the process to be quite timely. The overwhelming majority of appointments took place within one month of the physician's order.

The Monitoring Team observed that there has been improvement with regard to follow-up after specialty service appointments at SCI. The record contains a note by nursing staff and the physician, which documented that the results of the consultation or test were discussed with the patient after the patient had returned from the specialty appointment. The Monitoring Team notes that a high percentage of the follow-up visits with the doctor occurred on the same day that the patient returned from the off-site visit. As a result, the scheduling system in place, which is problematic, is bypassed and patients receive appropriate follow-up.

With regard to referrals for mental health specialty services, the Monitoring Team was unable to assess this provision due to the fact that no referrals had been made for mental health specialty services, such as a neurology clinic, during this monitoring period.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State implement procedures to ensure that all patients are scheduled on a timely basis for specialty appointments; that reports are tracked and returned on a timely basis; that a scheduled visit with the ordering clinician occurs on a timely basis; and that results and future plans are documented as having been discussed with the patient.

At DCC, the Monitoring Team recommends that:

- The State fully implement the off-site return progress note system so that follow-up occurs and patients are assessed at the time of return to the Facility, there is a primary care provider visit, and documentation of a discussion with the patient after the return from the service;
- Patients who go off-site for a procedure such as a CT scan, MRI scan, or endoscopy must have their reports tracked by a staff member, since their reports are not expected to be returned with the patient;⁸¹
- The Medical Director should review a sample of referrals to ensure that clinicians are documenting a progress note prior to making a request;
- The nursing staff should monitor the performance of the nurses who are receiving patients after the service is provided and completing the off-site return progress note form; and
- The Medical Director should monitor the documentation by the clinicians in progress note made after the patient returns to the Facility, ensuring that the note documents a discussion with the patient with regard to findings and plans.

At HRYCI, the Monitoring Team recommends that the State:

- Ensure that clinicians are aware that they must document an order and a progress note at the time of initiation of request for off-site services, and that when the patients return, they must be scheduled to be seen for a visit with the clinician in which there is a documented discussion of the findings and the plan; and
- Monitor performance of the program with regard to these elements.

At SCI, the Monitoring Team recommends that:

- The State encourage clinicians to document that findings and plans were discussed with the patient, who understands and accepts the plan; and

⁸¹ There has to be dictation and transcription for those diagnostic services performed off-site.

- For procedures for which a request must be made, but the report does not return with the patient (*i.e.* EEGs or MRIs), the scheduler should utilize a system in which calls to the service provider are made until the report is available in the institution.

14. Treatment or Accommodation Plans

A. Relevant MOA Provision

Paragraph 14 of the MOA provides:

Inmates with special needs shall have special needs plans. For inmates with special needs who have been at the facility for thirty (30) days, this shall include appropriate discharge planning. The DOJ acknowledges that for sentenced inmates with special needs, such discharge planning shall be developed in relation to the anticipated date of release.⁸²

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

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

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

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

⁸² According to Section II.F. of the MOA, "inmates with special needs" are,

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

multidisciplinary meeting should occur.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team reviewed the special needs list that had been submitted to the OHS, and the records of the three of the patients on the list. For each patient, a multidisciplinary team meeting had been conducted, and documented within the medical record within the previous month. Each of these patients reflected complex medical and mental health problems, as well as some behavioral issues. The progress notes documented each individual patient's problems and plans, including follow-up meetings of the interdisciplinary group. However, the plans did not include clear outcome objectives to be achieved and measured to determine whether the patient is making progress. It is preferable that the outcome objectives, where possible, be quantifiable. Such quantifiable objectives are desirable because the success of a variety of interventions with the patient may be more easily determined.

With respect to mental health special needs plans, the staff at Baylor reported to the Monitoring Team that limited discharge planning occurred, and generally had been initiated only when an inmate on the mental health caseload informed either the correctional counselor or mental health staff of their discharge date. The resulting discharge planning reportedly includes a 30-day supply of medication and assistance with housing and financial entitlements, if such assistance is requested by the inmate. However, the State has not initiated any audits with respect to this area, which means it was not possible for the Monitoring Team to verify the accuracy of these reports. Additionally, it was unclear how many inmates who should have been receiving discharge planning were, in fact, receiving such planning.

C. DCC

1. Assessment

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

2. Findings

DCC houses the most complex of the medical patients in the entire Delaware correctional system. The treatment and accommodation plans are meant to identify individuals with special needs that may require a multidisciplinary approach. The staff members at DCC have identified thirteen patients who fit into this category. Some of these patients have complex medical problems along with behavioral or mental health problems, and others have complex

problems compounded by the restrictions imposed according to their security level. Although the list has been developed, there had not been any multidisciplinary committee meetings as of the time of the Monitoring Team's visit.

The Monitoring Team also offered technical assistance to staff regarding this issue. Specifically, the Monitoring Team discussed in some detail with staff what constitutes an appropriate multidisciplinary committee note in the medical record. An appropriate multidisciplinary committee note would include a list of the patient's medical problems, and a listing of those issues which require special attention by the multidisciplinary committee. In addition, for those issues that require special attention, the desired outcomes should be documented. Finally, the note should document the strategies to achieve these outcomes and the timing of the follow-up. For each patient on the list, a designated staff member should act as the liaison with the Committee. If possible, particularly where behavioral issues are involved, items such as strategies to reduce self-destructive behavior, and quantifiable goals should be utilized and described in the note.

The Monitoring Team looks forward to reviewing the notes regarding these patients during the next monitoring period.

With regard to mental health special needs plans, it was reported to the Monitoring Team that discharge planning with respect to medications had improved. This improvement was attributed to staff monitoring of security printouts listing pending releases and the date of the inmate's release. This monitoring has resulted in staff doing a better job ordering medications as needed. Although medications are ordered from PharmaCor about fifteen days in advance of an inmate's release, problems exist with inmates actually receiving those medications. This problem occurs because medications are not directly given to correctional officers to give to the released inmate because there is no policy in place to do so, and there are legal questions as to whether this is allowed. As a result of nurses not being notified exactly when inmates are being released, it is estimated that approximately 50 to 80% of medications ordered are returned because they are not provided to the inmate.

The State has also begun tracking which inmates receive medications upon discharge. The night nurses have been instructed to communicate with the receiving room in order to facilitate the distribution of discharge medications to those inmates being released. Inmates who do receive medication sign an acknowledgment form, which is then filed in their record. This information is not tracked in a log.

Finally, SNU clinicians indicated that community mental health referrals were made as clinically appropriate for inmates being discharged.

D. HRYCI

1. Assessment

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

2. Findings

At the time of the Monitoring Team's visit to HRYCI, the staff had developed a special needs list consisting of twelve patients. The Monitoring Team's found that staff had conducted meetings with six of those patients; however, the Monitoring Team was able to find notes in only three of those six patients' health records. The Monitoring Team reviewed the records of the six who had been selected on this list and had been seen, and all of the patients seemed to be appropriate for this category.

The Monitoring Team also reviewed with the staff what information should be documented during the multi-disciplinary team's meetings. Such information includes: (1) the patient's problem list; (2) the issues to be addressed by this committee; (3) the outcomes to be achieved; (4) the strategies to be implemented, which should include assignments for the work associated with the strategies; and (5) when the follow-up visit will take place.

HRYCI staff demonstrated a clear understanding of this provision of the MOA, appeared to have identified patients appropriately and were following up with those patients. The remainder of the notes need to be drafted and six of the patients have yet to be seen.

With respect to discharge planning, the Monitoring Team found that two separate processes are being used at HRYCI, depending on the type of inmate being released. For inmates who have a known release date, medications are ordered at least three days prior to discharge and they are picked up by the inmate before they are released. Inmates whose release date is not known in advance, such as unsentenced inmates, are instructed to pick up a five day supply of medications at Eckerd Pharmacy.

While it was not clear whether any staff member is responsible for identifying unexpected releases, when an inmate was unexpectedly released, the medical records department was contacted and then communicated with the charge nurse for a review of the inmate's medical record. If necessary, a physician was notified and called in the 5-day prescription. Additionally, the physician would order a 30-day supply of medication and the inmate was instructed to return to HRYCI to pick up this supply. The discharge packet contains all of these instructions.

The Monitoring Team observed that there is not a CQI process in place to review either of the above processes. Additionally, there are no log books relevant to either process. The Monitoring Team discussed the need for a CQI process with administrative staff at HRYCI.

Finally, the State has met with State Medicaid officials in an effort to obtain permission to complete Medicaid applications in advance of an inmate's release. Inmates' entitlements are terminated upon admission due to their incarceration. The Monitoring Team discussed with the State the options it has to address this concern.

E. SCI

1. Assessment

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

2. Findings

SCI has developed a list of inmates for whom a multidisciplinary approach is indicated. At the time of the Monitoring Team's visit, the list only had five inmates on it. Also, multidisciplinary committee meetings had not yet occurred for these inmates.

Staff at SCI informed the Monitoring Team that discharge planning is occurring and includes assistance with entitlements, housing, and medical referrals. As part of the discharge planning, inmates are reportedly given discharge medications when appropriate. However, there are no audits or other tools currently in place at SCI which allow the Monitoring Team to verify this information.

F. Recommendations

At all of the Facilities, the Monitoring Team recommends that a CQI study be implemented to address discharge planning issues, especially with respect to discharge medications. Additionally, a log should be kept regarding the discharge medication process which would be useful for CQI purposes.

Additionally, the State should develop and implement a system to ensure that inmates receive certain financial entitlements, such as Medicaid and social security benefits, in a timely manner upon their release.

At Baylor and HRYCI, the Monitoring Team recommends that discharge planning be conducted at the time of the initial visit. The gathering of necessary information should be done by the counselor at the time of assessment and treatment planning and the inmate should receive a copy of referral sources at the time of assessment.

At Baylor, the Monitoring Team recommends that the State include in the progress note all interdisciplinary team meeting outcome objectives, preferably quantifiable, to be achieved by the time of the next multidisciplinary team meeting.

At DCC, the Monitoring Team recommends that the State begin to have Multidisciplinary Committee meetings, and document notes consistent with what has been described in the findings section above.

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

- Continue the process of identifying and holding these meetings and documenting in a manner consistent with the discussion above; and
- Monitor its performance with regard to achieving the outcomes for each of these difficult patients.

At SCI, the Monitoring Team recommends that the State initiate the multidisciplinary team meetings for each patient and document in the inmate health record the findings and plans including the outcomes sought and the timing of follow-up team meetings.

15. Drug and Alcohol Withdrawal

A. Relevant MOA Provision

Paragraph 15 of the MOA provides:

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

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

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

B. Baylor

1. Assessment

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

2. Findings

The Regional Medical Director has submitted a draft of drug and alcohol withdrawal protocols for approval, which will be used by nurses. In addition, the State has reached an agreement with Brandywine Counseling, a methadone program, which allows for pregnant inmates to receive care with regard to opiate use directed by an experienced program. This program is only available during the normal work week. The Monitoring Team recommends that the State work with Brandywine Counseling in order to provide adequate coverage for weekends. The Monitoring Team did not find any instances in which a pregnant inmate did, in fact, experience withdrawal at the Facility during this monitoring period.

C. DCC

1. Assessment

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

2. Findings

The Regional Medical Director has submitted protocols to be used by the nurses, which include instructions as to when to notify the physician. The Monitoring Team approves of these protocols, and now awaits documented training to be provided to staff so that these protocols will be consistently implemented.

The Monitoring Team did not track any inmates at DCC who experienced withdrawal symptoms while at the Facility. The Monitoring Team plans to do so when the protocols to be used by nurses in these instances have been finalized and the nurses have received training with respect to the protocols.

D. HRYCI

1. Assessment

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

2. Findings

The Regional Medical Director has submitted protocols to be used by the nurses, which include instructions as to when to notify the physician. The Monitoring Team approves of these protocols, and now awaits documented training to be provided to staff so that these protocols will be consistently implemented.

The Monitoring Team did not track any inmates at HRYCI who experienced withdrawal symptoms while at the Facility. The Monitoring Team plans to do so when the protocols to be used by nurses in these instances have been finalized and the nurses have received training with respect to the protocols.

E. SCI

1. Assessment

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

2. Findings

The Regional Medical Director has submitted protocols to be used by the nurses, which include instructions as to when to notify the physician. The Monitoring Team approves of these protocols, and now awaits documented training to be provided to staff so that these protocols will be consistently implemented.

The Monitoring Team did not track any inmates at SCI who experienced withdrawal symptoms while at the Facility. The Monitoring Team plans to do so when the protocols to be used by nurses in these instances have been finalized and the nurses have received training with respect to the protocols.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State submit the recommendations from the Brandywine clinic regarding strategies to be used on a temporary basis for pregnant inmates who may go into opiate withdrawal until their specific care can be directed by the Brandywine staff after patients are seen at their facility.

At DCC and HRYCI, the Monitoring Team recommends that the State:

- Document the training with regard to the drug and alcohol withdrawal protocols; and
- Begin tracking compliance with these protocols in its CQI program.

At SCI, the Monitoring Team recommends that the State:

- Submit the instruction sheet and training and implementation schedule for this program to the Monitor’s office; and
- Begin monitoring compliance with the drug and alcohol withdrawal protocol.

16. Pregnant Inmates⁸³

A. Relevant MOA Provision

Paragraph 16 of the MOA provides:

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

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

B. Baylor

The Monitoring Team found that Baylor is in substantial compliance with this provision of the MOA. The Monitoring Team reviewed the records of seven inmates in the system who had been identified as pregnant. In each instance, patients were assessed on a timely basis, and were appropriately followed by healthcare staff. The patients were provided with prenatal vitamins and appropriate laboratory testing. All patients were monitored closely by an appropriately trained and credentialed clinician, and monitoring occurred on a regular basis. Monitoring was consistent with the American College of Obstetrics and Gynecology guidelines.

17. Communicable and Infectious Disease Management

A. Relevant MOA Provision

Paragraph 17 of the MOA provides:

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

The NCCHC recommends that facilities with populations over 500 inmates should have a committee to oversee infection control practices. P-B-01. The infection control

⁸³ As Baylor is the only one of the Facilities which houses female inmates, it is the only one to which this provision applies.

committee should consist of representation from the facility's administration, the responsible physician or designee, nursing and dental services, and other appropriate professional personnel involved in sanitation or disease control. *Id.* Further, facilities should follow a TB control plan that is consistent with current published guidelines from the Centers for Disease Control.

B. Baylor

1. Assessment

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

2. Findings

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

An RN is designated as the infection control nurse ("ICN"). The Monitoring team found that the ICN lacks clarity regarding her role. She would benefit from additional training and supervision.

The Monitoring Team also found that the reportable disease reports are not complete and accurate. For example, the CMS Reportable Disease Log for the months of January through March 2008 reflected four cases of gonorrhea, and four cases of Chlamydia, yet separate Department of Public Health reports for the same period show six cases of gonorrhea, and eighteen cases of Chlamydia. The Monitoring Team performed a random check of ten names on the public health report to see how many cases were documented as being treated. The Monitoring Team found six cases that were not listed on the treatment list.⁸⁴ This raises significant concerns about the reliability of systems for identifying, treating, tracking, and reporting of patients with communicable diseases as required by the MOA.

Moreover, the Monitoring Team found that the State's policies and procedures currently do not call for routine screening of detainees and sentenced inmates for sexually transmitted infections ("STIs"), despite the very high risk profile of this population.⁸⁵ If a detainee has had a physical examination in the past year, she is not offered an STI screening, even if she has a high risk profile.⁸⁶ Because many individuals with STIs are asymptomatic, the current policy very likely results in patients entering and leaving Baylor with untreated STIs.

⁸⁴ It is unclear whether this reflects that the patients were not treated, or simply that they were being treated but were not listed as being treated.

⁸⁵ Staff reports that local law enforcement routinely performs mass arrests of prostitutes who may or may not be tested for STDs as well as women who exchange sex for drugs.

⁸⁶ The Monitoring Team notes that a review of sick call records reflected that even when screening for gonorrhea and Chlamydia were ordered, that test results were not in the records

The Monitoring Team has learned that the State is having discussions with the Department of Public Health regarding establishing an STI screening program. The Monitoring Team supports this step and believes that it is a positive step toward developing an effective communicable disease screening program.

Finally, the facility is not conducting local infection control meetings as required by the MOA.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team assessed compliance with this provision by reviewing policies and procedures, and actual practices related to infection control and reportable diseases. This includes determining whether there is an effective program to detect inmates with communicable diseases (*e.g.*, HIV, Chlamydia and gonorrhea, syphilis, Methicillin-Resistant *Staphylococcus Aureus* (“MRSA”), and TB infection), and whether the facility uses this information to identify, treat and control communicable diseases.

According to facility leadership, the infection control nurse was recently terminated due to failure to fulfill her duties. This included no reporting of communicable diseases to the state since January 2008. The facility has not conducted infection control meetings. Therefore there is no active system in place to monitor the prevalence and incidence of communicable diseases.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team evaluated this provision by reviewing policies and procedures related to infection control and communicable disease screening programs. The Monitoring Team reviewed nine health records to determine compliance with annual TB skin testing. The Monitoring Team reviewed ten employee records to assess compliance with TB skin testing, and Hepatitis B immunization. The Monitoring Team also reviewed compliance with infection control practices in the facility.

With respect to policies and procedures, CMS has an infection control manual dated 2007 that is compliant with OSHA guidelines, to which CMS is subject as a private company.

With respect to TB skin testing, staff track and schedule inmates who require testing using DACS. The infection control coordinator (“ICC”) prints out a monthly report, which shows the inmates due for the test that month. Nine out of nine records reviewed indicated that the inmate had a TB skin test performed in April 2008 as indicated by the DACS report.

The ICC indicated that employee TB skin testing and Hepatitis B vaccination is not being tracked. The ICC indicated she is in the process of developing an excel spreadsheet to track and implement employee TB skin testing. Four out of ten staff records revealed that those employees did not have a current TB skin test documented. One employee record did not have a record of Hepatitis B immunization even though a consent form had been signed.

With respect to engineering controls, personal protective equipment (*e.g.*, masks/eye shields, gloves, booties, barrier gowns) was not stored in a single location, but was located in two different rooms in the medical unit. The Monitoring Team recommends that the State consolidate these items into one area. Further, biohazard storage boxes were locked in a closet with the door labeled “Biohazard”; however, the boxes were not on pallets as required. The laboratory room does have an eyewash station, but it does not function correctly and sprays onto the floor and the covers that were attached did not fit over the eye wash nozzles. In addition, there was no record that quarterly testing of the station had been done.

When the Monitoring Team inquired about documentation of training content provided to inmate workers who clean up blood or other potentially infectious fluid spills, this information was not readily available.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team found that the infection control program at SCI is in the early stages of development. Extensive infection control policies and procedures are in place, and a nurse has recently been assigned to infection control duties. There is a job description for her position, but she has not had any formal training.

With respect to statistical data, SCI maintains records of patients with communicable diseases who have been reported to the local or state health department.

Currently, the infection control nurse monitors skin culture reports to detect MRSA infections, but no other culture reports (*e.g.*, urine culture, etc). SCI has not yet implemented infection control meetings in which trends in communicable diseases (*e.g.*, TB skin testing programs for staff and inmates, incidence of MRSA skin infections, etc.) are monitored and addressed. Finally, there is no schedule of sanitation and infection control activities to be performed in each clinical area.

F. Recommendations

At Baylor, the Monitoring Team makes the following recommendations:

- The Director of Nurses should provide additional training and supervision to the infection control nurse;
- The health care leadership should establish a more reliable system for screening, treating, tracking and reporting of communicable diseases;
- The State and CMS should implement a policy and procedure to routinely screen and treat detainees/sentenced inmates for STIs; and
- The health care leadership should implement infection control meetings to monitor trends in communicable diseases, and monitor compliance with infection control guidelines.

At HRYCI, the Monitoring Team recommends that the State:

- Complete the tracking log for employee TB skin testing and Hepatitis B vaccination. Perform and document the PPD testing and the Hepatitis B information per policy;
- Ensure that staff members who consent are given the vaccinations in a timely manner and that they are documented;
- Consolidate the personal protective equipment (“PPE”) that may be needed in an emergency in one area and educate staff on its use and location;
- Consider setting up PPE kits with plastic zip lock bags containing a barrier gown, mask/eye shield, gloves and a pair of booties;
- Place biohazard storage boxes on pallets in the storage closet;
- Obtain covers that fit the eyewash nozzles;
- Fix the eyewash station so it does not spray the floor; set up a log for quarterly testing and document the testing for functionality of the station; and
- Inmates who clean up blood spills should be provided training regarding use of PPE, offered Hepatitis B immunization if not already immune, and the training and immunization should be documented in the inmate’s health record.

At SCI, the Monitoring Team recommends that health care leadership arrange for the infection control nurse to receive appropriate training for her position. The facility should initiate infection control meetings that monitor and address trends in communicable diseases, as well as staff adherence to infection control practices such as hand-washing, use of PPE, disposal of sharps, etc. The infection control nurse should also monitor and ensure that sanitation and infection control practices in all areas of the medical clinic (pretrial and MSB) are developed and implemented.

18. Clinic Space and Equipment

A. Relevant MOA Provision

Paragraph 18 of the MOA provides:

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

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

- hand-washing facilities or appropriate alternate means of hand sanitization;
- examination tables;
- a light capable of providing direct illumination;
- scales;
- thermometers;
- blood pressure monitoring equipment;
- stethoscope;
- ophthalmoscope;

- otoscope;
- transportation equipment (*e.g.* wheelchair, stretcher);
- trash containers for biohazardous materials and sharps; and
- equipment and supplies for pelvic examinations if female inmates are housed in the facility.

Id.

B. Baylor

1. Assessment

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

2. Findings

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

The size of the medical clinic is essentially unchanged since the Monitoring Team's last visit. The clinic area is cleaner and better organized than before. However, the staff break room continues to serve as an office for the infection control nurse who counsels HIV-positive patients. This room does not afford adequate privacy to the patients. Storage space is also extremely limited, so items are stacked close to the ceiling, which poses a safety threat.

Although the medication room has been improved, the area is too small to adequately store equipment and medication supplies and cabinets are in disrepair (*e.g.*, missing cabinet doors and broken drawers).

The health records room is also very cramped, and contains two desks. There is a room in another part of the institution that is used to store other records, including those to be filed.

An additional examination room has been established for nurses to conduct nursing sick call; however, nurses continue to conduct encounters in the hallway due to lack of clinic rooms.

The Warden advised the Monitoring Team that as soon as renovations in another area of the facility are completed, medical space would be expanded into an adjacent area. The Monitoring Team believes that this effort will improve the ability of the facility to provide adequate clinic space significantly.

C. DCC

2. Assessment

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

1. Findings

To assess clinic space and equipment, the Monitoring Team toured the main medical clinic, the infirmary, the SHU Housing Unit and Maximum Housing Unit (“MHU”). The Monitoring Team reviewed each area with respect to sanitation, organization, lighting, access to hand-washing, medical equipment and supplies and the provision of privacy. The Monitoring Team also toured the medical administrative areas. The Monitoring Team found that although some improvements have been made with respect to clinic space and equipment, this area still requires significant improvement to achieve substantial compliance.

With respect to the medical physical plant, the Monitoring Team found that in the main medical clinic there is a moderately sized inmate waiting room with three locked doors controlling entry into the nurses’ station and other examination rooms, a hallway area that has mental health interview rooms and administrative offices, and the infirmary. Once the inmate is admitted into the back of the medical and the mental health/administrative area, there is no physical barrier to prevent inmates from accessing both clinical and administrative areas. This set up clearly represents a need for supervision of inmate movement in these areas.

In the main clinic area, the Monitoring Team noted active leaks in the ceiling near the staff break room, which required buckets to be placed in the hallway to collect water. Although the main hallways were clean, the Monitoring Team noted that offices and clinical areas were not clean (*e.g.*, floors and counters were dirty), and staff reported that clinical and administrative rooms are not cleaned and disinfected on a consistent basis.

The Monitoring Team toured the three clinical examination rooms in the back hallway and the treatment room behind the nurses’ station. The rooms were not uniformly equipped and supplied. Staff reported that there is no one designated as being responsible for ordering supplies, and, as a result, they frequently run out of supplies. One staff member reported that she hoards supplies to make sure that she is able perform adequate examinations.

The pharmacy/medication room is of insufficient size for pharmacy operations resulting in a cramped, disorganized environment. The floors were very dirty and did not appear to have been cleaned for some time.

There is no office designated for the Medical Director, and the DON and HSA are located in separate parts of the medical section.

The SHU administrative medical space and clinic examination rooms on the units

are inadequate for the size and mission of the facility (approximately 300 inmates). They are cramped, cluttered, and the floors dirty, which most likely is contributed to by the amount of furniture in the room. There is a room adjacent to the medical clinic that is used to store medical supplies. The supplies are stored on the floor and not inventoried for the purposes of establishing par levels. The Monitoring Team observed that both rooms could be reorganized in a manner that would permit sanitation activities to be more effectively performed in both rooms. The SHU medical clinics in the housing units also were not clean.

The MHU contains a Special Needs Unit for inmates with mental health conditions. The administrative medical space does not provide adequate space for medical and mental health operations given the size and mission of the building (approximately 600 inmates). The space consists of:

- An entry way used to store cabinets, a copier, wheelchairs and empty biohazard waste containers;
- A large room shared by eight mental health staff members;
- A small office shared by a physician and NP;
- An office used by a correctional lieutenant;
- A large office for correctional counselors;
- A staff break room and two staff bathrooms.

Although this unit has a major mental health mission, there is no medication preparation and storage room in this area. Each day large quantities of medications arrive for a pharmacy technician to sort for distribution to the housing units. The pharmacy technician performs this function in the hallway. If she is unable to sort and distribute all the medications on a daily basis, the medications are locked in the staff break room. This is not a secure and acceptable arrangement.

There are tables and chairs in the hallway, which serve as a work station for staff members, but the table partially obstructs the emergency exit door, which may pose a safety issue. Further, there are cleaning solutions stored openly on top of cabinets, which is also a safety issue.

The medical clinics in the MHU are well-organized and cleaner than the clinics in the SHU. Staff should be commended for their efforts in that regard.

D. HRYCI

1. Assessment

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

2. Findings

To assess this provision of the MOA, the Monitoring Team toured the medical clinic areas in both west and east buildings and the newly-established clinic in the booking area. The Monitoring Team reviewed each area with respect to sanitation, organization, lighting, access to hand-washing, medical equipment and supplies and the provision of privacy. The Monitoring Team also toured the medical administrative areas. Significant improvements have been made in this area with respect to clinic space and equipment, and HRYCI is close to achieving substantial compliance with this provision of the MOA.

In the booking area, medical screening has been relocated to a larger room, which has an adjacent room to store medical records. The room has been partially equipped with an otoscope/ophthalmoscope but does not contain an examination table. It does not have a sink for access to hand-washing but did contain hand sanitizer. Improvements are needed in floor sanitation in this area. There is no schedule of sanitation activities posted. As noted in prior reports, inmates stand at a half-door where they are interviewed by a nurse sitting at a desk. This arrangement does not permit adequate observation of the patient by the nurse and is not conducive to obtaining a thorough medical history and if necessary, performing a nursing assessment. The Monitoring Team learned that the reason the inmate was not permitted to come into the room was for security reasons. To address security concerns, the Monitoring Team recommends that consideration is given to installing cameras in the room and that the room is reorganized so that the nurse is closer to the door than the inmate.

The west side clinic/infirmery area is cleaner and better organized with improved use of existing space; however, it is still very cramped. In days just prior to the Monitoring Team's visit, the west side medication room was relocated to a larger room in the infirmary area. New cabinetry and shelving have been installed. The staff was in process of organizing the room. This area will serve as the medication room for both the east and west side, whereas previously, there had been medication rooms on both sides. Staff advised that the old medication room will be converted to a clinical examination room. These changes are significant improvements over previous conditions.

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

In the east side medical clinic, the archived medical records have been moved to a secure room in the booking area where they can be accessible when inmates return to the facility. A clean, organized, and well-equipped and supplied examination room has been established. The area that previously had been used to store and administer medications is no longer used for this purpose, as all medications have been moved to the west side medication room. There is currently only one examination room and staff advised us that both the clinician and nurse conduct sick call in the clinic room at the same time, which does not permit adequate privacy. Consideration should be given to converting the medication room into another examination room.

E. SCI

1. Assessment

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

2. Findings

The medical clinic space at the main medical area is completely inadequate for a facility of its size. Currently, there is only one room that is used for patient examinations. However, an administrative employee shares this office and the staff bathroom is in this room. Thus, clinicians see patients with another staff person continuously in the room, and staff trafficking to and from the bathroom. Under this arrangement, there is very little privacy. Often, two clinicians share this space even though there is only one examination table.

Moreover, two nurses conduct sick call at an open table side by side in the center of the clinic. These nurses do not have immediate access to an otoscope/ophthalmoscope to conduct health assessments. Inmates and officers are able to overhear conversations and observe any examinations that do take place. The medication room is too small and has makeshift cabinets for storage of medications and related-supplies.

Medical records are stored in unlocked file cabinets in the main medical clinic, and the medical records clerk (with health records on her desk) also sits in this area where inmates and officers circulate.

There is an administrative room in which four people work, which is cramped with desks, boxes and files. This arrangement makes it difficult to keep the room clean, and, as a result, the floors are dirty. The Monitoring Team observed mouse traps on the floor, and staff confirmed that mice have been observed in this room.

In the pretrial building clinic, there is a well-equipped clinic room that provides privacy of examinations. The sanitation of the floors was fair but needed improvement.

The State has advised the Monitoring Team that plans to purchase a triple trailer have been approved by the OHS and Facility leadership. This trailer will be used primarily for provision of mental health and dental services. The Monitoring Team views this step as positive, and it should reduce some of the congestion in the medical unit. However, the current plans for modification of the medical space following relocation of dental services do not include the addition of clinical examination rooms that would enable staff to provide appropriate clinical examinations with privacy. The current plans would result in nurse sick call still being conducted in the center of the clinic with the same limitations upon examinations and breaches of privacy. The plan does not permit the Facility to achieve a substantial compliance rating. The plans do include expansion of the medication room and a separate room for storage of medical records, which is appropriate.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State:

- Finalize and implement plans for expansion of the medical clinic area; and
- Inspect the facility for compliance with safety regulations and corrections as necessary.

At DCC, the Monitoring Team recommends the following:

- With respect to all health care service areas, the facility and health care leadership should develop and implement a master schedule of sanitation and disinfection activities;⁸⁷
- The health care and facility leadership should conduct a joint assessment of each area where medical services are delivered, and consider adjustments to optimize the use of existing space, such as the following:
 - Provide an office for the Medical Director;
 - If at all possible, establish physical separation (*e.g.*, adding walls or doors) of administrative space where inmate traffic does or should not occur (*e.g.*, health care leadership offices, medical records, staff conference room) from clinical areas where inmate traffic occurs (*e.g.*, examination rooms and mental health interview rooms);
 - Consider expanding the pharmacy/medication room into adjacent areas. The room should be regularly cleaned and completely reorganized;

⁸⁷ The schedule should list the type of activity (*e.g.*, stripping and waxing of floors, disinfecting examination tables, etc.), the frequency (*e.g.*, monthly, weekly, daily, each shift, etc.) and who is responsible for performing and monitoring each task. This system should include administrative areas and clinics in each of the housing units. An inspection system should be put in place to ensure that the desired results are achieved. Structural problems (*e.g.*, ceiling leaks) should be repaired in a timely manner.

- In the SHU, consider expansion of the administrative area into the room used to store medical supplies, which should permit more effective sanitation and improved organization. Inventory equipment and supplies and establish par levels; and
- In the MHU, establish a medication room to securely store medications and other medical supplies. Consider converting one staff bathroom to a storage room for cabinets, wheelchairs, etc. Optimize use of the entry way (*e.g.* establish work stations for mental health or nursing staff). Remove the work tables from the hallway that partially obstruct emergency exit doors. If this is not possible with existing use of space, consider relocation of non-health care personnel to other areas of the building.

At HRYCI, the Monitoring Team makes the following recommendations:

- In the booking area, nurses should interview inmates in the room to provide adequate privacy. To address security concerns, consideration should be given to installing a Plexiglas window or cameras in this area;
- On the west side, clinical encounters should be performed with adequate visual and auditory privacy. The establishment of an additional examination rooms in the infirmary and radiology room should provide additional options; and
- Consider converting the east side medication room into an examination room for nurses to conduct sick call.

At SCI, the Monitoring Team recommends that three clinical examination rooms be established in the clinic to enable nurses and clinicians to conduct examinations with adequate privacy. The Monitoring team also recommends that at least one room is established that provides the essential elements to provide adequate examinations and privacy. These examination rooms should be identically equipped and supplied. This will likely require that administrative staff relocate to other areas of the facility; however providing sufficient space to provide adequate medical services is the highest priority. The Monitoring team also recommends that the area designated for the secure storage of medical records be of sufficient size to permit medical records staff to perform their duties. The expanded medication room should include sufficient cabinetry for storage of medications and supplies and access to a running sink. The cabinets should be lockable.

ACCESS TO CARE

19. Access to Medical and Mental Health Services

A. Relevant MOA Provision

Paragraph 19 of the MOA provides:

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

NCCHC standards generally recommend that inmates have access to care to meet their serious medical, dental, and mental health needs, and that unreasonable barriers to inmates' access to health services are to be avoided.⁸⁸ J-E-01; P-E-01. The MOA provides the requirements for the Facilities' sick call process, which is a large part of affording inmates access to care. The MOA requires that appropriate medical staff screen⁸⁹ all written requests for medical and/or mental health care within 24 hours of submission, and see patients within the next 72 hours, or sooner if medically appropriate. Further, the MOA sets forth the required elements of the State's policies and procedures relating to the sick call process. Those elements are: (i) an explanation of the order in which to schedule patients, (ii) a procedure for scheduling patients, (iii) where patients should be treated, (iv) the requirements for clinical evaluations; and (v) the maintenance of a sick call log. With respect to patient scheduling, not every sick call slip requires an appointment; however, when a sick call slip describes a clinical symptom, a face-to-face encounter between the inmate and a health professional is required. J-E-07; P-E-07. The

⁸⁸ "Access to care" means that in a timely manner, a patient can be seen by a clinician, be given a professional clinical judgment, and receive care that is ordered. J-E-01; P-E-01. The NCCHC provides the following examples of unreasonable barriers to inmate health care: (i) punishing inmates for seeking care for their serious health needs; (ii) assessing excessive co-pays; and (iii) deterring inmates from seeking care for their serious health needs, such as by holding sick call at 2:00 a.m., when the practice is not reasonably related to the needs of the institution. *Id.*

⁸⁹ The process of screening the written requests for medical or mental health care is referred to as "triage." The NCCHC defines "triage" as "the sorting and classifying of inmates' health requests to determine priority of need and the proper place for health care to be rendered." J-E-07; P-E-07.

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

B. Baylor

1. Assessment

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

2. Findings

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

The Monitoring Team found that the sick call program at Baylor lacks an adequate system of tracking the timeliness of follow-up appointments for patients who have been referred by the nurse to the advanced level provider. The log book that the staff at Baylor was using at the time of the Monitoring Team’s visit did not track the sequence of the services provided.

The Monitoring Team found that while the initial screenings of sick call requests is occurring on a timely basis, only four out of ten patients were seen by a nurse within 72 hours for the face-to-face encounter as required by the MOA.⁹⁰ Of the remaining six patients, two were not seen at all, including a patient complaining of fever, nausea, vomiting and blood in her urine, suggesting a complicated urinary tract infection. The Monitoring Team referred this patient’s record to the DON for immediate evaluation.

The quality of the nursing assessments performed at nursing sick call⁹¹ also needs improvement with respect to the accuracy and completeness of both the patient history and physical assessment. Nursing sick call is conducted by the charge nurse, who is an RN. In her absence, however, nursing sick call may be conducted by an LPN. Sick call should be performed by RNs, who have had adequate training in health assessment and nursing protocols.

⁹⁰ One the patients cited had been seen by a nurse, but there was not a sick call request in her health record, so the timeliness of triage and the encounter could not be assessed.

⁹¹ “Nursing sick call” is the first clinical encounter with an inmate after he or she has submitted a sick call request, which is also known as a “sick call slip.” It is this clinical encounter that must take place within 72 hours of submission of the sick call request, and will lead to a referral to a physician if necessary.

Further, the Monitoring Team reviewed the nursing protocol forms, and found them to be poorly designed in some instances in that they do not prompt the nurse to elicit important presenting symptoms or information about a patient's medical history.

A nurse referred the patient to a clinician in three of the ten cases. In each case, the referral appointment either did not take place in a timely manner or did not take place at all. The Monitoring Team also found cases in which the primary care provider did not adequately address other significant problems such as hypertension, which were incidental to the reason for referral, or failed to follow up with patients as would have been appropriate following the initial treatment.⁹²

To evaluate the timeliness of the referral process for those patients who actually were referred to a primary care provider, the Monitoring Team selected eight records of patients known to have been seen by the primary care provider. In each of the eight records reviewed, follow-up occurred in less than one week from the patient's appointment with the nurse. Thus, in cases in which there was a referral to a provider, the timeliness of the visit was compliant with the requirements of this provision of the MOA. In addition, the clinical visits by the advanced level provider were appropriate. The Monitoring Team also found two records in which the nurses determined a more urgent need for follow-up, and these follow-ups occurred either the same day or the next day.

With respect to access to mental health services, the Monitoring Team randomly selected nine records from the sick call log based on whether there was an indication in the log that the inmate actually had been seen, but only six were appropriate for this study.⁹³ Of these records, only half met the criteria set forth by this provision of the MOA. There appears to be a decrease in performance with regard to responding to sick call requests. As staffing levels for mental health professionals at Baylor have not changed significantly (one counselor was moved to another site), it is possible that the decrease could be due to the lack of a mental health clerk who could track timeframes and generate clinical daily assignments for the counselors.

C. DCC

⁹² The Monitoring Team also notes that the sample records reviewed revealed that there were other instances aside from the encounter selected for review in which a nurse or clinician failed to see the patient in a timely manner or at all in response to a sick call request. In addition, the Monitoring Team also noticed that in three out of the ten records reviewed to monitor this provision of the MOA, the date of the patient's admission to Baylor that was listed on the intake screening report was incorrect. The discrepancies in dates of admission were three weeks, eight months and twelve months, respectively. Staff told the Monitoring Team that this is a problem stemming from DACS. The Monitoring Team recommends that the State review DACS to determine if this report is accurate if the State has not done so already, as such a glitch could impact the Monitoring Team's assessment of the timeliness of intake screening reports.

⁹³ Two records did not contain 2008 data, and therefore, were insufficient for review. One record was unavailable for review.

1. Assessment

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

2. Findings

While monitoring this provision of the MOA at DCC, the Monitoring Team examined the following: (i) the housing units (to determine whether there were lockable containers in which inmates could confidentially place sick call requests); and (ii) twenty health records selected from nursing sick call logs. The health records reviewed represented a sample from three areas of the facility where health care services are delivered: the main medical clinic (dispensary), the SHU, and the MHU. The health records were reviewed for the timeliness and appropriateness of nursing care delivered. Further, if the nurse referred the patient to a primary care provider, the Monitoring Team reviewed the timeliness and appropriateness of medical care.

Ability of Inmates to Submit Sick call requests

At DCC, there is a process that is supposed to be followed with respect to allowing inmates access to care, but it does not appear that the system is functioning adequately. The nurses are responsible for making sure that there is an adequate supply of blank Sick call request forms available to inmates in the various housing units. In the SHU and MHU, however, correctional officers are responsible for providing access to the sick call requests. Inmates sometimes complain that officers run out of forms.

Assuming that the inmate receives a blank sick call request, the inmate is supposed to be able to either put the sick call request in a locked box, or hand it to a nurse during medication rounds. Although most of the housing units have boxes in which the inmates can deposit Sick call requests, the Monitoring Team found that there are no locked boxes in the SHU (even though there are grievance boxes in the SHU). Nurses pass medications twice daily and pick up the sick call forms during medication passes. The LPN who collects the sick call requests is then supposed to give the forms to a different LPN who is to screen the sick call requests, and schedule the patient in DACS to see a nurse or physician.

When the Monitoring Team toured the SHU, one inmate complained that the sick call requests he gives to staff “disappear.” The Monitoring Team did not find corroborating evidence of the claimed disappearance of sick call requests. Further, nurses in the MHU report that they have not had DACS training. Thus, it would be difficult to ensure that those nurses are accurately scheduling nurse or physician appointments using DACS.

Staffing of Sick Call

Appropriate nurse staffing for sick call is an issue at DCC. Sick call is conducted either by an LPN or an RN.⁹⁴ The Monitoring Team observed an LPN conducting sick call in the main dispensary, and two RNs conducting sick call and medication passage in the SHU and the MHU. In the SHU and MHU, when the RNs have days off, the DON assigns LPNs to pass medications, but sick call is not conducted. The DON would like to add another RN to the evening shift to provide additional coverage for when the day RNs have off days, and has hired a new RN to be in charge of the nursing sick call.

Timeliness and Appropriateness of Sick Call

The Monitoring Team reviewed twenty health records of inmates who requested sick services. In sixteen out of the twenty records, the nurse completed the initial review of the Sick call request within 24 hours. One inmate subsequently cancelled his sick call request. Thus, the Monitoring Team then reviewed only nineteen of the twenty records.

Only nine out of the remaining nineteen records reflected that the face-to-face clinical encounter with the patient took place in a timely manner following triage of the Sick call requests. In eight out of nineteen records, the nurse directly referred the patient to a primary care provider and failed to perform any assessment. Of the fifteen patients who were referred to a physician, three were seen in a timely manner, four were not seen in a timely manner, and eight were not seen at all. Thus, 75% the records reviewed showed that patients were either not seen in a timely manner or at all.

The Monitoring Team reviewed ten health records of patients who had been referred to an advanced level provider after having been seen by a nurse. In each of these ten records, the patient was seen by the advanced level provider within five days of the referral, which is a reasonable period of time.

In some cases the evaluation and follow-up by the primary care provider was not appropriate. For example, one patient complained of fever, abdominal pain and vomiting. A nurse did not see the patient but referred him directly to the NP, who did not see him for 3 days. The NP ordered tests that were returned ten days later, and reflected that the patient had a urinary tract infection. The report was not reviewed for an additional five days, and at that time the NP wrote orders for antibiotics. The NP did not inform the patient of his diagnosis, and the applicable MAR showed that the patient never received the antibiotics. This is a serious case because the patient had signs and symptoms of a kidney infection. The Monitoring Team discussed this case with staff, and the NP planned to follow-up with the patient.

⁹⁴ Beginning in January 2008, the RNs conducting nurse sick call receive four hours of training on nursing assessment. For all intents and purposes, there is not an adequate health assessment and nursing protocol training program.

Other Access to Care Issues at DCC

Another serious access problem relates to the use of DACS to schedule patients. It appears that the number of available appointments in DACS may not be enough to keep up with patient demand. For example, although there is now an additional NP at DCC, the number of clinical appointments available to be scheduled in DACS has not been correspondingly increased. Once the appointment schedule in DACS is full for a given day, the program will not allow the patient to be scheduled that day, and he is bumped to the next business day. The practical result is a constant backlog of patients, some of whom are never seen.

In addition, staff reported that when they ask custody staff to have a patient escorted to the clinic for urgent matters (*e.g.*, abnormal laboratory or radiology test results), custody staff often refuse to do so because the patient is not on the DACS list. If it is reported to custody staff that the patient is not on the DACS list because it is an urgent matter, custody staff sometimes challenges that assertion. The Monitoring Team observed this phenomenon during a visit. When health care staff attempted to have a patient brought to the clinic for evaluation of a fractured hand, an officer refused to arrange to have the patient brought to the clinic. At that time, the waiting room was not overcrowded with inmates, which is one legitimate reason why an inmate might not be able to be brought to the clinic right away. The medical staff later called another correctional officer in the control station to arrange for the patient to be brought up.⁹⁵

Other Mental Health Issues

With respect to access to mental health services, the Monitoring Team randomly selected ten records from the sick call log, based on whether there was an indication in the log that the inmate actually had been seen, but only eight were produced. Of these eight records, only three met the requirements set forth by this provision of the MOA. In fact, in three of the five records which did not meet the requirements, there were no entries in the inmate's health record which indicated the request was screened or that the patient was seen.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed the sick call logs at HRYCI for the 90 days prior to the Monitoring Team's visit, and then selected twenty health records to review the timeliness

⁹⁵ The correctional officer did bring the patient to the clinic.

of triage of the sick call request and scheduled medical encounter. Of the twenty records selected, ten were from the west side of the facility, which houses pretrial detainees, and ten were selected from east side of the facility, which houses sentenced inmates.

In general, the Monitoring Team found that there were serious problems with access to care at HRYCI. Of the twenty records, five patients were seen in a timely manner by a nurse or NP, eight were not seen in a timely manner, and seven were not seen at all.⁹⁶ Thus, 75% of the patients whose health records were reviewed were either not seen in a timely manner or not seen at all. The reasons patients were not seen in a timely manner appear to be related both to health care and security practices.

The Monitoring Team found that the Sick call requests are collected each day, and an RN triages the form. Although the Monitoring Team believes that the triage process is occurring the same day, the nurses have not consistently initialed and dated the triage decision, so the Monitoring Team is unable to confirm if this is true. Importantly, in fifteen out of twenty records, a nurse did not clinically evaluate the patient at all. Instead, the patient was either directly scheduled to see an advanced provider or a nurse saw the patient but deferred an assessment pending referral to a provider. Further, only one out of five patients assessed by a nurse was appropriately evaluated. Of the nine patients who were referred to an NP or physician, the average period of time from the referral was 10.8 days, with an overall range of four to eighteen days).⁹⁷

The Monitoring Team also found that LPNs independently perform nurse sick call. LPNs do not have the requisite training and education to conduct independent assessments and should not be assigned to perform sick call.

With respect to the sick call tracking logs, the Monitoring Team found that the logs are supposed to be used to document (i) receipt of the sick call requests; (ii) the triage priority, (iii) the date the patient is scheduled for a clinical encounter, and (iv) the date the patient was seen. The log is also used as a tool to schedule patient appointments in DACS. However, the Monitoring Team found that many logs are not complete, so that it is difficult to determine when the patient was scheduled for a clinical encounter and when the clinical encounter actually took place.

Moreover, the Monitoring Team found that on the logs and in DACS, staff noted that patients had been seen by a health care professional when, in fact, they had not. In order to determine why such inaccuracies existed, the Monitoring Team retrieved a sick call report from DACS for a random date of April 2, 2008. From that report, the Monitoring Team randomly selected eight records of patients who were noted as having submitted a sick call request and

⁹⁶ The Monitoring Team confirmed that all seven of these patients were in the facility at the time the requests were submitted and triaged, and that an appropriate period of time had elapsed from the triage for an appointment to be scheduled had elapsed.

⁹⁷ In urgent cases, this process should take place within 24 hours, and in routine cases, within seven days.

been seen by a health care professional. The Monitoring Team then retrieved the health records of these patients in order to verify that they had been seen. The Monitoring Team found that in four out of eight records, patients were documented as having been seen who were not, in fact, seen.

After finding this level of inaccuracy, the Monitoring Team then generated a report of completed medical visits for the period of March 31, through April 14, 2008, randomly selected 13 names from this list, and compared them against the medical record. This review revealed that, of the 13 records reviewed, six patients were seen on the dates specified, two patients were not seen at all, four patients were not seen on the dates they were documented as having been seen, and one patient refused the encounter. Thus, the Monitoring Team concludes that, at least as of the time of the Monitoring Team's visit, DACS cannot be relied upon to accurately reflect the status of patient appointments.

With respect to security practices, the Monitoring Team found that two correctional officers have been assigned to the medical unit, both of whom are reported to be very conscientious with regard to sending for inmates and trying to ensure smooth operations with respect to patient flow into and out of the clinic. However, the Monitoring Team also received anecdotal information that on a "good" day, clinic staff is only able to see approximately 70% of inmates who are on the list to be seen. On a "bad" day this may drop to 50% or less. According to staff, contributing to this are frequent "code reds" throughout the day, which shut down all inmate movement at the facility. The practical result is that the number of "code reds" at the facility contribute to the problem of patients being seen on an untimely basis or not at all.⁹⁸

With respect to access to mental health services, through its review of records the Monitoring Team found that implementation of procedures related to the sick call process for mental health issues has been problematic. This is due to problems related to both the timeliness of the response and the nature of the responses themselves, which at times have not been coordinated within the mental health system. Specifically, the Monitoring Team reviewed some records where different mental health clinicians responded within close periods of time to the same inmate request without referencing or acknowledging recent assessments by colleagues.

E. SCI

1. Assessment

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

⁹⁸ The Monitoring team recognizes that "code reds" are a vital part of a correctional facility's efforts to maintain order and security. The Monitoring Team recommends, however, that the facility examine its current practices to determine whether it is possible to decrease the impact of these security procedures on the ability of the State to reach substantial compliance with respect to this provision of the MOA.

compliance with respect to mental health services, and not in compliance with respect to medical services.

2. Findings

The Monitoring Team found that although nursing sick call was taking place within 72 hours of inmate submission of the sick call request as required by the MOA, in eight of ten records reviewed, the nurse did not perform an appropriate assessment. In five out of the ten records reviewed, the nurse did not appropriately refer the patient. In four out of those five cases in which a nurse did refer the patient to a clinician, the referral appointment with the clinician did not take place. In the fifth case, the patient was seen by the physician the same day as the referral, but his health record revealed that from November 2007 to January 2008, this patient had requested to be seen by a doctor five times before he was seen. The day after the physician saw him, he was admitted to the hospital in acute renal failure and is currently undergoing dialysis.

The Monitoring Team found that nursing sick call is being performed by both LPNs, and by RNs, some of whom have not received adequate training in physical assessment and nursing protocols.⁹⁹ As discussed above, it is not appropriate for LPNs to independently perform nursing sick calls. Further, although nurses are using the nursing protocol forms, the Monitoring Team found that the nurses often select the wrong form. For example, one patient complained of scrotal pain, and the nurse used the musculoskeletal assessment form. As a result of choosing the incorrect form, the nurse did not perform an appropriate patient history or physical examination that was pertinent to the complaint. The Monitoring Team also found that nurses often document assessments such as “alteration in comfort” which, as a stand-alone nursing diagnosis, does not explain anything.

The Monitoring Team also found substantial delays in follow-up from referral by nurse to being seen by the physician. In fact, the Monitoring Team learned from both the physician and the HSA that there was a huge backlog of between 100 and 200 visits of patients to be seen. Thus, there is a delay as long as 30 days for a patient to be seen by a physician after referral from a sick call request.

The Monitoring Team reviewed the log tracking sheet referrals that are made after a nursing evaluation pursuant to a sick call request. The Monitoring Team found that the log tracking sheet contained many inconsistencies. For instance, there were names of patients on the list who do not appear from nursing note in their health record to have been referred. On the other hand, there were names of patients on the list as having no referral whose health record revealed had been referred. As a result, the tracking sheet is not a useful way of determining which patients should be seen. In fact, nurses were using codes on the tracking sheet that did not correspond to those listed on the legend of the form.

⁹⁹ The training that the RNs have been receiving concerning health assessment and nursing protocols is a total of eight hours, which is inadequate.

The substantial delays in referrals from nurse to an advanced level provider are symptomatic of other problems at SCI such as limited space, which limits the amount of provider time available. In addition, there is a problem with the number of hours available for primary care service. The Medical Director has other assignments, particularly with regard to seeing patients with communicable diseases at other institutions, so he is available less than 40 hours a week on-site. In addition, the NP has an assignment at the VOP facility, which also takes her away. There are twenty hours of part-time physician coverage, which might be reconfigured into 40 hours of an additional NP. For this to be an effective strategy, of course the space and security issues have to be resolved.

Finally, it appears that there are some issues at SCI with regard to access to patients due to security practices. The Monitoring Team was informed that when security believes that there are too many patients in the area, they turn away patients from the waiting area without any consultation with the medical staff. The Monitoring Team also learned that SCI also has frequent “code reds,” which essentially closed down the medical area while patients returned to their cells. These “code reds” can disrupt an hour or two within a given day.

Regarding access to mental health services at SCI, the Monitoring Team found that the mental health sick call log did not include dates regarding the duration of time between receipt of the mental health sick call and when the inmate was actually seen by the clinician. Due to staffing vacancies at the facility, there was a long waiting list of inmates waiting to be seen for routine mental health appointments.

The Monitoring Team reviewed the minutes from a monthly meeting of the SCI CQI committee. These minutes indicated an audit demonstrated triage time for sick call requests made on weekdays was within the required time period 53% of the time. Further documentation demonstrated triage time to sick call requests made on weekends was within the required time period 60% of the time. Staff confirmed that there are problems meeting the MOA timeframes as a result of the current staffing vacancies. Staff reported that the duration of time from receipt of sick call requests to staff actually assessing the inmate is approximately one week, well outside of the required time.

F. Recommendations

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

- Revise the sick call policies and procedures to require an RN or higher level provider perform nursing sick call;
- Assess and, if necessary, supplement RN staffing patterns to ensure that an RN is available to conduct sick call;
- Establish a triage system that ensures that patients receive an appropriate evaluation within 72 hours, and sooner if clinically indicated;

- Ensure that nurse referrals to a primary care provider take place in a timely manner. At the referral appointment, clinicians should address all significant problems, not just the reason for referral;
- Ensure the integrity of the information entered into DACS with respect to admission dates; and
- Remedy the aforementioned staffing vacancies.

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

- Implement a system that facilitates tracking the timeliness of advanced level provider visit after referral by a nurse;
- Ensure access to care by having health care staff responsible for providing sick call requests and by providing locked boxes in all units so that inmates may confidentially submit forms;
- Ensure that DACS is appropriately utilized to schedule patients in accordance with the demand;
- The Warden, facility-level healthcare leadership in collaboration, and OHS should ensure that health care staff has timely access to patients in accordance with clinical needs and custody staff does not refuse to bring patients to the clinic;
- Revise the policies and procedures to require an RN or higher level provider to perform nursing sick call;
- Assess and, if necessary, supplement RN staffing patterns to provide the resources necessary to accomplish the above;
- Establish a triage system that ensures that patients receive an appropriate evaluation within 72 hours and sooner, if clinically indicated; and
- Ensure that patient referrals to a primary care provider occur in a timely manner.

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

- Revise the policies and procedures to require an RN or higher level provider perform sick call;
- Assess and, if necessary, supplement RN staffing patterns to provide the resources necessary to accomplish the above;
- Establish a triage system that ensures that patients receive an appropriate evaluation within 72 hours and sooner, if clinically indicated;

- Ensure the integrity of the information entered into DACS with respect to patient status;
- The Monitoring Team recommends that the facility Warden, facility-level health care leadership, and the OHS collaborate to explore practices to expand access to patients while maintaining a safe and secure environment; and
- Develop and implement a policy in order to promote better coordination among mental health staff when responding to referrals.

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

- Ensure that OHS, CMS regional and on-site leadership, and custodial leadership should meet together to begin to resolve the Custody, resource, scheduling, and space issues in order to meet the demands for services;¹⁰⁰
- Ensure that only RNs should perform nursing sick call assessments;
- Develop and implement a more comprehensive training program for health assessment and nursing protocols;
- Ensure that health care assessments are performed in appropriate clinical settings with privacy; and
- Conduct quality improvement studies during the next six months to monitor progress and make corrections as indicated.

20. Isolation Rounds

A. Relevant MOA Provision

Paragraph 20 of the MOA provides:

The State shall ensure that medical staff¹⁰¹ make daily sick call rounds in the isolation areas, and that nursing staff¹⁰² make rounds at least three times a week,

¹⁰⁰ Included in those discussions should be a re-evaluation of security procedures, space utilization, staffing configuration, and a system for scheduling and tracking. The Monitoring Team would like to be apprised of the results of those discussions.

¹⁰¹ According to the MOA, the term “medical staff” includes “medical professionals, nursing staff, and certified medical assistants.” *See* MOA II.I. The term “medical professionals” includes “a licensed physician, licensed physician’s assistant, or a licensed nurse practitioner provision services at a facility and currently licensed to the extent required by the State of Delaware to deliver those health services he or she has undertaken to provide” *See* MOA II.J.

to give inmates in isolation¹⁰³ adequate opportunities to contact and discuss health and mental health concerns with medical staff and mental health professionals¹⁰⁴ in a setting that affords as much privacy as security will allow.

The purpose of this MOA provision is to ensure that inmates placed in isolation maintain their medical and mental health while physically and socially isolated from the rest of the inmate population.¹⁰⁵ J-E-09; P-E-09. The NCCHC recommends that, upon notification that an inmate is placed in segregation,¹⁰⁶ a qualified health care professional reviews the inmate's health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation, and that such an evaluation should be placed in the inmate's medical record. *Id.*

The Second Report identified some confusion over the proper interpretation of this provision of the MOA. The NCCHC standard that appears to be applicable to this provision of the MOA also appears to apply in a limited sense to provision 39 of the MOA. According to the NCCHC, monitoring of inmates in segregation should be dictated by the inmate's degree of isolation. *Id.* Inmates under extreme isolation¹⁰⁷ with little or no contact with other individuals should be monitored daily by medical staff and at least once a week by mental health staff. *Id.* Inmates who are segregated and have limited contact with staff or other inmates are monitored three days a week by medical or mental health staff. *Id.* Inmates who are allowed periods of recreation or other routine social contact among themselves while being segregated from the general population should be checked weekly by medical or mental health staff. *Id.*

¹⁰² According to the MOA, "Nursing Staff" means "registered nurses, licensed practical nurses, and licensed vocational nurses providing services at a facility and currently licensed to the extent required by the State of Delaware to deliver those health services he or she has undertaken to provide." *See* MOA II.M.

¹⁰³ According to the MOA, "isolation" means "the placement of an individual alone in a locked room or cell, except that it does not refer to adults single celled in general population." *See* MOA II.G.

¹⁰⁴ "Mental Health Professionals" means "an individual with a minimum of a master's-level education and training in psychiatry, psychology, counseling, psychiatric social work, activity therapy, recreational therapy or psychiatric nursing, currently licensed to the extent required by the State of Delaware to deliver those mental health services he or she has undertaken to provide." *See* MOA II.K.

¹⁰⁵ As this NCCHC standard applies to the MOA, it is more pertinent to MOA provision 39. Provision 20 of the MOA, is directed more towards ensuring that inmates in isolation have adequate access to care in general.

¹⁰⁶ A "segregated" inmate is one who is isolated from the general population and who receives services and activities apart from other inmates. J-E-09; P-E-09. Such segregation could include administrative segregation, protective custody, disciplinary segregation, or a SHU tier. *Id.*

¹⁰⁷ "Extreme isolation" means "situations in which inmates are seen by staff or other inmates fewer than three times a day." J-E-09; P-E-09.

In response to this confusion, the parties agreed that this provision of the MOA imposes requirements relating only to monitoring of inmates in isolation (as defined by the MOA; *see* above) by medical staff for medical and mental health issues, and provision 39 imposes requirements relating to monitoring of inmates in isolation by mental health staff.¹⁰⁸ Ultimately, in spite of all of the confusion, this MOA provision requires that medical staff make daily sick call rounds, and nursing staff make sick call rounds three times per week.

The sick call rounds performed pursuant to this provision of the MOA should ensure that each isolated inmate has the opportunity to request care for medical or mental health problems and allow staff to ascertain the inmate's general medical and mental health status. *Id.* The NCCHC standard recommends also that documentation of isolation rounds be made on individual logs or cell cards,¹⁰⁹ or in an inmate's health record and include: (1) the date and time of the contact; and (2) the signature or initials of the health staff member making the rounds. *Id.* Finally, any significant health findings should be documented in the inmate's health record. *Id.*

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team reviewed the State's policies and procedures relevant to this provision of the MOA, toured the isolation/segregation areas, and reviewed records of inmates placed in isolation.

The Monitoring Team was advised that nurses make the isolation rounds during the medication administration pass. The nurses document on the security log when they enter the unit; however, there is no documentation that isolation rounds are performed with respect to each inmate, and therefore, no documentation is placed in the health record.¹¹⁰ Therefore, the Monitoring Team is unable to determine if the medication administration passes that occur are sufficient to meet the requirement of this provision of the MOA, and, if so, if such rounds are adequate to afford, "inmates in isolation adequate opportunities to contact and discuss health and mental health concerns with medical staff and mental health professionals in a setting that affords as much privacy as security will allow," as required by the MOA.

¹⁰⁸ The State subsequently revised its policy regarding isolation rounds in order to cure any potential confusion, and provided the revised policy to the Monitoring Team.

¹⁰⁹ The applicable NCCHC standard also states that when the cards or logs are filled, they are filed in the inmates' health record.

¹¹⁰ Simply noting that a medication pass has occurred does not amount to appropriate documentation of the type of contact that inmates are required to have pursuant to this provision of the MOA.

C. DCC

1. Assessment

The Monitoring Team found that DCC is not in compliance with this provision of the MOA.¹¹¹

2. Findings

The Monitoring Team learned that nurses and mental health staff collaboratively conduct rounds in isolation/segregation six days per week. Nurses conduct rounds in the SHU three evenings per week, and mental health staff conducts segregation rounds on the alternate days. The Monitoring Team was unable to verify this information because it is not documented in the health record.

D. HRYCI

1. Assessment

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

2. Findings

To review compliance with isolation rounds, the Monitoring Team reviewed policy and procedures, toured isolation/segregation areas, and reviewed ten health records of inmates placed in isolation.

In all seven of the applicable segregation round documentation forms reviewed, the Monitoring Team found that segregation rounds were not documented as having taken place three times a week. In three of the seven forms reviewed, the date of the pre-segregation medical screening was blank. In eight of eight applicable health records, the pre-segregation exam form was not found.

The Monitoring Team notes that the DON has assigned an LPN to specifically conduct and monitor compliance with isolation rounds.

¹¹¹ This assessment of non-compliance is because the documentation to support that rounds are occurring in a timely and adequate manner was not adequate. If documentation can be provided, this assessment is likely to change.

E. SCI

1. Assessment

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

2. Findings

The facility has eighteen disciplinary isolation beds in Unit 4 (pretrial), and fourteen administrative segregation beds on MSB. The night shift makes daily rounds, and initials each sheet to documentation the rounds.

The Monitoring Team reviewed six logs of patients in segregation. In two of six records, the nurse did not document the date of notification that the inmate was placed in isolation. None of the records contained a note by the nurse regarding when the inmate was released from segregation. Thus, it was not possible from this documentation to determine if daily rounds were made in segregation.

F. Recommendations

At Baylor, the Monitoring Team makes the following recommendations:

- The DON should assign one staff member the responsibility for making and documenting segregation in compliance with applicable policies; and
- For inmates who are on the mental health caseload, the State should add a place on the form to document the date/time the inmate was placed in segregation and the date/time of release.

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

- Establish a system to document rounds in the health record; and
- For inmates who are on the mental health caseload, add a place on the form to document the date and time the inmate was placed in segregation, and the date and time he was released.

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

- Assign one staff member the responsibility for making and documenting segregation rounds three times weekly and on certain days (*e.g.*, Monday, Wednesday, and Friday); and
- Add a place on the form to document the date/time the inmate was placed in segregation and the date/time he was released.

At SCI, the Monitoring Team recommends that, for inmates who are on the mental health caseload, change the segregation form to reflect the date of admission to segregation as well as the date of release, and that nurses consistently complete this documentation.

21. Grievances

A. Relevant MOA Provision

Paragraph 21 of the MOA provides:

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

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

The NCCHC also recommends that in addition to the formal grievance mechanism, institutions attempt to informally resolve inmates' complaints about health services. J-A-11; P-A-11. The informal dispute resolution can consist of a face-to-face interview by a HSA, responsible physician, or nursing supervisor, and is often an effective way to resolve problems and demonstrate health staff's concern. *Id.* At the time of the Second Report, the State had informed the Monitoring Team that such an informal process had been put in place in at least one of the Facilities, with the face-to-face meetings occurring with the HSA. The Monitoring Team finds that such a process has been put in place for inmates who request such a meeting prior to submitting a grievance.

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

Finally, this provision of the MOA also requires that the State ensure that grievances and their outcomes are logged, reviewed, and analyzed on a regular basis to identify systemic issues in need of redress, and to develop and implement a procedure for discovering

and addressing all systemic problems raised through the grievance system. This requirement is most appropriately addressed in relation to provisions 54 and 55 of the MOA, which relate to the State's CQI efforts. *See* J-A-06; P-A-06 (NCCHC standards for CQI programs).

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

If the grievance is not resolved at Level 1, then it becomes Level 2. At Level 2, there is a committee that meets twice monthly, which consists of an RN, and two other medical staff members.¹¹² The Level 2 grievance process is to take place within 30 days of the date that the Level 1 grievance investigation is completed.

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

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

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team reviewed the existing grievances to determine the timeliness of the response. At both Level 1 and Level 2, grievances were handled on a timely basis, and the Monitoring Team did not find any overdue grievances at those levels. The Monitoring Team did not find that the review of any of the Level 3 grievances had exceeded the six month time period allotted for such review, and did not have the opportunity to assess the Level 3 grievances.

The Monitoring Team observed that the mental health staff is not involved with the grievance process at Baylor. This is true even in cases where the grievances are relevant to

¹¹² A security officer is also present, but only for security purposes and to enter information into DACS.

the mental health system.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team found that the DCC receives approximately 130 to 150 grievances a month. The Monitoring Team found that, at the time of the Monitoring Team's visit, there were outstanding grievances from previous years, including 136 that need to be resolved that were filed in 2007, and 350 from 2008 at the grievance Level 1. At the time of the Monitoring Team's visit, there were 107 outstanding Level 2 grievances. Finally, there were eighteen outstanding grievances at Level 3; however, those eighteen grievances were received as Level 3 beginning in early April 2008, and therefore, they are well within the time limits for Level 3 grievances.

D. HRYCI

1. Assessment

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

2. Findings

At the time of the Monitoring Team's visit, there were 32 Level 1 grievances outstanding. The oldest Level 1 grievance dated back to March 11, 2008, and 31 of the 32 Level 1 grievances were past due. Of the total Level 2 grievances, 29 were past due. Level 3 grievances were up to date.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team learned that at SCI the grievance process had broken down for over six months until late Fall 2007. As a result, there was a large backlog of grievances. At the time of the Monitoring Team's most recent visit, the Monitoring Team learned that there

were only 21 Level 1 grievances, and thirteen Level 2 grievances remaining of the initial backlog. The oldest Level 1 case was from January 21, 2008, and the oldest Level 2 case was from February 13, 2008.

Given the dramatic progress in resolving the backlog over just a couple of months, the Monitoring Team anticipates that the SCI grievance process should be up to date in relatively short order.

F. Recommendations

At Baylor, the Monitoring Team recommends that the OHS provide a report to the Monitoring Team with regard to all grievances that have reached the third level, when they were received and what is the current status.

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

- Develop a two-track system, with one person responsible for responding to new Level 1 grievances, and other individuals responsible for clearing up the backlog of overdue grievances from 2007 and 2008; and
- Track the number of grievances received per month in order to determine whether improvements in the efficiency of processes and continuity of care as well as improvements in provider performance result in a decrease in the number of grievances received.

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

- Continue its process of resolving the backlog of past-due grievances at Levels 1 and 2 while responding to timely to currently received grievances; and
- Monitor its performance with regard to timeliness of grievance responses.

At SCI, the Monitoring Team recommends that the State continue with its current strategies in order to resolve the small remaining backlog and to ensure maintaining timeliness for the ongoing grievances received.

CHRONIC DISEASE CARE

22. Chronic Disease Management Program

A. Relevant MOA Provision

Paragraph 22 of the MOA provides:

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

According to the NCCHC, an adequate chronic disease¹¹³ management program should identify patients with chronic diseases with the goal of decreasing the frequency and severity of symptoms, including preventing disease progression and fostering improvement in function. J-G-02; P-G-02. A chronic disease program should incorporate a treatment plan and regular clinic visits, according to the needs of the patient, and the generally accepted professional standards for the chronic disease(s) suffered by the patient.¹¹⁴ *Id.* The clinician responsible should monitor the patient's progress during clinic visits and, when necessary, change the treatment. *Id.* The program should also include patient education for symptom management. *Id.*

B. Baylor

1. Assessment

The Monitoring Team found that Baylor is in partial compliance with this provision of the MOA. For informational purposes, with respect to non-HIV chronic diseases, Baylor is in substantial compliance with this provision of the MOA.

¹¹³ A "chronic disease" is defined as "an illness or condition that affects an individual's well-being for an extended interval, usually (at least) 6 months, and generally is not curable but can be managed to provide optimum functioning within any limitations the condition imposes on the individual. J-G-02; P-G-02. Examples of a chronic disease include asthma, diabetes, high blood cholesterol, HIV, hypertension, seizure disorder, and TB. *Id.* Each chronic disease has a separate set of clinical guidelines that apply to appropriate treatment and control of the disease.

¹¹⁴ Each chronic disease has a separate set of clinical guidelines that apply to appropriate treatment and control of the disease. For example, the generally accepted professional standards for the treatment of TB can be found at the website for the Centers for Disease Control: http://www.cdc.gov/tb/pubs/PDA_TBGuidelines/default.htm.

1. **Findings**

Patients With Chronic Diseases Other Than HIV

The Monitoring Team reviewed nineteen records for care of the following diseases: Asthma (5), Hypertension (4), Diabetes (5) and Seizures (5). From these records, the Monitoring Team was able to assess 42 chronic disease clinic visits, as well as a substantial number of progress notes that were generated when patients were seen additional times for their chronic disease. The total number of patients with each of these diseases could not be ascertained since disease logs were incomplete or inaccurate. Currently, the Medical Director is attempting to accurately determine the number of diabetic patients at the facility.

The Medical Director saw the majority of patients in chronic care; occasionally, physicians from the other Facilities came to Baylor to provide coverage when the Medical Director could not see patients. Additionally, patients were seen between the chronic care clinic visits by both the Medical Director and the NP. The Monitoring Team found that when either of the facility providers saw the patients, care was complete, thoughtful and well documented. When providers from other sites came, however, care was less than optimal and the Medical Director lost continuity with these patients. The Monitoring Team has learned that the Medical Director has changed scheduling practices so that these providers will no longer be coming to Baylor.

The Monitoring Team found that appropriate laboratory data was ordered on patients with chronic disease (*i.e.*, HgA1c in diabetics, anticonvulsant levels in seizure patients); however, coordination of the drawing of blood for these tests in connection with the clinic visit is not adequate. The Monitoring Team found that the data available at the chronic care clinic was often old, and needed to be repeated. As a result, additional follow-up visits sometimes were necessary. The Monitoring Team has learned that the State is working on developing a system to rectify this problem. Specifically, the State has recently assigned a nurse to chronic care management and the newly-hired DON will be addressing this issue as well.

Patients With HIV

The Monitoring Team reviewed three separate lists of patients with HIV infection. The Monitoring Team found that the lists were not clear as to which inmates were still housed in the facility, and it took several attempts to obtain five records that were suitable for review. At the end of the visit, the Monitoring Team still was not able to determine the total number of HIV patients at the facility. Finally, only two of the five patients whose records the Monitoring Team reviewed had been prescribed HIV medications.

The Monitoring Team found that HIV patients were seen by both a primary care physician, and a physician with special training in HIV. The Monitoring Team did not find any serious patient care issues. However, in four of five records, HIV-related laboratory tests were not available at the time of the clinic visit. The delay was due to various reasons, including the physician not ordering the correct test, orders not being transcribed in a timely manner, and ordered tests not being obtained.

Although the Monitoring Team did not find any serious clinical issues, the Monitoring Team found one case in which the patient was eligible for HIV treatment, but there is no clear documentation that the physician has discussed treatment options with the patient. In another case, a physician started the patient on antiretroviral medication without current HIV laboratory tests. Laboratory tests should always be obtained prior to initiation of therapy to enable the clinician to evaluate the patient's response to treatment. In another case, the patient's order for HIV medications expired for three weeks before it was renewed. Finally, a patient arrived in early February 2008 whose last physical examination occurred during a previous admission in April 2007. She had a history of previous treatment with HIV medications, and her current laboratory test results showed significant immune suppression. She also had a history of a brain lesion (pituitary adenoma). The NP deferred the physical examination to the chronic disease visit; however, the patient was released in early March 2008 without ever having been seen, 28 days after arrival. Given this patient's significant medical history, either an intake physical examination or chronic disease visit should have taken place within seven days of arrival.

C. DCC

1. Assessment

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team found the HIV infection chronic care is not in compliance with the MOA, non-HIV chronic care in the general population to be in the low end of the partial compliance range, and the non-HIV chronic case in special management housing to be on the high end of the partial compliance range.

2. Findings

Patients With Chronic Diseases Other Than HIV

In order for the Monitoring Team to assess this provision of the MOA at DCC, the Monitoring Team sampled from records of inmates housed in both general population, and special Management because different physicians provide care in both of these areas. The Monitoring team reviewed a total of 36 records to examine the care provided for the following diseases: Asthma (7), Hypertension (7), Diabetes (10), Coumadin (blood-thinning medication) therapy (5) and Seizures (7). From these records, the Monitoring Team was able to assess 69 chronic disease clinic visits, as well as a substantial number of progress notes. Except for eight patients on Coumadin therapy, the total number of patients with the other chronic diseases was not available.

The Monitoring Team found that the forms used to document appointments with patients seen in chronic care clinics have been developed for the specific purpose of chronic care. The forms encompass a variety of chronic diseases, and include a comprehensive review for the initial visit and a more abbreviated form for follow-up visits. In many instances, the Monitoring Team found that the above-mentioned forms appear to have been perfunctorily and/or

incompletely filled out. The forms lacked narrative on the patient's condition or the thought processes of the provider treating the patient. Except in the T-2 Unit, patients did not appear to be assigned consistently to one provider as their primary care physician, instead seeing the physician who was in the clinic on the day of the appointment.

Overall, the quality of the care for chronic disease that patients received varied significantly depending on the provider seen, and the patient's chronic disease(s). Additionally, in some cases, even when appropriate care and follow up was ordered, there was a significant lag from the time when the order was written and when it was taken off the record by nursing staff. The Monitoring Team found that these patients' Problem Lists are incomplete, because they do not always include the listing of the audited chronic disease.

The Monitoring Team also identified a problem with respect to when patients with medical problems are admitted to the SNU for psychiatric care. Although their psychiatric needs are met promptly, these patients' health records are not routinely given to the responsible medical doctor for review of medical diseases. This resulted in a significant lapse in the medical treatment in one of the patients reviewed.

The Monitoring Team found that the degree of control and status of the chronic disease stated frequently are inconsistent with the objective findings in the record. Since timing of the next chronic disease clinic visit is dependent on accurate assessment of disease control, patients are not seen in an appropriate timeframe when the assessment of disease control is inaccurate. Further, laboratory testing necessary to assist in determining degree of control often is not performed prior to the clinic visit and physicians use data that is not current to assess and treat the patients. Although laboratory data is ordered at the visit, often the results are not addressed in a timely manner.

Disease-Specific Findings:

a. Anticoagulation (Coumadin therapy)

- None of the patients on anti-coagulation therapy had the therapy listed on the Problem List in their records.
- Four out of five of these patients did not have the diagnosis for which they were on anti-coagulation identified and did not have a target International Normalized Ratio ("INR")¹¹⁵ stated. The diagnosis that was presumed and for which Coumadin would be appropriate therapy was listed in the inmates' health records.
- The Monitoring Team found many instances in which the documentation of care ordered by a physician is not in the medical record. For instance, there is a paucity of Prothombin Time ("PT") and INR values in the records of patients with orders for weekly testing,

¹¹⁵ The INR measures the speed with which blood coagulates. It will be higher in patients on Coumadin therapy, but must be controlled. Otherwise, if the coagulation time becomes too long, the patient is at risk for uncontrolled bleeding.

including one health record in which there was documentation that blood was drawn for this test. Physicians did not request the results of the missing INRs, nor was their absence noted. The Monitoring Team discussed the lack of documentation with the medical records department, but the Medical Records Department personnel stated that there were no unfiled laboratory reports.

- Providers did not order rush PT/INR tests when current values were not available to assess treatment. Instead, they adjusted Coumadin dosages based upon outdated INR results in the record, which were dated as far back as two months prior to the physician's visit.
- There is one patient in special management on Coumadin therapy who was transferred from HRYCI. His care was managed appropriately once he was identified; however, there was a delay in identification and appropriate notification of the physician resulting in a nine-day lapse in treatment.

b. Asthma

- Peak flows were noted for most chronic care visits for these patients. This appeared to be obtained routinely along with vital signs by nursing upon checking the patient into the clinic.

i. Asthma-Special management housing

- The Monitoring Team found that these patients were appropriately followed and treated.

ii. Asthma-General Population

- The Monitoring Team identified one patient who did not receive his asthma medications from the time of intake until the time he was scheduled for his physical exam two weeks later. He had been in the facility on these medications in the past, and therefore, the facility had information regarding his condition and necessary medication.
- The Monitoring Team found that physicians did not elicit information about a patient's asthma symptoms during most chronic care visits. Instead, the focus of the visit appeared to be on inmates' other medical problems.
- One patient whose asthma was poorly controlled in early 2007 was subsequently brought into good control by one provider toward the end of the year. On his clinic visit in April 2008, he was seen by a different provider who noted that he was in good control and classified him as stable rather than improved. Although this was the first visit that he was in good control, the new provider abruptly stopped several of his medications without any documented reason, and scheduled the inmate to return in 90 days. The more appropriate course of action would have been to see the patient sooner in order to assess the effect of the change in regimen.

- The Monitoring Team found several patients whose condition had been classified as good or stable, but whose record reflected a lack of objective data to support that classification.

c. Diabetes

- The Monitoring Team found that six out of ten patients had current eye exams.¹¹⁶ The Monitoring Team found that there was an additional patient who had multiple requests for an eye exam, but there was no documentation in the record that this had occurred.
- The Monitoring Team found that six out of ten patients had microalbuminuria levels¹¹⁷ checked. The Monitoring Team found that there was one additional patient, for whom a test had recently been ordered.
- The Monitoring team found that eight out of ten patients had lipid levels¹¹⁸ checked.
- The Monitoring Team found that all of these patients had their blood pressures recorded. The Monitoring Team also found that, for patients housed in General Population, blood pressure elevations were not always addressed.
- The Monitoring Team found that current HgA1c tests¹¹⁹ were not available for most clinic visits.

i. Diabetes-Special Management housing

- Overall, the Monitoring Team found that care of these patients was thoughtful and well-documented.
- The Monitoring Team found that most patients' health records contained a complete diabetes care flow sheet, and had been prescribe an ACE inhibitor.¹²⁰
- The Monitoring Team found that blood sugar ranges or HgA1c (if current) were noted on all visits. Even when control of blood glucose was not optimal, the physician documented problems in patient compliance, and the attempts that were made to improve this.

¹¹⁶ Diabetes can cause eye disease, and even blindness.

¹¹⁷ This test assists with a determination of kidney functioning.

¹¹⁸ Lipid levels should be checked in diabetics to prevent further vascular disease.

¹¹⁹ These tests assist the physician with determining whether the patient's diabetes has been well-controlled.

¹²⁰ ACE inhibitors can help to prevent kidney damage in patients with diabetes.

- The Monitoring Team also found that laboratory data was signed off by the physician. When there were abnormal values in the laboratory test results, the tests were repeated and followed.
- The Monitoring Team found that the frequency of visits was appropriate to clinical findings.

ii. Diabetes-General Population

- The Monitoring Team found that, with respect to this population, even when HgA1c tests were not current, they were used to assess degree of control. An outdated test is not appropriate to use to determine the degree of control of diabetes.
- The Monitoring Team found that even though some patients were in poor control, they often were not rescheduled for an appointment for another 60 to 90 days. That period of time might be appropriate for a well-controlled diabetic.
- The Monitoring Team found that laboratory test results, when they were even in the record, were not signed off and acted upon in a timely manner.

d. Hypertension

- The Monitoring Team found two patients who had an elevated blood pressure at intake. Both of these patients' elevated conditions were timely and appropriately addressed by medical staff, and medical staff added these patients to the chronic disease roster.

i. Hypertension-Special Management housing

- The Monitoring Team found that patients' blood pressure was in good control. There was one patient who had not been seen by the usual provider, and whose diagnosis of hypertension was questionable. He was labeled as hypertensive presumably because he was on low dose propranolol; however, the patient had migraines and no blood pressure elevations are noted in the record.

ii. Hypertension-General Population

- One patient was newly diagnosed with hypertension at the time of physical exam. Laboratory testing was ordered and patient was scheduled for chronic disease clinic.
- Another patient had consistently elevated blood pressures which were either not addressed or incompletely addressed with inappropriate timing of follow-up such that ultimately the patient needed to be placed in the Infirmary for control of his blood pressure.
- In diabetic patients, blood pressure was not optimally controlled. This was found on a consistent basis.

e. **Seizures**

i. Seizures-Special Management housing

- The Monitoring Team found that patients with seizures were managed appropriately.
- The Monitoring Team found that patients' symptoms were monitored. In one case, the patient presented with symptoms consistent with Dilantin toxicity, and medical staff promptly and appropriately addressed the issue.
- In another case, a patient presented with a first time seizure. The patient was immediately sent to the emergency department. Upon return to the facility, the medical staff initiated a complete battery of tests, including CT, EEG and neurology consultation. The neurologist recommended starting Dilantin for that patient.

ii. Seizures-General Population

- The Monitoring Team found that in three of five records reviewed, the diagnosis of seizures is questionable. Two of the three patients came into the facility already having been diagnosed with seizures and taking Dilantin. It appears, however, that medical staff did not obtain any other confirmation of the diagnosis. The patients' Dilantin was continued with subtherapeutic levels, and the patients remained seizure free. The third patient was diagnosed with seizures, and started medication while in the facility without a diagnostic evaluation ever occurring.
- Tests for anti-epileptic drugs ("AED") levels were not performed in time to be current for patients' chronic disease appointments. There is no evidence that the test results ever were reviewed once they were performed, and there is no evidence that physicians reviewed MARs to determine if the patient was compliant with medication.
- When a patient reported a seizure since the last visit, there is no evidence that the progress notes were checked to verify this.
- The Monitoring Team also found that three of the five patients did not have precautionary measures ordered, such as assigning an inmate prone to seizures the bottom bunk.

Patients With HIV

The Monitoring Team assessed compliance with this area by selecting patients from the chronic disease care list, and from laboratory printouts of patients for whom chronic disease-related laboratory tests had been ordered. The Monitoring Team found that not all chronic care patients were listed on the chronic care list. In one case in particular, an AIDS patient was not listed, and the Monitoring Team also found a patient who was listed as having HIV when, in fact, he was HIV antibody negative. Thus, the list of chronic disease care patients

is not accurate.

The Monitoring Team reviewed seven (26% of the chronic care case load) records of patients with HIV infection/AIDS. The Monitoring Team found serious problems with HIV medical care, including one patient with a preventable hospitalization. Not one of the patients was seen every three months, or more frequently in accordance with their level of disease control. In only two of the seven records were HIV laboratory tests current. Further, only one of seven records reflected that a physician performed an appropriate clinical evaluation. The Monitoring Team found that, for patients who were on antiretroviral therapy and other chronic disease medications (*e.g.*, diabetes, hypertension), only one in six records reflected that there was medication continuity. The Monitoring Team found three cases in which the medication lapsed for one to two months. In only three of seven cases did patients receive appropriate immunizations, and two patients were overdue for TB skin tests.

For instance, in one of the records reviewed, the Monitoring Team found that a 46-year-old patient had AIDS, hypertension and diabetes. During the past year, physicians saw him multiple times for chronic disease management, but the physicians addressed only his diabetes and hypertension and ignored his HIV status. The patient did not have HIV-related tests from June 2006 until November 2007, when his laboratory tests showed his immune system to be severely depressed. However, the physician took no action to provide him medications to treat his HIV or to prevent opportunistic infections such as pneumonia.

By February 2008, a physician continued to assess the patient as being in good control despite weight loss and a severely depressed immune system. In March 2008, the inmate developed shortness of breath and a fever of 102°. The inmate had to be hospitalized for an AIDS-related pneumonia, which is largely a preventable infection. The Monitoring Team found that the inmate is now on appropriate medications. This patient had been seen by three different physicians during the past year, including the HIV specialist, and had received care that was not appropriate under the circumstances.¹²¹

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team found that chronic care at HRYCI is flawed at many points during the process.

¹²¹ The Monitoring Team presented this information to the state-level medical director, and understands that the State plans to make some personnel changes regarding HIV care at DCC.

Patients With Chronic Diseases Other Than HIV

First, although most chronic care patients are referred for chronic disease clinic appointments at intake, many are subsequently lost. The Monitoring Team found that patients who state at intake that they have a chronic disease are not reviewed to determine if they actually have the disease, even when the patient is specifically referred for this purpose. In many of the records reviewed, the Monitoring Team found diagnoses that were questionable and, with proper evaluation, the patient could potentially have been discharged from chronic care clinic.¹²² This would lessen the burden on staff, and allow them more time for patients who truly need the care.

In addition, the organization of the patients' medical record is such that various kinds of encounters are filed in separate sections rather than in chronological order. This organization makes it difficult for a physician to follow what is happening with the patient. Given the limited time that a provider has with a patient, it is unlikely that he or she will review every possible section where clinical encounters might be filed. As a result, sometimes this leads to duplication of services. For example, the NP doing physical exams may not think to check the chronic disease clinic section to see if the physical examination has already been completed or the chronic disease physician may not look at the infirmary or sick call section to see what has occurred with the patient since the last chronic care visit. Finally, health record problem lists frequently were incomplete, and failed to list a patient's chronic disease(s).

The Monitoring Team also found that patients who are not seen at the originally assigned appointment time frequently are not rescheduled. The Monitoring Team found several records, in which there was the notation "no show, security issue", and there were several patients subsequently lost to follow up after such notations. It appears from these notations, and from discussions with staff, that the time available for physicians to see patients can be quite limited. That said, this type of notation is inappropriate on several levels. First, the exact reason that the patient missed the appointment should be stated (*i.e.*, jail locked down, in court, etc.). Second, the need for a rescheduled appointment should be stated accompanied by an order. Finally, there also should be evidence that the physician reviewed the record to determine the necessary time frame for the reappointment or if it is critical that arrangements be made to see patient immediately.¹²³

The Monitoring Team also found a lack of physician ownership in the chronic care program, meaning that the same physician does not always track or take responsibility for

¹²² Also, the health records reflect that patients have their histories performed by a nurse, and the doctors failed to elaborate on the positive responses. Thus, the assessment of degree of control did not include relevant information from the history.

¹²³ The Monitoring Team reviewed documentation in two specific cases in relation to another provision of the MOA that bear upon chronic disease care. In each case, the patient had refused care for his chronic diseases, including hypertension. It appears that there had not been any physician counseling of the patient regarding his refusal of medical care. The Monitoring Team recommends requiring an inmate refusing chronic disease care to do so in the presence of a physician or advanced level provider in order to allow for such counseling to take place.

the care of the same inmates requiring chronic care. This lack of ownership might be related to the overall system structure, which includes significant time constraints on these physicians. Based on the Monitoring Team's record review, the Monitoring Team discerned that the physicians appear to be inattentive to the big picture regarding the patient's health, and frequently do not treat the patient beyond the limited scope of their assigned duty (*i.e.*, sick call, chronic disease, physical exam). One reason for this problem is that different providers see patients for physical exams, sick call and chronic care, which creates a lack of continuity in the patient's care.

As stated above, there is a lack of continuity of care in many chronic care patients due to disorganization and lack of physician continuity. The Monitoring Team found that the disorganization also results in some patients being seen by multiple providers within a few days, and others who are completely lost from the system. For example, one patient had an initial chronic disease clinic appointment on April 21, 2008, and then a physical examination by an NP on April 30, 2008.

The Monitoring Team also found that, rather than spending time working on the significant organizational issues in the chronic care clinic, the LPN assigned to chronic care has had to complete the documentation of the patient's history both with respect to the initial chronic care appointment and follow up visits. The physician does not augment this history, which results in a dearth of substantive information. The physician also rarely provides documentation of any discussion with the patient.

The Monitoring Team found that laboratory test results needed to assess patients' disease are not current at the time of clinic visits. The outdated information is used by providers to determine the current status of the patient and requisite treatment. When these laboratory studies were performed after a chronic care appointment, they were not reviewed in a timely manner and, frequently, abnormal values were not addressed when reviewed. Additionally, it appears that many of the laboratory test results are not reviewed by the chronic care physician, and instead are being reviewed by whoever happens to be reviewing records. This practice further undermines continuity of care.¹²⁴

¹²⁴ One final issue found by the Monitoring Team with respect to the continuity of care is that in health records for inmates with recurrent incarcerations, it is difficult to determine when one admission ends and another begins.

Disease-specific findings:¹²⁵

a. Anti-Coagulation (Coumadin) Treatment:

The Monitoring Team reviewed three health records of patients in the facility recently or currently on Coumadin therapy.

- Two of the three records reflected appropriate PT/INRs tests performed, and medication adjustment; however, both patients had been in the facility only a short period of time (ten days for one, five days for the second), so these records did not afford a deeper examination of this type of chronic care.
- The health record of the third patient, who had been in the facility for a longer period of time, revealed more problems. The PT/INR tests were drawn infrequently, and when there was a significantly elevated value, the timeframe within which was it addressed was excessive. This delay creates a risk for potentially fatal bleeding.
- There were multiple PT/INR draws documented in the progress notes for this patient, but the results were not documented in the record. The Monitoring Team learned that the chronic care physician keeps a book in his office containing these results. The Monitoring Team recommends that the test results be filed in the medical record after physician signs off on them, and that a flow sheet of PT/INR test results for each patient be maintained and available for the physician.

b. Asthma:

The Monitoring Team reviewed five records of patients with asthma. In two of the five records, the patient history was performed by a nurse. The history is critical to assessing degree of control over a patient's disease. In these two records, the nurse's history was disconnected from the assessment by the physician of the degree of control. In three out of five records, there were delays or discontinuities in patients receiving medications.

c. Diabetes:

The Monitoring Team reviewed five medical records for patients with diabetes. The health records collectively contained eleven chronic disease clinic visits and multiple progress notes.

- The Monitoring Team found the following generally positive results:
 - All diabetic patients had microalbuminuria and lipids checked or ordered.

¹²⁵ As a preliminary matter, the Monitoring Team had some difficulty with obtaining records requested from the chronic care lists provided, as those of patients who had been released were filed in a different area and their personnel was not always available to retrieve these records.

- Additionally, all patients were on an ACE inhibitor.
- Four out of five patients had eye exams ordered or completed.
 - In the one patient who did not have his eye exam completed, there was a significant lapse in his visits to chronic care. Although the physician had ordered a 30-day follow-up in November 2007, the patient was not seen in the clinic again until March 2008. The reason for this delay was not clear, but the physician commented on the March 2008 encounter that his was due to “administrative changes out of physician control.”
 - Another diabetic patient had a lapse in visits from March 2007 until February 2008. The State first noticed this problem in November 2007, when orders for rescheduling were entered. Although not as extreme, other patients had similar problems in being seen in the time requested by the physician.
- All diabetic patients’ blood pressure control was good.
- Three of the five patients had diabetic flow sheets in the record.
- Despite the positive findings above, in four of the five patients audited, glycemic control was extremely poor.
 - In the one patient in good control, the diagnosis of diabetes was questionable.
 - Significantly outdated laboratory results were used to assess the patients’ degree of control.
 - In one patient the Hemoglobin A1c from November 2007 was used to assess degree of control in February 2008.
 - Hemoglobin A1cs that were done after the appointments were not reviewed in a timely manner and not addressed when they were reviewed.

d. Hypertension:

The Monitoring Team reviewed two records for hypertensive-only chronic care patients, two records for patients with hypertension and diabetes, two records of patients with hypertension and seizures, and one record for a patient admitted to the Infirmary for uncontrolled hypertension.

- The Monitoring Team found that diabetic and seizure chronic care patients had good control of their blood pressure.

- Of the two patients identified with hypertension only, a review of one patient's health records showed no evidence of the patient having this disease, but instead had a single elevated systolic reading most likely related to crack use and withdrawal.
- The second hypertensive-only patient and the hypertensive admitted to the infirmary did not receive appropriate care.
 - Specifically, the degree of control listed in both cases was inappropriate in light of the blood pressure reading.
 - Further, the health record for the patient admitted to the Infirmary reflected that he did not have his blood pressure controlled prior to discharge; however, this record was extremely disorganized, so this could not be confirmed.

e. **Seizures:**

The Monitoring Team reviewed five records of patients with seizures. One patient was never seen in Chronic Disease Clinic, but eleven progress notes were reviewed. The remaining patients collectively had nine clinic visits for the Monitoring Team to review.

- The Monitoring Team was unable to find any verification of a seizure disorder at intake in any of the records.
- The Monitoring Team found that none of these patients had a seizure while in the facility, including those with subtherapeutic levels of AEDs. These patients were not assessed to ascertain if the diagnosis of seizure disorder was correct.
- All but one of the seizure patients had other chronic diseases, and the treatment of these other chronic diseases appeared to take precedence over the seizure disorder diagnosis.
- The one patient with seizure disorder as the sole diagnosis did not have follow up during his entire stay up until the time of the Monitoring Team's review.
- One patient, who had been transferred from DCC on March 12, 2008, had no progress notes or clinic visits noted in his record from the time of transfer until the time of the Monitoring Team's visit.

Patients With HIV

The Monitoring Team reviewed five health records of HIV positive patients. These health records included eleven chronic disease clinic visits, as well as progress notes. HIV positive patients are seen by both a primary care physician and one with special training in HIV.

- The Monitoring Team found that laboratory studies (*i.e.*, CD4 (T cell) count and viral load) frequently were not ordered within the appropriate timeframe.

- One health record reflected that the patient had a high CD4 count and an undetectable viral load, and there was no confirmation in the record that the patient was, in fact, HIV positive.
- The Monitoring Team found that patients with dropping CD4 counts and/or rising viral loads were not seen with the generally accepted frequency.
- In addition, other abnormal laboratory values associated with HIV disease such as abnormal lipids and low platelets were not addressed.
- Finally, medications were not always received by patients in a timely manner, resulting in lapses in treatment.

E. SCI

1. Assessment

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

2. Findings

Patients With Chronic Diseases Other Than HIV

The Monitoring Team reviewed ten records of non-HIV patients with hypertension and diabetes, at least nine records of patients with seizure disorder, and ten records of patients with asthma.

The Monitoring Team found improvement with regard to the chronic disease management program at SCI. However, significant areas for improvement remain. In particular, the chronic disease roster that the Monitoring Team used to select records was not accurate. There were names on the list of inmates who did not have the diseases for which they were listed, and there were other patients who should have been on the list and yet were not. The HSA is aware of this, and planned to personally review the roster, and the records of every patient in the system in order to re-enroll them and ensure proper follow-up. The HSA believes that a contributing factor to this problem is staff's lack of comfort with DACS. This has resulted in both scheduling problems and inconsistencies on the chronic disease roster.

In addition, other areas for improvement continue to be provider performance with regard to the appropriateness of the patient assessment, and the plans for disease intervention. Also, provider performance must improve with respect to ordering required immunizations and tests in a manner consistent with the existing guidelines.

The Monitoring Team notes that the patient history and physical examinations have improved. There is also some recent improvement in laboratory test scheduling so that they occur just prior to the scheduled chronic disease visit. This positive change is more recent, so

many of the records the Monitoring Team reviewed reflect chronic care visits prior to the implementation of the new scheduling strategy.

The Monitoring Team also found, as with sick call access, a backlog resulting in delays of patient care. For example, a patient for whom a 90-day visit was ordered might not be seen for 120 or more days. The facility leadership team is aware of this problem. The Monitoring Team believes that this problem could be reflective of the same problems identified in this report: a combination of space, resource availability, and custody policies, which result in diminished available time for seeing patients.

The Monitoring Team found that the seizure disorder clinic performance was somewhat improved from the last visit; however, there are some patients who need follow-up. In general, the asthma clinic also performed fairly well. There were problems at times with the absence of a peak flow reading, absence of immunizations, and obtaining complete histories.

Patients with HIV

The Monitoring Team reviewed six (55%) out of eleven records of patients with HIV infection. The Monitoring Team found that in all six records, HIV infection was listed on the Problem List; however, one patient's disease had progressed to AIDS, which should have been documented. None of the patients were seen every 90 days (or more frequently as clinically indicated). In only three of the six records were laboratory test results available when the clinician saw the patient.

In general, the clinician did not document an adequate HIV disease-specific interval history. Further, the records reflected that medication adherence and side effects were not addressed with the patients. The Monitoring Team also found that the clinician failed to document or reference HIV laboratory parameters (CD4 cell count and HIV viral load), which are used to assess degree of disease control. The Monitoring Team found an accurate assessment of disease control in only two of six records. Finally, only two of the six records reflected that the patient had received appropriate immunizations (*see* discussion of provision 23 of the MOA).

The Monitoring Team also found clinical problems that included: subtherapeutic dosing of antiretroviral therapy (Retrovir 150 mg twice daily versus the recommended 300 mg twice daily); failure to administer medications in accordance with food requirements (*e.g.* Reyataz being administered at bedtime instead of at mealtimes, etc.); lack of routine monitoring for medication side effects (*e.g.* lipid panels for patients on protease inhibitors); noting but not addressing significant laboratory test results abnormalities (triglycerides >850); and not initiating disease prophylaxis when medically indicated. Further, in one case, the physician gave a verbal order to start the patient on antiretroviral medication before ever seeing the patient. Antiretroviral therapy should not be started before the clinician has evaluated and educated the patient and determined understanding and willingness to accept and comply with therapy.

F. Recommendations

At Baylor, regarding non-HIV chronic diseases, the Monitoring Team makes the following recommendations:

- Since the regular facility providers provide excellent care and their scheduled hours are adequate for a facility of this size, the provision of care by other providers was discussed with the CMS Medical Director, and he made the decision to no longer have these providers at Baylor; and
- Laboratory tests necessary to make clinical decisions should be drawn at an adequate time frame prior to the chronic care clinic so that the results are both current and available to the provider at the clinic visit.

At Baylor, regarding HIV cases, the Monitoring Team makes the following recommendations:

- Clinicians should order HIV laboratory tests and specify that they are to be obtained within two weeks of the next scheduled laboratory test;
- The health care leadership should ensure that clinician's orders are transcribed and implemented in a timely manner;
- Clinicians should offer HIV treatment and monitor patients in accordance with current guidelines;¹²⁶ and
- To avoid medication discontinuity, clinicians should order HIV medications to last until the next scheduled HIV clinic visit, and following a clinical assessment reorder or modify the medications as appropriate.

At DCC, regarding HIV cases, the Monitoring Team makes the following recommendations:

- The State/CMS should provide access to HIV care by properly trained and credentialed physicians;
- The State/CMS should provide training in primary care of HIV infected patients that includes performing HIV-targeted interval history and physical examinations, criteria for initiating antiretroviral therapy and prophylaxis for opportunistic infections, and clinical monitoring of patients on antiretroviral therapy;
- At each visit, clinicians should perform HIV-targeted interval history and physical examinations and develop a plan that includes laboratory testing, reordering all medications, and a follow-up interval that is based upon disease control;

¹²⁶ See Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents (2008).

- DCC health care leadership, in collaboration with the OHS, should reassess the DACS scheduling system to ensure that it has the necessary scheduling capacity for appointments and is properly utilized; and
- The State should provide appropriate immunizations and annual TB skin testing.

At DCC, regarding non-HIV cases, the Monitoring Team makes the following recommendations:

- Supervisory review of all providers should take place with constructive corrective action occurring when deemed necessary;¹²⁷
- To improve continuity of care and the development of a therapeutic relationship between doctor and patient, patients ideally should be assigned to a single provider and attempts made to have the patient seen by that provider for all scheduled appointments;
- Laboratory data necessary for disease assessment and treatment modifications should be obtained prior to the chronic disease appointment in a timeframe that allows current data to be available at the appointment;
- Flow sheets should be used to track PT/INRs and these as well as the results of glucose finger sticks, hypertension logs, etc. should be available to providers at the clinic appointments;
- Accurate logs of patients with various chronic diseases should be maintained;
- All clinic staff should be educated in the use of the problem list and have the ability to add information to it; and
- Records of all patients transferred into the SMU or MHU should be referred upon transfer to the medical physician for review of any chronic medical needs.

At HRYCI, the Monitoring Team makes the following recommendations:

- Supervisory review of all providers should take place with constructive corrective action occurring when deemed necessary;
- Physician assignments should be reviewed;¹²⁸

¹²⁷ This process has begun and one physician reviewed is no longer working at the Facility.

¹²⁸ To improve continuity of care and the development of a therapeutic relationship between doctor and patient, patients ideally should be assigned to a single provider and attempts made to have the patient seen by that provider for all scheduled appointments.

- Organization and procedures for the chronic care clinics should be reviewed and standardized;¹²⁹
- Laboratory testing needed to assess the patient should be drawn in prior to the visit in a timeframe such that they are available for the appointment yet are still current;
- As the current medical record structure leads to discontinuity of care, this structure should be reviewed;¹³⁰
- Administrative and/or security issues that limit the time providers have available to see patients should be assessed and remedied;
- Physicians, not the clinic nurse, should complete the history on chronic care patients;
- The issues that prevent patients from being seen as ordered should be investigated and remedied;
- Physicians should be expected to review and sign off on laboratory tests within 24 to 48 hours on weekdays and 72 hours for weekends;
- Abnormal laboratory values should be addressed at the time of this review and that this review documented in the progress notes;
- For patients with recurrent stays at the facility, a mechanism to identify separate stays should be developed;¹³¹ and
- Training in the use of the problem list should occur and all clinical staff should be encouraged enter medical problems including intake personnel.

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

- Obtain a thorough HIV disease-specific interval history and physical examination;
- Begin antiretroviral therapy and other medications only after patient evaluation and consent to therapy;
- Obtain, review, and document HIV specific and other relevant laboratory tests;

¹²⁹ Logs of patients may prove helpful in tracking as well as disease specific logs and flow sheets.

¹³⁰ A structure of strict chronological order for all clinical encounters including physical exams, progress notes, sick call, chronic care clinic, infirmary admissions and referrals out would make it easier for providers to follow all medical events of the patient.

¹³¹ This could be as simple as an entry in the progress notes at readmission or a colored sheet paper separating intakes.

- Review and adhere to FDA approved dosing and administration requirements for antiretroviral therapy;
- Evaluate medication adherence (*e.g.* >90%, >80%, etc) and monitor patients for medication side effects (*e.g.* lipid panels for patients on protease inhibitors, liver function tests for non-nucleoside reverse transcriptase inhibitors, etc.);
- Review criteria and monitor patients in accordance their HIV disease control;
- Periodically document patient understanding of their disease process;
- Implement a plan to ensure an accurate chronic disease roster and effective utilization of the DOC scheduling and tracking system that facilitates compliance with DOC clinical guidelines;
- Continue the Regional Medical Director's reviews of performance with an eye towards institution-wide strategies that focus on immunizations, eye exams, and other required process measures; and
- Enhance the Regional Medical Director's reviews by focusing more on the appropriateness of the assessment as well as the appropriateness of the diagnostic and treatment plan.

23. Immunizations

A. Relevant MOA Provision¹³²

Paragraph 23 of the MOA provides:

The State shall make reasonable efforts to obtain immunization records for all juveniles¹³³ who are detained at the Facilities for more than one (1) month. The State shall ensure that medical staff members update immunizations for such juveniles in accordance with nationally recognized guidelines and state school admission requirements. The physicians who determine that the vaccination of a juvenile or adult inmate is medically inappropriate shall properly record such determination in the inmate's medical record. The State shall develop policies and procedures to ensure that inmates for whom influenza, pneumonia and Hepatitis A and B vaccines are medically indicated are offered these vaccines.

This provision of the MOA requires that the State make reasonable efforts to obtain immunization records for all juveniles who are detained at the Facilities for more than one month. This requirement means that the State will need a system to track which juveniles have been detained for more than one month. Although there are no official guidelines available to determine what reasonable efforts would be under these circumstances, the Monitoring Team believes that reasonable efforts would consist of an attempt to acquire the juvenile's school records, and records from any health care providers in the community that have provided care to the juvenile that the State is able to identify after asking the juvenile. The MOA further requires that, for juveniles, the State ensure that medical staff members update immunizations for such juveniles in accordance with nationally recognized guidelines and state school admission requirements. Those guidelines and admission requirements were attached to the Second Report as Appendix III.

This provision of the MOA also requires that the State develop procedures to ensure that inmates for whom influenza, pneumonia and Hepatitis A and B vaccines are medically indicated are offered these vaccines. For example, influenza vaccine is recommended to be administered in adults aged 50 and older unless there is evidence of immunity or prior vaccination. *See* <http://www.cdc.gov/mmwr/pdf/wk/mm5641-Immunization.pdf>. Further, if a physician determines that vaccination of a juvenile or adult inmate is medically inappropriate, the physician shall properly record such determination in the inmate's medical record. An example of when a vaccination might be medically inappropriate is in the case of a pregnant female and a vaccination that has not been deemed safe for pregnant females to have.

¹³² The Monitoring Team reviewed at least ten inmate health records at each of the Facilities to make the findings listed below.

¹³³ The term "juveniles" means "individuals detained at a facility who are under the age of eighteen (18)." *See* MOA II.H.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team reviewed this provision of the MOA in connection with its review of the records of chronic care patients (*see* discussion of provision 22 of the MOA). The Monitoring Team found that immunizations were appropriately ordered; however, documentation that the immunizations actually were administered is inconsistent. Specifically, some of the immunizations were first documented on a log, but then inconsistently transcribed into the patient's medical record. When the immunization information was recorded in the medical record, it was not recorded consistently in the same place. The Monitoring Team found such information in several locations, such as the immunization consent form, the problem list, the progress notes or the chronic care clinic note.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team reviewed this provision of the MOA in connection with its review of 36 records of chronic care patients (*see* discussion of provision 22 of the MOA). The Monitoring Team found that influenza vaccine was current in 25 of those patients, and Pneumovax¹³⁴ was current in fifteen of those patients. Since the current recommendation for Pneumovax is once every five years in patients with immune compromise, this is harder to track in patients with records that may have this information in another volume, but was not carried forward into newer volumes. Additionally, there is no single place in the record where immunization administration is recorded.

¹³⁴ The influenza vaccine is recommended for patients over the age of 55, and who have, among other health issues, diabetes and pulmonary disease. The Pneumovax vaccine is used to prevent or mitigate serious bacterial infections such as meningitis. It is recommended for patients with, among other health issues, diabetes or pulmonary disease.

D. HRYCI

1. Assessment

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

2. Findings

HRYCI has a process in place for reviewing the immunization records of juveniles as they enter the system. The staff at HRYCI reviewed the entire pool of juveniles one week prior to the Monitoring Team's visit, and found that two of the juvenile patients housed at HRYCI had incomplete records for which the State had already ordered an immunization update. However, the Monitoring Team found that juvenile patients ordinarily do arrive at the facility with an immunization record, and the infection control nurse has access to the State database. The Monitoring Team recommends that the State monitor this provision on a regular basis so that a review is not done just prior to the Monitoring Team's visit.

The Monitoring Team reviewed this provision of the MOA in connection with its review of the records of chronic care patients (*see* discussion of provision 22 of the MOA). HRYCI generally offered immunizations to adult chronically ill patients for whom they were indicated, as evidenced by the Monitoring Team's review of the records of patients with diabetes and asthma.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed this provision of the MOA in connection with its review of the records of chronic care patients (*see* discussion of provision 22 of the MOA). Approximately 60% of diabetics and asthmatics whose records were reviewed had not received the recommended immunizations. Two out of six records reviewed of patients with HIV infection showed that they had received both influenza and pneumococcal vaccinations, another two out of six had received one of the two vaccines, and the final two had received neither vaccine. These vaccines are recommended for individuals with compromised immune systems and should be administered to HIV patients.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State ensure that documentation of all injections, including immunizations, be placed in patients' health records.

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

- Implement a standardized system for tracking and administering immunizations; and
- Ensure that documentation is in a single designated area of the medical record.

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

- Monitor the process by which juveniles are seen at intake, ensuring that they have a timely physical exam and updating their immunization needs at the time of the exam; and
- Continue to monitor its compliance with offering immunizations to those for whom there is an indication, including those with specific chronic diseases and those who are above the age of 65.

At SCI, the Monitoring Team recommends that the chronic disease program refocus its attention on compliance with guideline immunization recommendations.

MEDICATION

24. Medication Administration

A. Relevant MOA Provision

Paragraph 24 of the MOA provides:

The State shall ensure that all medications, including psychotropic medications, are prescribed appropriately and administered in a timely manner to adequately address the serious medical and mental health needs of inmates. The State shall ensure that inmates who are prescribed medications for chronic illnesses that are not used on a routine schedule, including inhalers for the treatment of asthma, have access to those medications as medically appropriate. The State shall develop and implement adequate policies and procedures for medication administration and adherence. The State shall ensure that the prescribing practitioner is notified if a patient misses a medication dose on three consecutive days, and shall document that notice. The State's formulary shall not unduly restrict medications. The State shall review its medication administration policies and procedures and make any appropriate revisions. The State shall ensure that medication administration records (“MARs”) are appropriately completed and maintained in each inmate’s medical record.

Medications are appropriately prescribed if they are prescribed upon the order of a physician, dentist, or other legally authorized individual, and only when clinically indicated. J-D-02; P-D-02. Administration of medications should be done in a manner that complies with federal and State of Delaware laws. J-D-01; P-D-01. The NCCHC recommends that institutions maintain a self-medication or KOP program,¹³⁵ which permits inmates to carry medications necessary for the emergency management of a condition as appropriate. J-D-01; P-D-01.

This provision of the MOA further requires that the State develop and implement policies and procedures for medication administration and adherence. Also, the State shall review its medication administration policies and procedures and make any appropriate revisions. The Monitoring Team finds that the State has adopted appropriate policies. *See* State Policy D-02.

B. Baylor

1. Assessment

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

¹³⁵ “Self-medication programs” are programs which “permit responsible inmates to carry and administer their own medications.” J-D-02; P-D-02.

2. **Findings**

The Monitoring Team evaluated compliance with medication administration by reviewing the order transcription process, assessing medication administration procedures, observing nurses prepare medications, and reviewing MARs.

The Monitoring Team also observed a nurse administering medications to five to ten inmates. In general, the nurse was very professional and followed proper nursing procedures for administering medications. However, the nurse did not consistently have the inmate show proper identification, and neither she nor the correctional officer performed oral cavity checks to ensure that the patient ingested the medication.¹³⁶

The Monitoring Team reviewed thirteen physician orders and the corresponding MARs. All of the medication orders were complete, but in only seven of thirteen was the order both dated and timed. In only three of thirteen records did a nurse transcribe the medication order within four hours; most medication orders were not transcribed until the following day. The Monitoring Team also found cases during the course of its review of other MOA provisions in which orders were not being transcribed for up to one month.

The Monitoring Team found that the MARs were neat and legible. However, medication transcription errors were noted in four of thirteen records. For example, there was a failure to discontinue a medication, failure to transcribe new medications onto the MAR, and failure to transcribe start and stop dates. In another record, PharmaCor printed an incorrect medication dosage onto the MAR that resulted in a patient not receiving the increased dosage of blood pressure medication for two weeks.

C. **DCC**

1. **Assessment**

The Monitoring Team found that DCC is in partial compliance with this provision of the MOA. For informational purposes, the Monitoring Team finds that DCC is in partial compliance with this provision of the MOA as it relates to medical services, but is not in compliance with respect to mental health services.

2. **Findings**

The Monitoring Team evaluated compliance with medication administration by reviewing the order transcription process, assessing medication administration procedures, observing nurses prepare medications, and reviewing MARs.

¹³⁶ The State does not require correctional officers to perform oral cavity searches unless the nurse suspects that the inmate is failing to ingest the medication by “cheeking” (*i.e.*, hiding the medication in his or her cheeks) the medication.

As noted in previous reports, medication administration is challenging due to the size of the facility (>2500 inmates), institutional schedule, multiple locations that medications are administered, and staff allocated to perform this critical function. However, the end result is that medication administration at DCC is not being performed in accordance with standards of nursing practice, and does not ensure that patients receive medications in a timely manner.

The Monitoring Team reviewed ten records for compliance with this provision of the MOA. In eight of the ten records, the nurse transcribed the order in a timely manner; however, in four of those eight records, the nurse incorrectly transcribed the order by crossing out the dates of a previous order and entering the dates of the new order. This practice defaces a previous order and is not in accordance with standard nursing practices.

The Monitoring Team interviewed nurses involved in medication administration, who reported that the average turnaround time from the time the physician order is faxed to the pharmacy is five days, which is not timely. Further, staff reported that the stock supply of prescription medications is not standardized, and the practical effect is that they are not able to initiate medications within 48 hours pending the receipt of medications from PharmaCor.

With respect to the medication administration process, the State has decentralized medication administration due to DCC's geography. Medication administration has been decentralized in three areas: the main compound, the SHU, and the MHU, which contains some inmates with mental health treatment needs. The Monitoring Team believes that decentralization of medication administration in the SHU and the MHU is appropriate, but decentralization in the main compound is not appropriate, with the exception of the pretrial area. Such decentralization is much more staff intensive because it causes the nurses to go out to each housing unit to administer medications, rather than have inmates come to the medication administration window. The Monitoring Team recognizes that other considerations enter into the State's decisions regarding how to organize medication administration; the Monitoring Team recommends, however, that the State examine this process in order to determine if any modifications can be made to improve efficiency.

For various reasons, including lack of adequate staffing and institutional schedules, medication administration at DCC is a 24 hour a day process, beginning at 1:00 a.m. in the MHU, 2:30 a.m. in the pretrial unit, and ending at 8:00 p.m. The Monitoring Team finds this schedule to be unreasonable. Moreover, medications are being administered throughout the day but are documented as being given only in the AM, PM and HS, which does not accurately reflect the time the patient received the medication. Standard nursing practice is that medications are to be given within one hour before or after a designated administration time. This is not possible in the current situation.

The Monitoring Team notes that nurses violate standard nursing practice by pre-pouring medications from properly dispensed and labeled containers into improperly labeled envelopes. Specifically, during the Monitoring Team's site visit, the Monitoring Team observed that a nurse had pre-poured medications into envelopes (including narcotics), but then was reassigned to another location. A brand new employee who had been employed for three days

and was still in orientation was assigned to pass medications for this nurse. The Monitoring Team intervened by bringing this to the attention of the DON, who promptly addressed the situation; however, the practice continues. While it is understandable that such a practice has developed given the current staffing patterns and decentralized practices, it is not appropriate and should be stopped.

As described previously in the Second Report, the Monitoring Team observed that problems continue to be present regarding the continuity of medications when an inmate changes housing units. This is due to medical records not following the inmate in a timely manner after housing moves.

Additionally, while the Monitoring Team notes that the nursing staff does an adequate job of documenting missed doses, they are not doing an adequate job of making a referral to mental health staff related to that missed dose. Some problems also exist with regard to restocking of medications. Both staff and inmates report that interruptions to medications continue to result from stock medications being depleted, and the restocking takes anywhere from two to seven days.

Finally, the Monitoring Team reviewed requests for non-formulary drugs and found that all of the requests made in the previous four months were approved in a timely fashion. However, while a new process was initiated where preapproval of the chief psychiatrist was not required for certain non-formulary drugs, there was some confusion about this new directive and some delays remained where nursing staff continued to wait for approval.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team evaluated compliance with medication administration by observing nurses prepare and administer medications. In addition, the Monitoring Team reviewed ten health records, including the MARs. The Monitoring Team also reviewed eight records of patients on psychotropic medications who had missed more than three consecutive doses to determine whether a nurse notified the prescribing practitioner.

Inmates do not consistently receive medications in a timely manner. With respect to the medication administration process, the Monitoring Team notes that medications are scheduled to be administered twice daily, once in the morning and once in the evening. Three LPNs are assigned to administer medications, and it takes approximately five to six hours for nurses to complete administration of the morning medications. This does not meet the standards of nursing practice to administer medications within a one-hour window of a designated time. For example, if morning medications are to be administered at 9:00 a.m., nurses could administer

medications from 8:00-10:00 a.m., and be in compliance with standards of nursing practice. A review of staffing shows that currently there are insufficient numbers of LPNs to meet this standard.

The Monitoring Team observed nurses administering medications. The nurses did not adhere consistently to the practice of checking the inmate identification card prior to administering the medication. The ID was not checked for 15 of 27 inmates observed. Oral cavity checks were not performed for 8 of 27 inmates observed, which is not required to occur in all circumstances.

Another area of concern is the administration of narcotics. Each of the three nurses observed used a different procedure to administer narcotics. One nurse took a full blister pack of a controlled substance from the locked cabinet, signed out all 30 tablets to inmates who were scheduled to receive them into the narcotics book, and went out into the units to deliver the medications with the controlled substance still in the blister pack. When the nurse administered the medication, she documented this onto the MAR. A second nurse obtained the controlled substance from the locked cabinet, and punched out the number of pills she would need into an unlabeled plastic bag. As the nurse administered each pill, she documented administration onto the MAR. The third nurse punched out each controlled substance, crushed it, placed it into a single cup with the inmates name on it, put a piece of tape over the top of the cup, signed the medication out in the narcotics book, and documented onto the MAR following administration of the medication. The first method is the closest to adherence to standard nursing practices; however, signing out so many narcotics in advance of being administered presents potential problems with respect to waste of the narcotics. The latter two methods referred to above, are not compliant with standard nursing practices.

The Monitoring Team reviewed ten health records, and the accompanying MARs to assess the completeness of the physician order, the timeliness and accuracy of medication order transcription, timeliness of medication delivery and legibility of MAR documentation. In three of ten records the physician documented the date but did not time the order. In five of ten cases, the orders were not transcribed on the day the order was written (range one to fourteen days). Also in five of ten cases, the patient did not receive medications within 24 hours of the order being written. In two of ten cases, the nurse did not accurately transcribe the order onto the MAR.

With respect to documentation on the MAR, most of the MARs were legible. The Monitoring Team found, however, that nurses are not consistent in the manner that they document discontinuation of medications. Standard nursing practice is to draw a line on the date of the last dose the patient is to receive and write "D/C" (*i.e.*, discontinue). The nurse should legibly sign and date the entry to indicate who transcribed the order to discontinue the medication. Instead, nurses at HRYCI use several different methods to document discontinuation, including highlighting the entire order or crossing the order out. Neither of these approaches documents the actual date of discontinuation. In addition, highlighting and/or crossing out the MAR can obliterate the order itself, thus defacing the MAR, which is not consistent with standard nursing practice.

The Monitoring Team also reviewed eight records of patients who missed multiple doses of psychotropic medications. All of the cases reflected that a nurse had not notified the prescribing practitioner, and, even when the practitioner did see the patient, progress notes suggest that the prescriber was unaware of the patient's noncompliance.

With regard to a administration of mental health-related medications, after conducting a record review, the Monitoring Team observed that there is a timelier filing of MARS than was noted during the last reporting cycle. However, problems continue to arise regarding timely renewal of medications. Additionally, nursing staff acknowledged problems with identifying and appropriately intervening with inmates who were non-compliant with taking psychotropic medications. Finally, evening medications are often being administered beginning around 6:30 p.m., which is not appropriate for medications ordered HS (at night), due to either sedative effects or other side effects. Such medications should not be administered prior to 8:00 p.m.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team found significant problems with the medication administration processes, resulting in patients not receiving medications in a timely manner. The Monitoring Team found frequent and significant delays in transcription of medication orders (*see* discussion of provision 4 of the MOA).

In MSB, nursing staff are required to deliver medications to the housing units for the morning and evening medication administration pass, although most of these inmates come to the medical unit during the mid-day medication passes. The requirement to deliver medications to the housing units was intended to avoid inmate movement during darkness. However, the preparation for this decentralized approach has resulted in nurses violating standard nursing practices with respect to medication administration. These violations include pre-pouring medication, and transferring medications from properly labeled containers into improperly labeled envelopes.

The nurses also document medication administration in advance of giving the medication to the patient, which is a violation of standard nursing practice. The nurses' stated intent was to return to the health care unit after medication rounds to reconcile the MAR and document medication refusals or medications not given. However, circumstances could arise that can result in this documentation not occurring. On the other hand, the practice of prior documentation medications raises serious questions about the credibility of the MARs. Nurses should document medications (or any action) only after they have been implemented.

The practice of pre-pouring medications also results in controlled substances not being securely maintained until administered. The Monitoring Team observed a nurse pre-pour and document that she had given a controlled substance (Vicodin) hours in advance of actually administering the medication. Further, there is an institutional policy to crush all narcotics--presumably to ensure ingestion. However, this practice should only be done upon a physician order and for a valid reason (*e.g.*, patient known to hoard medication, etc.).

The Monitoring Team found that the MARs reviewed were neat and legible. However, only one of the ten MARs showed that nurses documented administration status for every dose of medication. The Monitoring Team found that nurses' document discontinuation of medications by yellowing out the order on the MAR, but the date of discontinuation is not documented or initialed. The standard nursing practice for discontinuation of orders is to draw a line through the date the medication was discontinued, documenting "D/C", and dating and initialing the entry.

With regard to the administration of mental health-related medications, the Monitoring Team found that no audits had been performed for issues concerning medication noncompliance. The Monitoring Team observed that more medication noncompliance mental health referrals¹³⁷ are generated in the compound, which houses sentenced inmates, as compared to housing units for pretrial detainees. The Monitoring Team believes this is due to a training issue for nursing staff. Nursing staff needs to receive training redefinitions of medical noncompliance and related policies and procedures concerning identification of medical noncompliance, related counseling, and referrals.

During its record reviews, the Monitoring Team identified very serious problems resulting from medications not being available due to stocking issues. As a result of this observation, the Monitoring Team reviewed all MARs of sentenced inmates from April 2008 for evidence of any notations of out of stock for psychotropic medications. In its review of 128 MARs, the Monitoring Team found 30 records (23%) where medications were noted as being out of stock. In some cases, medications were out of stock for over a week. Documentation exists of at least one situation where this caused an adverse patient outcome. The Monitoring Team is reluctant to provide more specific details about this outcome, in order not to violate the inmate's privacy. However, as a general matter, inmates not receiving prescribed psychotropic medications are at an increased risk of clinically deteriorating.

F. Recommendations

The Monitoring Team recommends that staff at each of the Facilities obtain a pharmacy expiration list on a weekly basis to assist in establishing a more effective process to ensure timely renewal of medications.

¹³⁷ When nurses note a pattern or medication refusals or failure to pick up medication, they are supposed to generate a referral to mental health so that clinical staff and/or the psychiatrist can address the matter with the inmate before an adverse outcome arises.

With respect to stocking issues, the State should implement appropriate CQI's to determine where in the process a breakdown is occurring so that the process can be improved to meet acceptable levels of care.

At Baylor, the Monitoring Team makes the following recommendations:

- Health care leadership should ensure that nurses follow standard procedures for administering medications, including checking the patient's identification each time;
- For medical/legal purposes, clinicians should date and time all health record entries; and
- Through CQI studies, health care leadership should ensure that medication orders are accurately transcribed and implemented in a timely manner.

At DCC, the Monitoring Team restates the following recommendations made in previous reports:

- Institutional leadership, state and CMS health care leadership should reassess the system for medication administration at DCC. The end result should be policy and procedures and practice that administers medications to inmates at reasonable hours, predictable times, accurately documents administration status on an MAR that is filed in the health record in a timely manner. Staffing, mechanisms of delivery and perhaps institutional schedules likely require adjustment to accomplish this goal. Many correctional systems administer medications on an approximate schedule of 0600, 1200, 1600 and 2000. Exceptions are made for insulin-dependent inmates or in cases where meals conflict with medication administration requirements (insulin administered prior to meals or medications that must be administered with or without meals etc). Regardless, medications should be administered within a one hour window period of designated times.
- CMS should work with PharmaCor to ensure more timely delivery of medications and standardize stock supplies of medications.
- Nurses must prepare medications in accordance with standard nursing practice by comparing the current MAR against the medication blister pack, administering medications from legal containers (not handwritten envelopes), and documenting administration at the time the medication is given to the patient, not before or after.

At HRYCI, the Monitoring Team makes the following recommendations:

- Health care leadership, in consultation with the Warden should establish designated medication administration times and administer medications within a one-hour window period of the designated time;
- Although most medications are administered once or twice daily, at most institutions with which the Monitoring Team is familiar, medication administration is typically scheduled

four times per day (*e.g.*, 0600, 1200, 1600 and 2000), and one designated time (*e.g.*, 1200) is typically reserved for administration of KOP medication thus permitting the nurse-administered medications in the morning and evening to be given more efficiently;

- Health care leadership should ensure that policies and procedures address all aspects of medication administration from physician orders to discontinuation of medication; and
- Nurses should refrain from giving medications beyond the medication expiration date.

At SCI, the Monitoring Team recommends that the State revamp its medication administration process to ensure accurate, timely administration and documentation of administration that complies with standard nursing guidelines.

25. Continuity of Medication

A. Relevant MOA Provision

Paragraph 25 of the MOA provides:

The State shall ensure that arriving inmates who report that they have been prescribed medications shall receive the same or comparable medication as soon as is reasonably possible, unless a medical professional determines such medication is inconsistent with generally accepted professional standards. If the inmate's reported medication is ordered discontinued or changed by a medical professional, a medical professional shall conduct a face-to-face evaluation of the inmate as medically appropriate.

This provision of the MOA is meant to ensure continuity of care from the entry of an inmate into a facility. J-E-12; P-E-12. Further, this provision can assist with preventing adverse patient outcomes, which are more likely to happen with respect to medication services practices when a provider frequently changes orders, the provider fails to review patient medication histories, or treating staff are unaware of each other's prescribing behaviors. J-D-02; P-D-02.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team evaluated this provision by reviewing health records of inmates who were prescribed chronic or psychotropic medications, and the system for reordering chronic medications.

The Monitoring Team found serious problems with medication continuity, which the Monitoring Team attributes primarily to problems with the medication renewal system. The system in place involves the use of a calendar log book, which is used to notify PharmaCor that a patient's medication needs to be refilled. Nurses are supposed to note when a patient's chronic care medications are due to be refilled, and should place the inmates' names and type of medication in the log book on the day that it should be reordered with sufficient allowance of time so that medication continuity occurs. The Monitoring Team found that this system is not consistently being used. For example, on April 29, 2008, the Monitoring Team found that the medication log book reflected that, for the month of May 2008, there were no medications due to be ordered from PharmaCor for the dates of May 1, 3, 11, 12, 23, 28, 29, and 30, and on the other dates, there were very few medications listed. Given the caseload at Baylor, it is unlikely that these results are accurate, and indicate that the medication reorder system is not actively used. Additionally, in one case that the Monitoring Team reviewed, an HIV patient whose medication order had expired had to wait three weeks before her medication was reordered.

The Monitoring Team observed that continuity of mental health medications is a significant problem at Baylor. This observation is based on reports from the nursing director, mental health supervisor, and from a review of records. In a review of six inmates' records who entered the Facilities on certain medications, the Monitoring Team found that in only one of these was a proper bridging order¹³⁸ obtained. The DON has identified issues relevant to medications being verified and bridging orders being obtained and has implemented a corrective action plan.

Baylor has examined this problem through a CQI study and has formulated a corrective action plan independent of the Monitoring Team's review.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team evaluated this provision by reviewing health records of inmates who were prescribed chronic or psychotropic medications to determine continuity of

¹³⁸ A bridging order is one for medications the inmate took outside the facility that is usually verified by jail nursing staff and then issued by a physician until the inmate is scheduled to be seen by a psychiatrist on site. That way there is as little disruption in their care as possible. In general, medications should be ordered that are the same preparation the inmate took outside the facility and not altered until a physician actually evaluates the inmate and in their clinical judgment determines that changes in prescriptions are safe and equally effective as the prior medication.

medications. The records were randomly obtained from: (a) inmates who were newly arrived or transferred into the facility; (b) chronic disease rosters; and (c) sick call.

The Monitoring Team reviewed six health records for continuity of medication for patients who were on antiretroviral therapy and other chronic disease medications (*e.g.*, diabetes, hypertension). In only one of the six cases was medication continuity achieved. Further, the Monitoring Team found three cases in which the medication lapsed for one to two months.

The Monitoring Team was informed that DCC tracks bridging orders. However, their record review included only three records that were relevant. Of these three, none of the inmates received medications within 24 hours of being admitted. During its own review of records, the Monitoring Team found only one relevant record in the sample selected. In this record, no bridging order was given until one month after the inmate was admitted. Finally, the requirement that discontinuation of medication only occur after a face-to-face assessment is not currently measured by CMS.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team evaluated this provision by reviewing health records of inmates who were prescribed chronic or psychotropic medications to determine continuity of medications. The records were randomly obtained from: (a) inmates who were newly arrived or transferred into the facility; (b) chronic disease rosters; and (c) sick call.

The Monitoring Team reviewed ten health records of patients with medication orders. The Monitoring Team found that five out of ten records revealed that the patients did not receive their medications in a timely manner upon entering the facility. The Monitoring Team also reviewed records selected from other sources for purposes of assessing other provisions of the MOA (*see* discussion of provisions 4, 19, and 22 of the MOA). Those records reflected six cases in which medication orders expired, one case in which the patient's medication was not discontinued as ordered resulting in his continuing to receive a dangerous drug, and one case in which the nurse gave prescription medications to the patient beyond the medication expiration date. Also, the Monitoring Team's review of chronic care records revealed instances of chronic medication order lapses.

With regard to mental health, the Monitoring Team reviewed the records of inmates who had recently been released and were on the mental health caseload and found that timely bridging orders had been obtained when these inmates entered the facility. However, based on its review of records and discussion with staff, the Monitoring Team identified issues

relevant to staff's attempts to verify medications that were in fact verifiable. Additionally, problems continue regarding untimely follow-up by psychiatrists after medications are started or significantly changed. For instance, it was not uncommon for planned follow-ups to be scheduled as many as 90 days after a significant change was made in an inmate's medication.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team evaluated the continuity of medications by determining whether patients who are on chronic medications for medical or mental health reasons have their medications continued without interruption. The Monitoring Team sampled records of newly arriving or transferred inmates, and those in the chronic disease program.

As of the time of the Monitoring Team's visit, the chronic disease management program does not ensure that patients are seen in a timely manner, which results in lapses in medication renewal for serious medical conditions. For example, the Monitoring Team reviewed five health records of patients with HIV. In two out of five records, the orders for antiretroviral medications expired and were not renewed in a timely manner. Lapses in antiretroviral therapy may lead to the development of viral drug resistance. In another case, medications for treatment of diabetes and hypertension lapsed for over a three-month period. Aside from patients not being seen on a timely basis, delays in order transcription may further contribute to discontinuity of medication. The Monitoring Team found that of six health records of inmates who transferred into the facility, only two of the inmates were receiving medications, and both received their medication in a timely manner.

With regard to mental health, while staff at SCI reported that bridging orders were obtained with respect to psychotropic medications, there have been no audits performed relevant to this issue. The Monitoring Team was unable to identify a large enough sample to accurately review this provision. Of two records reviewed that should have involved bridging orders, neither inmate received such an order.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State and CMS develop, implement and monitor a medication renewal and refill system that ensures continuity of essential medications.

At DCC, the Monitoring Team recommends that the State monitor chronic care medications in order to eliminate medication lapses.

At SCI, the Monitoring Team recommends that facility health care leadership review systems to ensure that the following take place:

- Nurses schedule patients with chronic diseases in accordance with clinician ordered follow-up visits, and patients are seen as scheduled;
- Clinicians renew or change their medications in accordance with disease control;
- Nurses transcribe orders in a timely manner and fax the order to PharmaCor;
- The pharmacy dispenses and ships the medications in a timely manner; and
- Nurses administer the medications from the stock supply until the patient's medications arrive from PharmaCor.

26. Medication Management

A. Relevant MOA Provision

Paragraph 26 of the MOA provides:

The State shall develop and implement guidelines and controls regarding the access to, and storage of, medication as well as the safe and appropriate disposal of medication and medical waste.

According to the NCCHC, the guidelines and controls developed by the State should include the following components:

- The Facility complies with all applicable state and federal regulations with regard to prescribing, dispensing, administering, and procuring pharmaceuticals;
- The facility maintains a formulary for providers;
- The facility maintains procedures for the timely procurement, dispensing, distribution, accounting, and disposal of pharmaceuticals;
- The facility maintains records as necessary to ensure adequate control of and accountability for all medications;
- The facility maintains maximum security storage of, and accountability by use for, Drug Enforcement Agency ("DEA")-controlled substances;
- The facility has an adequate method for notifying the responsible practitioner of the impending expiration of a drug order, so that the practitioner can determine whether the drug administration is to be continued or altered;

- Medications are kept under the control of appropriate staff members;
- Inmates do not prepare, dispense, or administer medication except for self-medication programs approved by the facility administrator and responsible physician (e.g., “keep-on-person” programs). Inmates are permitted to carry medications necessary for the emergency management of a condition when ordered by a clinician;
- Drug storage and medication areas are devoid of outdated, discontinued, or recalled medications;
- Where there is no staff pharmacist, a consulting pharmacist is used for documented inspections and consultation on a regular basis, not less than quarterly;
- All medications are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Antiseptics, other medications for external use, and disinfectants are stored separately for internal and injectable medications. Medications requiring special storage for stability (e.g., medications that need refrigeration are so stored);
- An adequate and proper supply of antidotes and other emergency medications, and related information (including posting of the poison control telephone number in areas where overdoses or toxicological emergencies are likely) are readily available to the staff.

J-D-01; P-D-01.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team evaluated this provision by inspecting the medication room and assessing access to, storage of as well as safe and appropriate disposal of medication and medication waste.

The Monitoring Team found that the pharmacy/medication room is small and cramped. There is insufficient room to store all pharmaceuticals. As a result, some medications are stored in another area of the clinic. The pharmacy/medication room is cleaner and more organized since the Monitoring Team’s last visit. The cabinets are still in disrepair with missing cabinet doors and drawers with broken locks, however. The medication room has a valid DEA license, which expires in 2009.

The Monitoring Team found that there is no accountability system for stock (versus patient-specific) prescription medications. This is problematic because of the potential for drug diversion, or administering medications without a valid order.

With respect to medication storage, the Monitoring Team found that medications that are to be applied externally (skin preparations) are not clearly separated and labeled from medications that are to be taken internally (oral medications), which presents the risk of accidental dispensing of topical medications for ingestion. This problem must be remedied in order for the State to be in compliance with this provision of the MOA.

With respect to narcotic accountability, the Monitoring Team randomly selected seven narcotics blister packs, and compared the amount remaining in the blister pack with the amount recorded in the narcotic book. The Monitoring Team found that six out of seven counts were accurate. One blister pack was discrepant with the narcotic book.¹³⁹ Staff corrected this discrepancy during the same shift. The Monitoring Team also found a discrepancy with the needle and syringe counts, but staff later reported that they were able to account for the syringes. The Monitoring Team believes that these discrepancies are due to staff not signing out narcotics and needles at the time they are used.

The Monitoring Team found that the medication refrigerator was clean, but a large amount of ice had accumulated in it. The refrigerator should periodically be defrosted to ensure proper functioning and temperature control. The Monitoring Team found that temperatures are checked daily.

The Monitoring Team learned that asthma patients in segregation/isolation were not permitted to keep short-acting (rescue) inhalers on their person. This presents a risk that inmates will not receive their medications in a timely manner which could exacerbate their condition.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team evaluated this provision by inspecting the medication room and assessing access to, the storage of disposal procedures for medication and medication waste. The Monitoring Team found that there have not been any significant changes in this area since

¹³⁹ A patient had been prescribed Ultram 50 mg., and the narcotic book reflected that there should be 156 pills present but there were only 154 pills in the blister pack.

the Monitoring Team's last visit.

The pharmacy/medication room is of insufficient size for pharmacy operations resulting in a cramped, cluttered and disorganized environment. The floors were very dirty and did not appear to have been cleaned for some time. The countertops are full of log books, which make it difficult to perform sanitation/infection control activities.

The Monitoring Team learned that a pharmacist periodically comes to the facility to collect expired medications and conduct inspections; however, the Monitoring Team found numerous vials of expired injectable medications.¹⁴⁰ Some of these medications had expired as long ago as July 2007. The Monitoring Team found that there are large quantities of stock (versus patient-specific) prescription medications for which there is no accountability. This lack of accountability is problematic because of the potential for drug diversion, or the administration of medications without a valid order.

With respect to medication storage, the Monitoring Team found that medications that are to be applied externally (skin preparations) are not clearly separated and labeled from medications that are to be taken internally (oral medications). The State must separate these medications in order to be in compliance with this provision of the MOA.

With respect to narcotic accountability, the April 2008 narcotic count sheets show that there were sixteen shifts in which narcotics counts were not performed, and eighteen shifts in which only one staff member counted narcotics.¹⁴¹ The Monitoring Team conducted a random check of narcotics, which revealed that five of six counts were accurate. One accountability sheet reflected that 112 Ultram pills should have been present, but the blister pack contained only 108 pills.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team evaluated this provision by inspecting the medication room and assessing access to, the storage of disposal procedures for medication and medication waste. The Monitoring Team found significant improvements in medication management, and HRYCI is close to being in substantial compliance for this provision of the MOA.

¹⁴⁰ The expired medications were Dilantin, Vancomycin, Hydroxyzine, Haldol, and Prolixin.

¹⁴¹ Generally accepted practice is for two staff members to count narcotics.

The medication room has been relocated from a small room in the infirmary that was in poor condition to a larger room previously used to store medical records. The room was spacious, clean and well-organized. It has sufficient cabinetry to store medications, and provides secure (double lock) storage for narcotics. With respect to medication storage, the Monitoring Team found that medications that are to be applied externally (skin preparations) are not clearly separated and labeled from medications that are to be taken internally (oral medications). This should be done.

With respect to medication accountability the Monitoring Team randomly selected five narcotics blister packs, and compared the amount remaining in the container to the accountability log, and found that all counts were correct. The Monitoring Team found that once narcotics are taken out of the container and placed in the medication cart, they are no longer under double lock.

The Monitoring Team also found that there are large quantities of stock (versus patient-specific) prescription medications for which there is no accountability (sign out system) after they arrive at the facility. This lack of accountability is problematic because of the potential for drug diversion, or administering medications without a valid order. In fact, the Monitoring Team learned that an employee was recently dismissed for diversion of non-narcotic medication. Finally, the Monitoring Team also found instances in which nurses provided stock medications to patients beyond the medication expiration date.

It was reported that a PharmaCor pharmacist visits the facility periodically to dispose of medications, including narcotics. The Monitoring Team reviewed the documentation that showed that narcotics were properly disposed of.

Finally, the Monitoring Team found that the medication administration nurse did not have keys to the medication cart, and therefore, cannot lock the medication cart containing narcotics.

E. SCI

1. Assessment

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

2. Findings

There is inadequate space and cabinetry in the medication room to store all pharmacy related items and to separate internal from externally applied medications. The Monitoring Team found that there is no system for accountability of stock prescription medications. The Monitoring Team was able to verify that narcotics are stored in a locked cabinet and counted each shift; however, the Monitoring Team found that there is not adequate security for all controlled substances because nurses pre-pour these medications several hours in

advance of administering the medication. Both of these practices pose a risk of medication diversion.

With respect to medication disposal, the Monitoring Team learned that a PharmaCor representative was supposed to check medication expiration dates, and pick up and dispose of controlled substances at the facility on a monthly basis. The Monitoring Team found, however, that the PharmaCor representative had cancelled two previous appointments to pick up the medication. As a result, staff had to continue to count narcotics for inmates who are no longer at the facility. Finally, the Monitoring Team found that there is a system in place for needle and syringe accountability.

F. Recommendations

At Baylor, the Monitoring Team makes the following recommendations:

- The medication room space should be expanded or relocated in order to permit storage of all pharmaceuticals, and broken cabinets should be repaired or replaced;
- The health care leadership should develop an accountability system for stock medications that is periodically checked to detect diversion or improper administration;
- Staff should sign out all narcotics and syringes at the time they are removed;
- Periodically clean and defrost the refrigerator; and
- Permit inmates in segregation to have rescue inhalers.

At DCC, the Monitoring Team makes the following recommendations:

- Facility and health care leadership, in collaboration the OHS, should expand the pharmacy into adjacent areas to provide adequate space for pharmacy/medication administration operations and storage;¹⁴² and
- Health care leadership, in collaboration with PharmaCor, must ensure comprehensive and reliable medication room/pharmacy inspections. These inspections should address medication room sanitation and organization, ensure that no expired medications are maintained in the medications room, separate and label externally applied from oral medications, and ensure accountability for stock medications and narcotics.

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

¹⁴² In the interim, the medication room should be completely reorganized and cleaned. A schedule of sanitation/infection control activities should be developed, implemented and monitored. Develop an accountability system for stock medications that is periodically checked to detect diversion or improper administration.

- Separate and label externally applied from oral medications;
- Develop an accountability system for stock medications that is periodically checked to detect diversion or improper administration;
- Narcotics transported in the medication carts should be double locked. The Monitoring Team suggests obtaining a lockable container that can be placed in one of the drawers; and
- The medication nurse should have keys to the medication cart, and except when in active use, the cart should be locked.

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

- Implement a system to provide strict accountability for stock medications (*i.e.*, a nurse signs out each dose of medication and documents which patient received the medication);
- Narcotics should be removed and signed out when the patient presents to the medication window to receive the medication;
- Ensure that any plans to expand the medication room ensure that it is of sufficient size to store and secure pharmacy related items;¹⁴³
- Separate internal medications from external medications, and label the respective shelves or cabinets; and
- Facility health care leadership should work with PharmaCor to ensure consistency in picking up medications and controlled substances for credit and/or disposal.

¹⁴³ Installing above and below lockable cabinets should facilitate expanded storage.

EMERGENCY CARE

27. Access to Emergency Care

A. Relevant MOA Provision

Paragraph 27 of the MOA provides:

The State shall train medical, mental health and security staff to recognize and respond appropriately to medical and mental health emergencies. Furthermore, the State shall ensure that inmates with emergency medical or mental health needs receive timely and appropriate care, including prompt referrals and transports for outside care when medically necessary.

The NCCHC recommends that the provision of 24-hour emergency medical, mental health, and dental services. J-E-08; P-E-08. In order to ensure timely and appropriate emergency services, the NCCHC recommends that institutions have a written plan including arrangements for emergency transport of the patient from the facility, use of an emergency medical vehicle, use of one or more designated hospital emergency departments or other appropriate facilities, emergency on-call physician, mental health, and dental services when the emergency health care facility is not located nearby, security procedures for the immediate transfer of patients for emergency medical care, and notification to the person legally responsible for the facility. *Id.* Further, emergency drugs, supplies, and medical equipment should be regularly maintained. *Id.*

B. Baylor

1. Assessment

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

2. Findings

It is unknown how many patients presented to the infirmary reporting acute symptoms, so it is possible only to evaluate those inmates that were, in fact, sent to an emergency room. The Monitoring Team reviewed the records of five patients who were sent to an emergency room. The Monitoring Team found that these patients generally were identified and sent off-site on a timely basis, and that follow-up care was appropriate once the inmate returned to the facility. Specifically, in five out of five cases, the transfers took place within a period of time that met the medical needs of the patient.¹⁴⁴ In addition, five out five of the

¹⁴⁴ In the case of access to emergency care, there is no set period of time that will *per se* be reasonable. The period of time that is appropriate will be that period of time which meets the needs of a patient under the circumstances.

patients were seen by a provider at the facility within 24 hours of return from the emergency room.

The Monitoring Team did find some weakness in the documentation relating to these cases. First, in two of the records, there was no documentation of the events leading to the emergency department transfer. Therefore, the Monitoring Team was not able to verify that the care leading up to the emergency room transfer was appropriate or that the emergency transfer should not have taken place earlier. In addition, one patient with a chronic disease did not get referred to the physician at intake, which led to discontinuity in care. As a result, the inmate became sick enough to require a trip to the emergency room. Finally, in one instance, the patient was transferred to the emergency room, but there was not an order from a provider for her to be transferred there.

As this provision applies to mental health services, the Monitoring Team found that after-hours coverage is provided by the director of mental health via a paging system and by the psychiatrist through the State's on-call system. Additionally, there have been no referrals to the Delaware Psychiatric Center ("DPC") in the past seven months.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team reviewed five records of patients sent off-site on an emergency basis. In five out of five cases, the patient's problems were responded to on a timely basis, and the off-site transport was timely. The only problem identified has been follow-up in two of the five records in that no follow-up visits with primary care clinicians were documented in the patients' health records.

As this provision relates to the provision of mental health services, the Monitoring Team found that access to emergency care is adequate. Clinical hours are unchanged since the last visit and appropriate after hours coverage is provided. Additionally, meetings between DOC and DPC personnel have resulted in the expedition of DOC inmates being accepted by DPC. Three inmates have been accepted in recent months, and one is pending an open bed. There are no civil beds available to move people into when they exhaust their criminal commitment but remain under civil commitments, but meetings are planned to address this issue.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed four records of patients selected from the emergency log. From these records, the Monitoring Team reviewed twenty different encounters. Three out of the four patients were sent to the emergency room, and one patient was treated on-site. The Monitoring Team made the following findings:

- All patients sent out to the emergency room had a physician order to be sent out, there was no apparent delay once the decision to send the patient was made, orders were given upon return and all were seen with 24 hours of return by a provider.
- There were no entries on the Problem List in two of the four patients.
- One of the cases in which the patient had to be sent to the emergency room was potentially avoidable had different actions been taken earlier in the patient's course of care.
- No hospital records of the emergency department's complete evaluation returned with the patients nor were these obtained later even when requested. There was no apparent mechanism to track that these reports never arrived.
- One patient who was admitted to the infirmary after return from the emergency room for evaluation of a first time seizure was released from the facility the following day without medical notification or clearance; therefore, no arrangements could be made or information given to the patient regarding follow up assessment of his new medical problem.

The Monitoring Team found no changes in the way psychiatric emergencies are handled at HRYCI and notes that the process continues to be adequate.

E. SCI

1. Assessment

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

2. **Findings**

The Monitoring Team reviewed the records of several patients who presented in emergency situations. In each of the records, the Monitoring Team found that the physician was called, the patient was promptly sent out, and upon return, the patient was placed in the infirmary for follow-up care. In general, the care was both timely and appropriate.

The Monitoring Team was unable to determine the timeliness of the ambulance response. The Monitoring Team recommends that the facility track the time of the ambulance response, because it is important to document for the CQI program. In addition, the CQI program should include an examination of the time of initial phone call, the time the ambulance arrives at the institution, the time the ambulance arrives at the medical service, and the time of departure from the medical service.

F. Recommendations

At Baylor, the Monitoring Team recommends the following:

- Logs of all patients seen for unscheduled appointments should be maintained;¹⁴⁵
- Events leading up to the transfer to the emergency room should always be documented in the progress notes;
- Nursing staff should be reminded that a provider must order all transfers to the emergency room prior to sending except for proscribed critical events as determined by the Medical Director;¹⁴⁶ and
- Providers should also be notified upon the patient's return so as to provide follow up orders.

At DCC, the Monitoring Team recommends that the State ensure that all patients sent off-site and either hospitalized or returned from the emergency room are seen by a physician on a follow-up visit within a reasonably appropriate period of time.

At HRYCI, the Monitoring Team recommends the following:

- As part of the CQI process, all patients sent to the emergency room should be reviewed not only for the immediate circumstances of the send out, but also prior care to determine if earlier treatment might prevent some emergencies; and

¹⁴⁵ These should record the date of the encounter, patient identifying data, the reason for the encounter, the preliminary and final diagnosis and the outcome of the encounter (*i.e.*, returned to pod, sent to ER, admitted to the infirmary).

¹⁴⁶ In these instances, the on-call provider should be notified as soon as possible.

- The facility should develop a relationship with the hospital and a procedure should be jointly developed so that complete information of the care of patients sent to the hospital is sent to the facility in a reasonable timeframe.

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

- Track the time of emergency response, including the time the ambulance is called, the time the ambulance arrives at the prison, the time ambulance arrives at the medical unit, and the time the ambulance leaves the medical unit for all off-site emergencies;¹⁴⁷ and
- Maintain an on-site emergency log that tracks all emergency calls with the number of the patient, representing problem, and the disposition, which is reviewed by the on-site physician on a daily basis, and records selectively reviewed, so the physician can determine the adequacy of the on-site response.

28. First Responder Assistance

A. Relevant MOA Provision

Paragraph 28 of the MOA provides:

The State shall train all security staff to provide first responder assistance (including cardiopulmonary resuscitation (“CPR”) and addressing serious bleeding) in an emergency situation. The State shall provide all security staff with the necessary protective gear, including masks and gloves, to provide first line emergency response.

This provision of the MOA defines the complete standard for first responder assistance. For further information, see discussions of provisions 9, 32, and 52.

B. Baylor

1. Assessment

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

¹⁴⁷ The goal for response time should be an ambulance arriving at the medical unit within twenty minutes from the time of call.

2. Findings

The Monitoring Team reviewed personnel records for security staff in order to determine the State's compliance with several provisions of this MOA. In reviewing those records, the Monitoring Team found that each of the records demonstrated that security staff had received the training required by this provision of the MOA.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team reviewed personnel records for security staff in order to determine the State's compliance with several provisions of this MOA. In reviewing those records, the Monitoring Team found that each of the records demonstrated that security staff had received the training required by this provision of the MOA.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed personnel records for security staff in order to determine the State's compliance with several provisions of this MOA. In reviewing those records, the Monitoring Team found that each of the records demonstrated that security staff had received the training required by this provision of the MOA.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed personnel records for security staff in order to determine the State's compliance with several provisions of this MOA. In reviewing those

records, the Monitoring Team found that each of the records demonstrated that security staff had received the training required by this provision of the MOA.

MENTAL HEALTH CARE

29. Treatment

A. Relevant MOA Provision

Paragraph 29 of the MOA provides:

The State shall ensure that qualified mental health professionals provide timely, adequate, and appropriate screening, assessment, evaluation, treatment and structured therapeutic activities to inmates requesting mental health services, inmates who become suicidal, and inmates who enter with serious mental health needs or develop serious mental health needs while incarcerated.

This provision of the MOA is an overall standard governing the timeliness and appropriateness of the following components of mental health care to be provided at the Facilities:

- mental health screening;
- assessment;
- evaluation;
- treatment; and
- structured therapeutic activities.

The NCCHC recommends that there be mental health services¹⁴⁸ available for all inmates who require them. J-G-04; P-G-04. The MOA, on the other hand, requires that mental health services be available to all inmates *requesting* them, inmates who become suicidal, and inmates who enter with serious mental health needs or develop serious mental health needs while incarcerated. The NCCHC standards state that mental health treatment is more than prescribing psychotropic medications; treatment goals include the development of self-understanding, self-improvement, and development of skills to cope with and overcome disabilities associated with various mental disorders. J-G-04; P-G-04. The NCCHC provides that facilities housing significant numbers of patients with mental health problems who have longer sentences are expected to offer more extensive mental health programming. *Id.* Correctional facilities that provide for the needs of patients requiring psychiatric hospitalization levels of care are expected to mirror treatment provided in inpatient settings in the community. *Id.*

¹⁴⁸ “Mental health services” includes “the use of a variety of psychosocial and pharmacological therapies, either individual or group, including biological, psychological, and social, to alleviate symptoms, attain appropriate functions, and prevent relapse.”

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team reviewed twenty records for the purpose of examining this provision of the MOA. The Monitoring Teams selected these records based on the first twenty records (in alphabetical order) of inmates on the mental health caseload at Baylor who were prescribed drugs such as Depakene,¹⁴⁹ lithium,¹⁵⁰ carbamazepine,¹⁵¹ or Clozaril,¹⁵² all of which have potentially dangerous side effects. Overall, the Monitoring team found that 60% of the psychiatric follow-up visits reflected in the records were performed within appropriate timeframes.¹⁵³ Additionally, 89% of records reviewed reflected that clinicians ordered appropriate laboratory studies.¹⁵⁴

Several records that the Monitoring Team reviewed indicated that laboratory studies were ordered but not obtained in a timely fashion. Upon closer examination, the Monitoring Team found that the laboratory report forms are recorded and dated on the laboratory form itself. Additionally, treatment plans frequently are not completed and filed in the record. They are also infrequently updated as required.

The Monitoring Team also found that certain inmates who were Hepatitis C positive had been placed on medication with hepatotoxic risks in order to treat their mental illness symptoms. In such cases, the psychiatrist should document why agents such as Depakene (valproic acid) are used in light of this condition and take steps to ensure that adequate liver

¹⁴⁹ Depakene is used to treat seizure disorders.

¹⁵⁰ Lithium is used to treat and prevent episodes of mania.

¹⁵¹ Carbamazepine is used to treat epilepsy and bipolar disorder.

¹⁵² Clozaril is used to treat schizophrenia.

¹⁵³ Appropriate timeframes are based on the assessed clinical need determined by the presenting symptoms as well as a reasonable time period in which the response to the treatment initiated or changed can be monitored.

¹⁵⁴ The Monitoring Team notes significant improvement by one psychiatrist at Baylor. This psychiatrist is obtaining appropriate laboratory studies more frequently, and has begun seeing inmates for follow-up appointments within 30 days of the initiation of new medication regimens.

function panels are obtained before initiation of the medication. These tests should continue throughout the course of treatment as well.

In addition to the problems described above, other sections of this report have described significant problems that bear on this provision. These problems include, but are not limited to:

- inadequate physical plant, with specific reference to office space in the infirmary and problems with other office space due to sound privacy issues;
- significant medication management issues, including problems with continuity of medications, noncompliance practices, and obtaining necessary laboratory tests;
- problems with the grievance system due to lack of direct involvement from mental health staff;
- medical records have significant filing backlogs; and
- a problematic mental health referral system.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team observed that significant improvements had been made since the last visit which included the following:

- a slight increase in programming in the SNU;
- fewer medication management problems;
- improved practices regarding laboratory tests; and
- increased supervision of non-licensed clinicians.

However, the Monitoring Team continued to find other significant problems with treatment. Some of these are summarized in other sections of this report and include the following:

- inadequate physical plant, with specific reference to office space in the infirmary and lack of adequate office space in some housing units;

- mental health staffing allocation shortages, including psychiatric coverage;
- inadequate psychiatrist staffing for the infirmary;
- treatment services consisting primarily of medication and welfare checks by mental health counselors, despite the increased programming in the SNU;¹⁵⁵
- SNU inmates are treated as if they are medium high security level unit inmates, which results in decreased access to good time activities, decreased visiting privileges, and decreased commissary benefits;¹⁵⁶
- significant medication management issues;
- significant problems with the grievance system;
- significant problems meeting the initial 72 hour timeframe for completion of pretrial detention inmates' sick call requests due to staffing allocation issues; and
- barriers to access to inpatient psychiatric hospitalization for inmates in need of such treatment is also very problematic due to both bed availability and legal logistical issues.

D. HRYCI

1. Assessment

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

2. Findings

As a result of the increase in staffing allocation hours, the Monitoring Team found that psychiatric services have improved in the areas of the timeliness of initial assessments. Additionally, documentation of bridging orders in some of the records reviewed has improved.

Overall, the mental health staff does an excellent job of responding to sick call requests within 24 hours, conducting new assessments, and monthly reviews. However, there is little to no evidence that individual counseling is occurring beyond the required monthly review.

¹⁵⁵ Programming for SNU inmates should include reasonable access to education and job opportunities and access to at least ten hours per week of structured therapeutic activities that are treatment plan driven based on individualized needs.

¹⁵⁶ The State has indicated that it is in the process of remedying this problem. *See* discussion of MOA paragraph 37.

Additionally, although there is evidence that doctors are ordering more laboratory studies, oftentimes the laboratory study orders are not specific enough. For instance, a blood level may be ordered, but the order doesn't specify when the test should be performed, which is extremely important if the results are going to be clinically useful.

There are other problems with treatment that are addressed elsewhere in the report, but which are briefly mentioned again below:

- monthly mental health visits on the Transitions Unit are not occurring as private individual meetings;¹⁵⁷
- inadequate office space and inadequate sound privacy for interviews in the dormitories and infirmary;
- although there has been some improvement, mental health staffing shortages continue;
- the treatment services being provided to inmates consist primarily of welfare checks; and
- significant medication management issues.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed seven records of sentenced inmates, and eight records of pretrial inmates. The records were randomly selected for review from the chronic care list based on the sole criteria that the inmate is on psychotropic medication requiring laboratory monitoring.

The Monitoring Team found that with respect to the frequency and quality of psychiatry visits, only eight of the fifteen records were compliant with the MOA provision. The Monitoring Team found that the period of time elapsing between psychiatric follow-up visits (90 days) is inappropriate, especially when new medication regimens are initiated for inmates who have been diagnosed with serious mental disorders, such as mood disorders.

The Monitoring Team also observed that in nine of the fifteen records reviewed the contents of the treatment plan were not adequate. The Monitoring Team believes that the

¹⁵⁷ This information came from an interview of all inmates in the unit and was confirmed by the counselor on the unit, who had recently resumed services at the facility.

initial evaluations and assessments need to show greater detail in describing clinical symptomatology in measurable terms so that the response to treatment can be more measurably tracked. Other psychiatrists who review the record or later treat the patient should have sufficient data in the documented history to reach the same diagnostic conclusion as the documenting psychiatrist. In some cases, especially with unsentenced inmates, treatment plans were absent altogether.

Additionally, there are other problems with treatment that are addressed elsewhere in the report, but which are mentioned briefly again below:

- inadequate office space and inadequate sound privacy for interviews in many areas of the facility, especially in the infirmary;
- mental health staffing vacancies continue;
- mental health referral system is problematic due to the staffing shortages; and
- significant medication management issues, including continuity of medication issues.

F. Recommendations¹⁵⁸

At Baylor, the Monitoring Team recommends that a multidisciplinary treatment team be implemented to develop and implement treatment plans for general population mental health caseload inmates who exhibit behavioral problems and/or continued psychiatric symptoms.

The Monitoring Team also recommends that the State develop a consent form for Lamictal. This medication can have serious side effects and appears to be used in increasing frequency.

30. Psychiatrist Staffing

A. Relevant MOA Provision

Paragraph 30 of the MOA provides:

The State shall retain sufficient psychiatrists to enable the Facilities to address the serious mental health needs of all inmates with timely and appropriate mental health care consistent with generally accepted professional standards. This shall include retaining appropriately licensed and qualified psychiatrists for a sufficient number of hours per week to see patients, prescribe and adequately monitor psychotropic medications, participate in the development of individualized treatment plans for inmates with serious mental health needs, review records in

¹⁵⁸ These recommendations do not include ones made elsewhere in this report; other recommendations made in this report apply to some of the issues highlighted in this section of the report.

the context of rendering appropriate mental health care, review and respond to the results of diagnostic and laboratory tests, and be familiar with and follow policies, procedures, and protocols. The psychiatrist shall collaborate with the chief psychologist in mental health services management as well as clinical treatment, shall communicate problems and resource needs to the Warden and chief psychologist, and shall have medically appropriate autonomy for clinical decisions at the facility. The psychiatrist shall supervise and oversee the treatment team.

This provision of the MOA does not differ significantly from the standards applicable to provision 6 of the MOA with respect to the requirement for sufficient psychiatrist staffing, and therefore, the Monitoring Team refers to the standards set forth with respect to that provision. *See J-C-07; P-C-07.*

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team found that the psychiatrist hours allocated for Baylor have been decreased from 22 hours per week to only sixteen hours per week. Additionally, the psychiatric coverage provided occurs during two consecutive days. The psychiatrists' caseload is approximately 145 inmates. At this point, it is unclear to the Monitoring Team whether the decreased coverage will be adequate.

C. DCC

1. Assessment

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

2. Findings

DCC is allocated and provided 60 psychiatric hours per week. Those 60 hours are provided by four different psychiatrists. However, scheduling difficulties exist which result in a lack of predictable hours in which these psychiatrists provide clinics. CMS regional staff has reported that they are attempting to determine how to improve scheduling so that more predictable clinic hours are provided.

Additionally, there is coverage by a psychiatrist in the infirmary on only two out of every seven days. Psychiatric coverage for the approximately 60 SNU inmates reportedly was

five to eight hours per week. Five hours of coverage is not adequate. While eight hours per week is marginally adequate to complete follow-up clinical visits, it is an inadequate amount of time for the psychiatrist to be an active participant in a multidisciplinary team and treatment planning. The psychiatrist at DCC does not attend SNU “staffing” meetings. Finally, the SHU has about five to eight hours per week of psychiatric coverage.¹⁵⁹

D. HRYCI

1. Assessment

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

2. Findings

At HRYCI, the Monitoring Team found that, in general, psychiatrists start work at 2:30 p.m. or later. This is a problem because the majority of the mental health staff leaves around 4:00 p.m., but clinicians know in advance about scheduling issues and generally are able to alter their schedules accordingly.

Staff at HRYCI reported that the psychiatrist allocation needs to be 1.5 FTE, which is an increase from the current 1.0 FTE allocation. A request for this increase has not yet been submitted by CMS.

E. SCI

1. Assessment

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

2. Findings

The allocation for psychiatrists at SCI has been 0.6 FTE since July 2007. However, this position has been vacant since December 2007. Instead, psychiatry services have been provided by telepsychiatry via three psychiatrists four days per week from 4:30 p.m. to 7 p.m.

While telepsychiatry can be a useful process in light of the current vacancies, policies or procedures regarding this sort of telepsychiatry are not yet in place.¹⁶⁰ Additionally,

¹⁵⁹ The Monitoring Team will examine more closely whether this amount of coverage is adequate psychiatric coverage during the next monitoring cycle.

¹⁶⁰ The State submitted to the Monitoring Team a policy covering telepsychiatry on June 19, 2008. This policy is under review and has not yet been implemented.

there are problems with the use of telepsychiatry from a logistical perspective. For instance, relevant documents from medical records are not faxed to the telepsychiatrist. Additionally, nursing staff is unavailable to the telepsychiatrist during the session because these sessions occur during off hours.

There is a locum tenens psychiatrist¹⁶¹ who sees inmates on site and focused on infirmary mental health patients and emergency cases. However, at the time of the Monitoring Team's visit, he had not been to SCI for over two weeks.

F. Recommendations

At Baylor, while it is unclear what the effect of the decreased coverage will be, the Monitoring Team recommends that the two day per week coverage not be provided on consecutive days so as to better utilize this coverage.

As mentioned above, at SCI, policies should be developed so that the practice of telepsychiatry can be more effective.

31. Administration of Mental Health Medications

A. Relevant MOA Provision

Paragraph 31 of the MOA provides:

The State shall develop and implement policies, procedures, and practices consistent with generally accepted professional standards to ensure that psychotropic medications are prescribed, distributed, and monitored properly and safely and consistent with generally accepted professional standards. The State shall ensure that all psychotropic medications are administered by qualified medical professionals or other health care personnel qualified under Delaware state law to administer medications, who consistently implement adequate policies and procedures to monitor for adverse reactions and potential side effects and to adequately document the administration of such medications in the MARs. Documentation in the MARs shall include a clear and consistent indication of whether the inmate refused or otherwise missed any doses of medication, as well as doses consumed. As part of the CQI program set forth in Section V of this Agreement, a qualified medical professional or RN supervisor shall review MARs on a regular and periodic basis to determine whether policies and procedures are being followed.

The MOA provides that the State shall develop and implement policies, procedures, and practices consistent with generally accepted professional standards to ensure that

¹⁶¹ Locum tenens (Latin for "place-holder") psychiatrists are those who temporarily fill the position until the position can be permanently filled.

psychotropic medications are prescribed, distributed, and monitored properly and safely and consistent with generally accepted professional standards. The State has developed policies consistent with generally accepted professional standards and the requirements of the MOA. *See* Policy D-02.

The State shall ensure that all psychotropic medications are administered by qualified medical professionals or other health care personnel qualified under Delaware state law to administer medications, who consistently implement adequate policies and procedures to monitor for adverse reactions and potential side effects and to adequately document the administration of such medications in the MARs. According to the MOA, adequate documentation in the MARs shall include a clear and consistent indication of whether the inmate refused or otherwise missed any doses of medications, as well as doses consumed. These standards have been addressed with respect to provisions 24 and 25 of the MOA.

The MOA also requires that the State have a qualified medical professional or RN supervisor review MARs on a regular and periodic basis to determine whether policies and procedures are being followed. This can take place as a part of the CQI process. *See* discussion of paragraph 54.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team bases the following assessment on the same findings that are discussed with reference to MOA paragraphs 4, 24, 25, and 54.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team bases the following assessment on the same findings that are discussed with reference to MOA paragraphs 4, 24, 25, and 54.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team bases the following assessment on the same findings that are discussed with reference to MOA paragraphs 4, 24, 25, and 54.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team bases the following assessment on the same findings that are discussed with reference to MOA paragraphs 4, 24, 25, and 54.

32. Mental Illness Training

A. Relevant MOA Provision

Paragraph 32 of the MOA provides:

The State shall conduct initial and periodic training for all security staff on how to recognize symptoms of mental illness and respond appropriately. Such training shall be conducted by a qualified mental health professional, registered psychiatric nurse, or other appropriately trained and qualified individual, and shall include instruction on how to recognize and respond to mental health emergencies.

The Monitoring Team interprets this provision of the MOA as being encompassed by provision 9 of the MOA, and therefore, the Monitoring Team refers to the standards set forth with respect to that provision. Also, the Monitoring Team notes that correctional officers should be trained at least every two years with respect to recognizing signs and symptoms of mental illness. J-C-04; P-C-04.

The Monitoring Team conducted a review of this provision of the MOA in connection with its review of provision 9 of the MOA. The Monitoring Team found that greater than 90% of the security staff at each of the Facilities had received training in accordance with

this provision of the MOA. Therefore, the Monitoring Team found that the Facilities are in substantial compliance with this provision of the MOA.

33. Mental Health Screening

A. Relevant MOA Provision

Paragraph 33 of the MOA provides:

The State shall develop and implement adequate policies, procedures, and practices consistent with generally accepted correctional mental health care standards to ensure that all inmates receive an adequate initial mental health screening by appropriately trained staff within twenty-four (24) hours after intake. Such screening shall include an individual private (consistent with security limitations) interview of each incoming inmate, including whether the inmate has a history of mental illness, is currently receiving or has received psychotropic medications, has attempted suicide, or has suicidal propensities. Documentation of the screening shall be maintained in the appropriate medical record. Inmates who have been on psychotropic medications prior to intake will be assessed by a psychiatrist as to the need to continue those medications, in a timely manner, no later than 7-10 days after intake or sooner if clinically appropriate. These inmates shall remain on previously prescribed psychotropic medications pending psychiatrist assessment. Incoming inmates who are in need of emergency mental health services shall receive such care immediately after intake. Incoming inmates who require resumption of psychotropic medications shall be seen by a psychiatrist as soon as clinically appropriate.

The NCCHC recommends that individuals conducting the receiving screening (*see* discussion of provision 10 of the MOA) make adequate efforts to explore the potential for suicide. J-E-02; P-E-02. Both reviewing with an inmate any history of suicidal behavior and visually observing the inmate's behavior (delusions, hallucinations, communication difficulties, speech and posture, impaired level of consciousness, disorganization, memory defects, depression, or evidence of self-mutilation) should be done at the screening. *Id.*

Within 24 hours after the intake screening takes place, the initial mental health screening should take place and include a structured interview with inquiries into:

- a history of:
 - psychiatric hospitalization and outpatient treatment;
 - suicidal behavior;
 - violent behavior;
 - victimization;
 - special education placement;
 - cerebral trauma or seizures, and
 - sex offenses; and

- the current status of:
 - psychotropic medications;
 - suicidal ideation;
 - drug or alcohol use, and
 - orientation to person, place, and time;
- emotional response to incarceration; and
- a screening for intellectual functions (*i.e.*, mental retardation, developmental disability, learning disability).

J-E-05; P-E-05. The NCCHC further recommends that the inmate's health record contains results of the initial screening. *Id.*

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team reviewed medical records relevant to this issue by selecting sixteen records of inmates who had been admitted between January and March 2008. Of these records, 94% received timely intake screens as required by this provision.

The Monitoring Team also bases the following assessment on the same findings that are discussed with reference to MOA paragraphs 19 and 25. While intake screenings are compliant, problems exist with respect to bridging medications, which is the basis for the partial compliance rating.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team reviewed medical records relevant to this issue by selecting 16 records of inmates who had been admitted between January and March 2008. All of these

inmates received a screening when it was appropriate or within 24 hours as required by the MOA.

The Monitoring Team also bases the following assessment on the same findings that are discussed with reference to MOA paragraphs 19 and 25. While the intake screenings are compliant, problems exist with bridging medications, which is the basis for the partial compliance rating.

D. HRYCI

1. Assessment

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

2. Findings

Inmates who arrive at HRYCI and are either carrying medications with them or report they are currently on medications, generally receive those medications within the required timeframes¹⁶² if nursing staff can verify them. However, staff reported that it was not uncommon for inmates who enter HRYCI reporting that they are on medications not to have such medications verified by nursing staff. This issue has not been addressed by any CQI studies and as a result it is unclear what percentage of newly admitted inmates are in such a situation, or why this is occurring.

Until recently, due to significant psychiatrist vacancies, inmates who arrived on non-verifiable medications did not receive the required assessments for one to two weeks, which is outside the time period required by the MOA. Although these vacancies have been addressed, it is too soon to know the effects on the timeliness of the required assessments.

The Monitoring Team also bases the following assessment on the same findings that are discussed with reference to MOA paragraphs 19 and 25. While intake screenings are compliant, problems exist with bridging medications, which has caused the partial compliance rating.

E. SCI

1. Assessment

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

¹⁶² The Monitoring Team believes that 48 hours is an appropriate timeframe in which an inmate should receive his first dose of medication after entering the facility.

2. Findings

The Monitoring Team reviewed the records of five inmates who were on medications requiring laboratory monitoring. The Monitoring Team found that all five were screened within 24 hours as required by the MOA. However, as described in the findings for SCI in MOA paragraph 25, there was not enough data to judge compliance with respect to bridging orders, which is an aspect of this provision as well. In the small sample examined for bridging orders, the Monitoring team found some delays.

34. Mental Health Assessment and Referral

A. Relevant MOA Provision

Paragraph 34 of the MOA provides:

The State shall develop and implement adequate policies, procedures, and practices consistent with generally accepted professional standards to ensure timely and appropriate mental health assessments by qualified mental health professionals for those inmates whose mental health histories, or whose responses to initial screening questions, indicate a need for such an assessment. Such assessments shall occur within seventy-two (72) hours of the inmate's mental health screening or the identification of the need for such assessment, whichever is later. The State shall also ensure that inmates have access to a confidential self-referral system by which they may request mental health care without revealing the substance of their request to security staff. Written requests for mental health services shall be forwarded to a qualified mental health professional and timely evaluated by him or her. The State shall ensure adequate and timely treatment for inmates whose assessments reveal serious mental illness, including timely and appropriate referrals for specialty care and regularly scheduled visits with qualified mental health professionals.

Any inmates with positive screenings for mental health problems should be referred to qualified mental health professionals for further evaluation. J-G-04; P-G-04. The health record should contain the results of the evaluations with documentation of referral or initiation of treatment when indicated. *Id.* Patients with needs that require acute mental health services beyond those available at the facility are transferred to an appropriate facility. *Id.*

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team bases the following assessment on the same findings that are discussed with reference to MOA paragraphs 12 and 19.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team conducted a review of applicable records in order to assess this provision. The Monitoring Team used the same sample that was examined in order to assess provision 33 of the MOA. The Monitoring Team found that, of the seven inmates who required an assessment, only two received that assessment within the 72 hours required by this MOA provision.

The Monitoring Team found that DCC is not meeting the timeliness requirement contained in this provision of the MOA. The Monitoring Team believes that the staff at DCC is behind in meeting the 72 hour requirement because there is only one person assigned to cover pretrial sick call requests and assessments. When this person is absent, there is no ability to cover this area because other employees are occupied with other responsibilities. However, shortly before the Monitoring Team's visit, CMS hired a mental health clerk to assist the mental health clinicians with administrative tasks. The Monitoring Team is hopeful that this action will have the effect of increasing the clinical availability for one of the mental health clinicians, who had been covering some of the administrative duties.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team examined the Mental Health referral log, which is used to track response times by mental health counselors to mental health referrals. Although record reviews indicated rapid responses to the requests, 28% of all mental health referral records failed to indicate what action was taken in response to the referral.

Additionally, referral responses by the non-psychiatrist mental health staff to sick call requests generally has been timely, in contrast to the response by psychiatrists for reasons previously summarized (vacancies and lack of an effective triage process)

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team selected five records of pretrial inmates who were on medications that require laboratory monitoring. The Monitoring Team found that two out of the four applicable records lacked a comprehensive mental health assessment as required by this provision. With respect to the timeliness of responses to mental health referrals, the Monitoring Team found that mental health staff does respond in a timely fashion to urgent and emergency referrals.

35. Mental Health Treatment Plans

A. Relevant MOA Provision

Paragraph 35 of the MOA provides:

The State shall ensure that a qualified mental health professional prepares in a timely manner and regularly updates an individual mental health treatment plan for each inmate who requires mental health services. The State shall also ensure that the plan is timely and consistently implemented. Implementation of and any changes to the plan shall be documented in the inmate's medical/mental health record.

A mental health treatment plan should include, at a minimum, a description of: (i) the frequency of follow-up for medical evaluation and adjustment of treatment modality; (ii) the type and frequency of diagnostic testing and therapeutic regimens; and (iii) when appropriate, instructions about diet, exercise, adaptation to the correctional environment, and medication. J-G-01; P-G-01. Further, the plans should include ways to address the patients' problems and enhance their strengths, involve patients in their development, and include relapse prevention risk management strategies, which should describe signs and symptoms associated with relapse or recurring difficulties, how the patient thinks that a relapse can be averted, and how best to help him or her manage crises that occur. *Id.*

B. Baylor

1. Assessment

The Monitoring Team finds Baylor is not in compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed twenty records, and found that eleven of the records reflected inadequate treatment plans. Specifically, the Monitoring Team found that the treatment plans frequently were not completed or filed in the record. In addition, the treatment plans lacked individualization, and quality narrative material. Additionally, the State needs to better track the required timeframes¹⁶³ to ensure completion and updates of individualized treatment plans for all inmates on the mental health caseload. Finally, the Monitoring Team found cases in which treatment plans did exist, but they were illegible.

C. DCC

1. Assessment

The Monitoring Team finds DCC is not in compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the records of eleven inmates who were on medications requiring laboratory monitoring. The Monitoring Team found that only three of the eleven records reflected complete and adequate treatment plans. In four of the records, treatment plans either were delinquent or entirely absent from the record. The treatment plans should be problem-focused, with measurable goals and objectives. The Monitoring Team also noted that treatment plans were being updated on too infrequent of a basis, and the quality of the plans in existence was deficient.

D. HRYCI

1. Assessment

The Monitoring Team finds HRYCI is not in compliance with this provision of the MOA.

¹⁶³ These timeframes, set by DOC policies, require individualized treatment plans be completed and updated every 90 days.

2. Findings

The Monitoring Team reviewed treatment plans at HRYCI and found that there had not been any improvement with regard to the adequacy of treatment plans from the observations made during the previous visit to HRYCI to monitor this provision of the MOA. As noted in the Second Report: “Treatment plans, when present, were particularly weak from the perspective of planned interventions and often were not very individualized. Inmates interviewed were uniform in their complaints that meetings with the mental health clinicians were essentially brief welfare checks in contrast to counseling sessions.” The Monitoring Team’s review during this review period is consistent with that statement.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed the records of 15 inmates who were on medications requiring laboratory monitoring. The Monitoring Team found that treatment plans were completed and updated with an adequate plan in six of the fifteen records. Treatment plans were absent in several records, most often in records of unsentenced inmates. It was not clear whether this absence was related to a delay in filing medical documents.

F. Recommendations

The State should implement training so that treatment plans include more patient-specific components. For instance, more complex treatment plans may be necessary for inmates with serious mental illnesses, while simpler forms may be all that is required for inmates who are not routinely involved in programming. Additionally, with regard to outpatient mental health caseload inmates, the frequency of treatment plans should be changed to every six months or as clinically indicated.

36. Crisis Services

A. Relevant MOA Provision

Paragraph 36 of the MOA provides:

The State shall ensure an adequate array of crisis services to appropriately manage psychiatric emergencies. Crisis services shall not be limited to administrative/disciplinary isolation or observation status. Inmates shall have access to appropriate in-patient psychiatric care when clinically appropriate.

An adequate array of crisis services should include not only observation beds, but also some form of a crisis intervention specialist or team.

B. Baylor

1. Assessment

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

2. Findings

The infirmary at Baylor has three cells. One cell is designated for suicide watch purposes, and the other two cells are used for medical purposes.¹⁶⁴ The mental health staff reported that the observation cell was the only cell available for mental health purposes. This cell was designed for two inmates although on rare occasion three inmates are housed in this cell. The cell has a fixed bed and room for an additional mattress on the floor if needed. The other cells, used for inmates with medical problems, are not appropriate for use by inmates with mental health problems due to safety concerns.

In Unit 8, there are four cells designed for mental health observation overflow purposes.

The Monitoring Team found that there were significant miscommunications between mental health and custody staffs concerning property restrictions and constant observation issues specific to inmates housed in the infirmary and mental health observation cells. For instance, the mental health staff reported being told by security that the warden had ordered that anyone on any level of watch could only have a suicide prevention gown. As a result, certain inmates on observation were not issued uniforms and underwear even though DOC policy required this. When brought to the warden's attention, he indicated that he had not issued

¹⁶⁴ The Monitoring Team will assess the issue of whether a single designated suicide cell is adequate for Baylor during the next reporting cycle.

this guideline. Some of these misperceptions had already been clarified, and the warden indicated that other misperceptions would be clarified following scheduled meetings between mental health and correctional staff.

C. DCC

1. Assessment

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

2. Findings

As mentioned in the Second Report, and as discussed in the section covering MOA paragraph 30 in this Report, the Monitoring Team notes that inadequate psychiatric staffing has resulted in significant coverage and treatment issues within the infirmary.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team observed that there continues not to be an available interview room for seeing inmates on PCO status in the infirmary, as discussed in the Second Report. The Monitoring Team was informed that this was in the process of being remedied.¹⁶⁵

The continuity of care is also hampered by a lack of a psychiatrist specifically assigned to the infirmary as the primary psychiatrist. Instead, multiple psychiatrists are used to provide psychiatric coverage to mentally ill inmates in the infirmary. Additionally, there is not a sufficient process in place by which emergency referrals are assigned to mental health counselors. This creates time management issues for the line mental health staff.

Finally, there are problems with respect to access to inpatient psychiatric hospitalization for inmates in need of such treatment due to lack of available space at DPC. However, there are attempts currently being made to improve access to DPC.

¹⁶⁵ This remedy is the same one discussed in the HRYCI section for MOA 11.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed the records of four inmates who were on PCO status due to suicide risk issues. As the complete records were not available, it is unclear whether post discharge follow-up occurred as required by the MOA. Suicide risk assessments occurred in all four cases and, in general, the documentation by mental health and nursing staffs was good.

The Monitoring Team also found that significant assessment and treatment issues were present due to the absence of an onsite psychiatrist, and specifically due to the absence of a psychiatrist assigned to the infirmary. Treatment plans were generally absent from records.

During April 2008, 16 out of the 43 admissions to the infirmary involved inmates on PCO status. Due to the limited number of safety cells, inmates are periodically double celled in cells designed only for single occupancy. The infirmary safety cell is not designed for double occupancy.

F. Recommendations

At Baylor, the Monitoring Team first emphasizes that the referenced misperceptions and miscommunications between mental health and correctional staff must be resolved. Additionally, the Monitoring Team recommends that the fixed bed in the cell used for PCO purposes be repositioned to allow for two beds being placed in the cell. This would avoid the need for a second inmate to be sleeping on a mattress on the floor.

At DCC, the Monitoring Team recommends that the State address the staffing allocations to provide more coverage by a psychiatrist in the infirmary.

At HRYCI, the Monitoring Team recommends that the State implement a more formalized process for assigning emergency mental health consultations or referrals to the mental health staff.

At SCI, most of the problems and lack of compliance with this provision are due to staffing vacancies, which needs to be remedied. As mentioned above, the State needs to address the need for more safety cells for PCO purposes, as the current cells are not designed for double occupancy, but are being used as such anyways.

37. Treatment for Seriously Mentally Ill Inmates

A. Relevant MOA Provision

Paragraph 37 of the MOA provides:

The State shall ensure timely and appropriate therapy, counseling, and other mental health programs for all inmates with serious mental illness. This includes adequate space for treatment, adequate staff to provide treatment, and an adequate array of therapeutic programming. The State shall ensure that inmates who are being treated with psychotropic medications are seen regularly by a physician to monitor responses and potential reactions to those medications, in accordance with generally accepted correctional mental health care standards.

This provision of the MOA will assist the State with providing continuity of mental health care, and provides a complete general standard against which to assess the State's compliance with this provision of the MOA, or the standards are discussed with regard to other provisions of the MOA (*see, e.g.*, discussions of provisions 6, 18, 24, 25, 31 and 33 of the MOA). To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team met with available inmates in the Harbor House unit and noted significant improvement in the programming on this unit as compared to prior site visits.¹⁶⁶ Despite this improvement, issues remain with programming. Specifically, the program is not treatment plan driven or individualized to the needs of the inmate. While the number of hours of programming has increased, it still remains less than the recommended ten hours, which is both required by generally accepted professional standards and is independently recommended by the Monitoring Team.

¹⁶⁶ The Harbor House unit has a mixed population of inmates with serious mental illness, and those who do not have a serious mental illness, but have been court-ordered to complete a six-month treatment program. The Monitoring Team's findings and recommendations do not apply to those inmates in the Harbor House who are not seriously mentally ill. The Monitoring Team's findings and recommendations are meant for those inmates with serious mental illness.

Inmates reported that they were offered four hours per week of group therapy, two hours per week of community therapy, individual therapy on an as needed/requested basis, psychiatric visits approximately every ninety days, and about four peer run groups such as Alcoholics Anonymous (“AA”) and Narcotics Anonymous (“NA”) each week. Although the programming did not generally contain any individualized treatment, it was described by inmates in a positive light. Inmates did complain that on average, one scheduled group meeting per week was cancelled related to staffing issues.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team observed a community meeting in one of the housing units and met with the inmates in a group setting following the meeting. Inmates reported good access to the psychiatrist, who reportedly saw most inmates on a monthly basis. They also described reasonable access to the mental health clinicians. The inmates indicated they are currently offered about four groups per week. Two of these groups consist of NA/AA groups which are peer run. These groups are held in either a classroom setting or in the dining area. The latter area is problematic because it is heavily trafficked area and multiple disruptions occur when meetings take place here. While the amount of programming in the SNU has slightly increased, structured therapeutic groups are still inadequate in number and breadth to meet the needs of the seriously mentally ill.

With respect to inmates on psychotropic medications, the Monitoring Team reviewed records and noted an increased frequency in the obtaining of laboratory studies for these inmates. However, there were problems found in the records including drug levels often ordered too long after a dosage increase was made, or not ordered at all. In other cases there were missed orders or delays in the completion of those orders.

The Monitoring Team also found that there is an increased frequency in the amount of doctor visits at this site. However, the Monitoring Team did find records where medication was discontinued and inmates were removed from the doctor’s caseload without the doctor ever meeting with the inmate. Overall, the content of the psychiatry records is adequately detailed and the treatment approach is understandable.

There was not a SNU coordinator at DCC at the time of the Monitoring Team’s visit. The Monitoring Team believes such a position is necessary to effectively run and program a mental health unit. This person could be used to coordinate treatment planning meetings and effective treatment programs for inmates.

One final problem the Monitoring Team noted was that inmates in the SNU were being treated and classified as MHU inmates from a security perspective. This classification arose after SNU inmates were relocated to this climate controlled medium housing area by DOC in an effort to avoid inmates being exposed to extreme summer heat. However, despite the DOC's good intentions, these inmates are being treated as if they meet the classification requirements of a MHU, which means that, as compared to general population inmates in the facility, they have restricted privileges regarding visitation rights, commissary privileges, telephone calls, and out of cell time. In addition, SNU inmates do not have access to work assignments and have very limited access to education classes. The Monitoring Team believes that the SNU should not be treated as a MHU from a custody perspective. To do so essentially punishes inmates with serious mental disorders, who do not meet classification criteria for MHU.¹⁶⁷

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team met with a group of inmates on the mental health caseload. The Monitoring Team observed a strong positive relationship between these inmates and the mental health counselor assigned to their unit. Although the Monitoring Team found that access to psychiatry is reported as better since the last visit, the contact period is still consistently too brief. Private and confidential mental health meetings should be conducted on a monthly basis to remove any impediment to the exchange of sensitive material.

The Monitoring Team observed there is still a paucity of programming and access to meaningful activities in the "Transition Unit," which is a special housing unit for inmates with mental health needs. This results in idleness most of the time for inmates. Group therapy is limited to three focused groups and two community meeting groups per week. The only other organized activities consist of Church services once a week and a Bible College once a week. The unit also has gym time for one hour per week. No library materials are provided for recreation and the facility only has a law library.

¹⁶⁷ In their Compliance Report, the DOC states that there are currently two SNU housing units located in the maximum security tiers of DCC. DOC states that one of these units is in the process of being relocated to the general population housing area of DCC. The Monitoring Team anticipates reviewing this progress during its visits in the fall.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team found that due to previously mentioned staffing shortages at SCI, inmates with serious mental illnesses are not routinely seen every thirty days. Staff has prioritized the available resources to focus on mental health screening and the sick call process.

The Monitoring Team reviewed one record where an inmate was prescribed with Clozaril. This drug is an effective antipsychotic agent but because of its potential for serious side effects, it should be used as a third line agent for serious and persistent symptoms of schizophrenia. In this case, there was no informed consent obtained for the prescription of this drug. Additionally the follow-up visit for this inmate was set for ninety days, which is far too long when initiating a medication like Clozaril. Finally, the Monitoring Team has serious concerns about Clozaril being prescribed at a facility like SCI where there is no on-site psychiatrist.¹⁶⁸

F. Recommendations

The Monitoring Team recommends that DCC reexamine its policy of classifying the SNU as a MHU from a custody perspective. Additionally, the State should remedy the physical plant issues referenced above so that meetings are not occurring in highly trafficked areas. Finally, the Monitoring team recommends that the state do a CQI study to determine how often inmates on the SNU are seen by the psychiatrist to see if the frequency is consistent with the clinical needs of the inmates housed on these units.

The State should also develop a policy and treatment protocol for the use of Clozaril and other high risk agents to ensure that inmates are safely and appropriately monitored while on these agents.¹⁶⁹

¹⁶⁸ It should be noted that in this case the inmate never actually received the Clozaril. There is no indication why he did not receive it in his records however.

¹⁶⁹ After the Monitoring Team's visit, the State showed the Monitoring Team an appropriate protocol, which encompasses this recommendation.

38. Review of Disciplinary Charges for Mental Illness Symptoms

A. Relevant MOA Provision

Paragraph 38 of the MOA provides:

The State shall ensure that disciplinary charges against inmates with serious mental illness who are placed in Isolation are reviewed by a qualified mental health professional to determine the extent to which the charge may have been related to serious mental illness, and to determine whether an inmate's serious mental illness should be considered by the State as a mitigating factor when punishment is imposed on inmates with a serious mental illness.

This provision of the MOA will assist the State with providing continuity of mental health care, and provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Assessment

The Monitoring Team finds Baylor is not in compliance with this provision of the MOA.

2. Findings

The State has not yet implemented a policy to involve mental health staff in the disciplinary process. This policy was submitted to the Monitoring Team, which provided feedback, and the State has made appropriate revisions to the policy. Approval and implementation is pending.

The Monitoring Team believes that Baylor will have little trouble coming into compliance with this provision once the policy is in place, due to the unique disciplinary system employed at Baylor. The Warden does not believe in using isolation or disciplinary segregation for extended periods of time. Instead, placement in these settings is kept to a brief timeframe of a few days. Then there is some accommodation such as a change in housing or a return to the inmate's previous setting with a loss of some privilege for awhile.

C. DCC

1. Assessment

The Monitoring Team finds DCC is not in compliance with this provision of the MOA.

2. Findings

The State has not yet implemented a policy to involve mental health staff in the disciplinary process. This policy was submitted to the Monitoring Team, which provided feedback, and the State has made appropriate revisions to the policy. Approval and implementation of the policy is pending.

D. HRYCI

1. Assessment

The Monitoring Team finds HRYCI is not in compliance with this provision of the MOA.

2. Findings

The State has not yet implemented a policy to involve mental health staff in the disciplinary process. This policy was submitted to the Monitoring Team, which provided feedback, and the State has made appropriate revisions to the policy. Approval and implementation of the policy is pending.

E. SCI

1. Assessment

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

2. Findings

The State has not yet implemented a policy to involve mental health staff in the disciplinary process. This policy was submitted to the Monitoring Team, which provided feedback, and the State has made appropriate revisions to the policy. Approval and implementation of the policy is pending.

39. Procedures for Mentally Ill Inmates in Isolation or Observation Status

A. Relevant MOA Provision

Paragraph 39 of the MOA provides:

The State shall implement policies, procedures, and practices consistent with generally accepted professional standards to ensure that all mentally ill inmates on the facility's mental health caseload and who are housed in Isolation receive timely and appropriate treatment, including completion and documentation of regular rounds in the Isolation units at least once per week by qualified mental

health professionals in order to assess the serious mental health needs of those inmates. Inmates with serious mental illness who are placed in Isolation shall be evaluated by a qualified mental health professional within twenty-four [sic] hours and regularly thereafter to determine the inmate's mental health status, which shall include an assessment of the potential effect of the Isolation on the inmate's mental health. During these regular evaluations, the State shall evaluate whether continued Isolation is appropriate for that inmate, considering the assessment of the qualified mental health professional, or whether the inmate would be appropriate for graduated alternatives. The State shall adequately document all admissions to, and discharges from, Isolation, including a review of treatment by a psychiatrist. The State shall provide adequate facilities for observation, with no more than two inmates per room.

This provision of the MOA makes clear that those inmates already on the mental health caseload must receive appropriate and timely treatment, regardless of their status as being in isolation. This means that these inmates must have adequate access to mental health care. *See* J-E-07; P-E-07. According to this MOA language, this treatment includes, but is not limited to, weekly rounds in the isolation units. *See* discussion of MOA provision 20 above.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team found no changes at Baylor since its last visit. As discussed in the preceding MOA paragraph, segregation status is infrequently used at Baylor.

C. DCC

1. Assessment

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

2. Findings

Under this provision, all inmates admitted to isolation status should receive a mental health screening to ensure that there are no contraindications with respect to such placement. This should be done regardless of whether an inmate is on the mental health caseload. The Monitoring Team found that there is no formal process at DCC which results in mental staff being notified or identifying newly admitted inmates to isolation within twenty four hours of their admission. However, staff members reported that practices are in place that result

in mental health staff members being notified in a timely manner of inmates with *known* serious mental illnesses being admitted to the isolation units.

The Monitoring team reviewed the records of seven inmates with serious mental disorders who had been admitted to the SHU sometime in 2008. Of these inmates, only three received a mental health assessment with twenty-four hours of their admission to SHU as required by the MOA.

D. HRYCI

1. Assessment

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

2. Findings

Mental health staff reportedly is notified by nursing staff whenever a new inmate who is on the mental health roster is admitted to a segregation unit. This determination is made based on a medical record review prior to the admission to the segregation unit. As a failsafe, the mental health clerk also looks up the movement roster on a daily basis in case the mental health staff does not receive a referral from nursing staff. This latter process was started due to problems in receiving referrals from the nursing staff. The mental health clinician assigned to the segregation unit reportedly then performs an assessment within 24 hours as required by the MOA. This process could not be verified by review of mental health charts or other records as this information would not be documented in those records.

The Monitoring Team also observed inconsistencies with the DOC's Suicide Prevention Policy as related to inmates on close observation. In several instances, the physician interviewed inmates placed on psychiatric observation and signed off on their care without completing a physical evaluation. Additionally, inmates are seen by nursing staff but vital signs are not performed during their admission to an infirmary bed. This is particularly essential when medications frequently initiated are known to cause hypotensive reactions.

E. SCI

1. Assessment

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

2. Findings

At the time of the Monitoring Team's visit, there was no process in place that results in mental health staff being notified within twenty-four hours of inmates who are admitted to isolation. Additionally, mental health staff does not evaluate such inmates within 24

hours to determine the inmate's mental health status. The Monitoring Team believes that this assessment should include at minimum a brief suicide risk assessment that should be performed out of cell in an office setting, unless the inmate refuses to participate in such a setting. Finally, the psychiatric vacancies described earlier pose significant problems to the State being able to comply with this provision as the provision requires a psychiatrist's review.

The State is complying with the portion of this provision which requires "completion and documentation of regular rounds in the Isolation units at least once per week."

40. Mental Health Services Logs and Documentation

A. Relevant MOA Provision

Paragraph 40 of the MOA provides:

The State shall ensure that the State maintains an updated log of inmates receiving mental health services, which shall include both those inmates who receive counseling and those who receive medication. The log shall include each inmate's name, diagnosis or complaint, and next scheduled appointment. Each clinician shall have ready access to a current log listing any prescribed medication(s) and dosages for inmates on psychotropic medications. In addition, inmate's files shall contain current and accurate information regarding any medication changes ordered in at least the past year.

This provision of the MOA will assist the State with providing continuity of mental health care, and provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team found that Baylor does maintain a log of inmates who receive mental health services. As required by the MOA, this log includes inmates who receive counseling and those who receive medication. However, Baylor does not provide a log listing prescribed medications and dosages of inmates on psychotropic medications as required by this provision.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team found that DCC continues to maintain a spreadsheet which contains all of the elements required by the MOA.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team noted in the Second Report that all of the required elements were present except for the date of the next scheduled appointment and in some cases the dosages of medications. During its reporting in this cycle, the Monitoring Team found that the dosages of medications were consistently included in the log, but that the log still does not contain the date of the next scheduled appointment.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team found that SCI continues to maintain a spreadsheet which contains all of the elements required by the MOA.

F. Recommendations

At Baylor, the pharmacy should be able to produce a log listing prescribed medications and dosages. Alternatively, a process should be developed to make current MARs available to the psychiatrist that will serve as such a log.

SUICIDE PREVENTION

41. Suicide Prevention Policy

A. Relevant MOA Provision

Paragraph 41 of the MOA provides:

The State shall review and, to the extent necessary, revise its suicide prevention policy to ensure that it includes the following provisions: 1) training; 2) intake screening/assessment; 3) communication; 4) housing; 5) observation; 6) intervention; and 7) mortality and morbidity review.

The MOA provides the complete standard against which the State is to be assessed for this provision of the MOA. The required substance of the required policy is, in large part, set forth in the MOA provisions and standards applying to each of the categories enumerated in this provision of the MOA.

The Monitoring Team found that the State is in substantial compliance with this provision of the MOA, because it has an adequate suicide prevention policy in place. The Monitoring Team notes that this provision of the MOA does not relate to the implementation of the suicide prevention policy; this provision requires only that the State review and revise its policy. Therefore, this rating of substantial compliance should not be construed as assessing the State in substantial compliance with the implementation of its suicide prevention policy.

42. Suicide Prevention Training Curriculum

A. Relevant MOA Provision

Paragraph 42 of the MOA provides:

The State shall review and, to the extent necessary, revise its suicide prevention training curriculum, which shall include the following topics: 1) the suicide prevention policy as revised consistent with this Agreement; 2) why facility environments may contribute to suicidal behavior; 3) potential predisposing factors to suicide; 4) high risk suicide periods; 5) warning signs and symptoms of suicidal behavior; 6) case studies of recent suicides and serious suicide attempts; 7) mock demonstrations regarding the proper response to a suicide attempt; and 8) the proper use of emergency equipment.

The MOA provides the complete standard against which the State is to be assessed for this provision of the MOA. The required substance of the training curriculum is, in large part, set forth in the MOA provisions and standards applying to each of the categories enumerated in this provision of the MOA.

The Monitoring Team found that the State is in substantial compliance with this provision of the MOA, because it has an adequate suicide prevention training curriculum. The Monitoring Team notes that this provision of the MOA requires the State to review and revise its suicide prevention training curriculum, and does not relate to conducting the training. Thus, the Monitoring Team's assessment of substantial compliance is limited only to an assessment that the State has reviewed and revised its suicide prevention training curriculum.

43. Staff Training

A. Relevant MOA Provision

Paragraph 43 of the MOA provides:

Within twelve months of the effective date of this Agreement, the State shall ensure that all existing and newly hired correctional, medical, and mental health staff members receive an initial eight-hour training on suicide prevention curriculum described above. Following completion of the initial training, the State shall ensure that a minimum of two hours of refresher training on the curriculum are completed by all correctional care, medical, and mental health staff each year.

The Monitoring Team refers to its findings and assessments relating to MOA provision 8 and 9 because the Monitoring Team interprets those provisions as requiring all correctional, medical, and mental health staff to complete the required suicide prevention training. As a result, each of the Facilities is in partial compliance with this provision of the MOA.

44. Intake Screening/Assessment

A. Relevant MOA Provision

Paragraph 44 of the MOA provides:

The State shall develop and implement policies and procedures pertaining to intake screening in order to identify newly arrived inmates who may be at risk for suicide. The screening process shall include inquiry regarding: 1) past suicidal ideation and/or attempts; 2) current ideation, threat, plan; 3) prior mental health treatment/hospitalization; 4) recent significant loss (job, relationship, death of family member/close friend, etc.); 5) history of suicidal behavior by family member/close friend; 6) suicide risk during prior confinement in a state facility; and 7) arresting/transporting officer(s) belief that the inmate is currently at risk.

The requirement for intake screening and assessment to include these factors is discussed above, with regard to provision 33 of the MOA. The Monitoring Team found that the State has developed policies consistent with the requirements of this provision of the MOA. In addition, the Monitoring Team found that the State has implemented this policy in a manner generally consistent with this provision of the MOA. In order to make this determination, the

Monitoring Team reviewed intake screening records (*see* discussion of provision 33 of the MOA), and State internal audits, if any.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team found that the initial screenings continue to be completed in a timely fashion and contain the process described in MOA provision 44 for the identification of newly arrived inmates who might be at risk for suicide. The Monitoring Team reviewed a State-conducted audit from March 2008, which indicated 100% compliance with this provision of the MOA, and found the audit to be reliable.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team found that intake screenings continue to be performed appropriately and include the screening process described in MOA provision 44 for the identification of newly arrived inmates who might be at risk for suicide.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team found that intake screenings continue to be performed appropriately and include the screening process described in MOA provision 44 for the identification of newly arrived inmates who might be at risk for suicide. In addition, the Monitoring Team reviewed State-conducted audits relevant to this provision of the MOA and found that they were consistent with compliance and reliable.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team found that SCI continues to conduct intake screens in a timely fashion.

45. Mental Health Records

A. Relevant MOA Provision

Paragraph 45 of the MOA provides:

Upon admission, the State shall immediately request all pertinent mental health records regarding the inmate's prior hospitalization, court-ordered evaluations, medication, and other treatment. DOJ acknowledges that the State's ability to obtain such records depends on the inmate's consent to the release of such records.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Assessment

The Monitoring Team finds Baylor is not in compliance with this provision of the MOA.

2. Findings

The Monitoring Team found that there were no changes at Baylor with respect to this provision. In the Second Report, the Monitoring Team noted that there were no community mental health records, but it was uncertain that the lack of these records was due to a lack of requests made by the State or a lack of responses to those requests. During this reporting cycle, while the Monitoring Team still was not able to locate any community mental health records, they were able to determine this was due to the State not making requests for these records.

C. DCC

1. Assessment

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

2. Findings

In the Second Report, the Monitoring Team observed that while DCC is making requests of outside providers for inmates' records, the response to these requests has been poor. The Monitoring Team recommended that the State review its procedures via a CQI process to determine what the reasons for the poor response rates are. This CQI process has not been implemented as recommended.

D. HRYCI

1. Assessment

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

2. Findings

HRYCI follows the same procedures used by DCC with the same results. There has not been a CQI process implemented at HRYCI either. Additionally, mental health line staff reported that they do not routinely request such information.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team found that SCI is now requesting mental health records from outside providers. Nursing staff reported that they are making these requests during the reception center healthcare screening process. However, as is the case at DCC and HRYCI, significant difficulties were reported in obtaining these records from providers in a timely manner.

F. Recommendations

At Baylor, the Monitoring Team recommends that the State implement a policy or procedure to begin making requests of these records as required by the MOA. At the other Facilities, the Monitoring Team recommends that the State implement a CQI process to determine what the causes for poor response rates to their requests are. If the CQI study results in a determination that the lack of response is solely due to lack of response from providers, and not because of a failure in the request system implemented by the State, then the State may be able to achieve substantial compliance with this provision of the MOA.

46. Identification of Inmates at Risk of Suicide

A. Relevant MOA Provision

Paragraph 46 of the MOA provides:

Inmates at risk for suicide shall be placed on suicide precautions until they can be assessed by qualified mental health personnel. Inmates at risk of suicide include those who are actively suicidal, either threatening or engaging in self-injurious behavior; inmates who are not actively suicidal, but express suicidal ideation (*e.g.*, expressing a wish to die without a specific threat or plan) and/or have a recent prior history of self-destructive behavior; and inmates who deny suicidal ideation or do not threaten suicide, but demonstrate other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury.

The MOA requires that the State place any inmate at risk for suicide¹⁷⁰ on suicide precautions until they can be assessed by qualified mental health personnel. Suicide precautions refer to the housing and observation requirements set forth in paragraphs 49 through 51 below. The State has developed a policy that suicide precautions will consist of placing the inmate under constant observation by correctional staff in a safe cell while an order for placement on psychiatric observation is obtained from the appropriate medical or mental health personnel. G-05. The Monitoring Team finds that this policy conforms to generally accepted professional standards. *See* J-G-05; P-G-05. As set forth in paragraph 47 below, the assessment by qualified mental health personnel should be performed within 24 hours of the initiation of suicide precautions.

¹⁷⁰ The MOA defines an “inmate at risk for suicide” as one who is (i) actively suicidal by threatening or engaging in self-injurious behavior; (ii) not actively suicidal, but expresses suicidal ideation; and/or has a recent prior history of self-destructive behavior; and (iii) who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior indicating the potential for self-injury.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team found that staff at Baylor places inmates at risk for suicide on watch, and that staff at Baylor is making appropriate determinations regarding those inmates who are at risk for suicide.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team notes that there has been improvement with regard to this provision at DCC. The Monitoring Team selected ten records of inmates who had been placed on PCO status and then examined five of those records where the inmate actually was placed on PCO status because of suicide risk issues. One of these inmates had just been discharged from the infirmary, so it was premature to assess compliance with the 24 hour follow-up requirement. In the other four cases, documentation was present that the 24 hour follow-up requirement was met. However, this sample size was small and as is noted in the discussion under MOA 51, other observation requirements are not being met.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team's review of records was consistent with their findings in the Second Report that inmates are placed on watch if HRYCI staff determines they are at risk of suicide, and that the determinations regarding which inmates are at risk of suicide are appropriate.

E. SCI

1. Assessment

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

2. Findings

As discussed elsewhere in this Report, adequate psychiatric coverage is not provided at SCI due to psychiatric vacancies. This has resulted in a lack of compliance with the requirement in this provision that “inmates at risk for suicide shall be placed on suicide precautions until they can be assessed by **qualified mental health personnel**” (emphasis added). The Monitoring Team found that, due to the psychiatric vacancies, there is often a delay in an inmate’s release from PCO status. Thus, while staff at SCI might be appropriately placing inmates on watch, they are not being stepped down appropriately.

47. Suicide Risk Assessment

A. Relevant MOA Provision

Paragraph 47 of the MOA provides:

The State shall ensure that a formalized suicide risk assessment by a qualified mental health professional is performed within an appropriate time not to exceed 24 hours of the initiation of suicide precautions. The assessment of suicide risk by qualified mental health professionals shall include, but not be limited to, the following: description of the antecedent events and precipitating factors; suicidal indicators; mental status examination; previous psychiatric and suicide risk history, level of lethality; current medication and diagnosis; and recommendations/ treatment plan. Findings from the assessment shall be documented on both the assessment form and health care record.

This provision of the MOA requires a formalized suicide risk assessment to be performed by a qualified mental health professional¹⁷¹ within an appropriate period of time, which, in any event, is not to exceed 24 hours of the initiation of suicide precautions as described above in relation to paragraph 46 of the MOA. The formalized suicide risk assessment should designate the individual’s level of suicide risk, level of supervision needed, and the need for transfer to an inpatient mental health facility or program. J-G-05; P-G-05. In addition, the MOA provides that the assessment of the individual’s level of suicide risk should include at least: (i) a

¹⁷¹ The State has developed a policy that a mental health staff (*i.e.*, an employee with a master’s degree or greater level of certification) is qualified for the purposes of initiating an order for psychiatric observation, but that only a psychologist with a Ph.D., or a psychiatrist may discharge or downgrade an inmate’s level of risk while on psychiatric observation. *See* State Policy G-05. The Monitoring Team found that policy to be adequate.

description of the antecedent events and precipitating factors; (ii) suicidal indicators; (iii) mental status examination; (iv) previous psychiatric and suicide risk history, (v) level of lethality; (vi) current medication and diagnosis; and (vii) recommendations/treatment plan.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team found that Baylor had performed a 30-record audit of health records of inmates who had been placed on PCO status because it had been determined that they were at risk for suicide. The results of this audit demonstrated that Baylor was 97% compliant with this provision. The Monitoring Team conducted its own record review, which verified the results of the Baylor's internal audit.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team notes that there has been improvement with regard to this provision at DCC. As reported in connection with provision 44 of the MOA, the Monitoring Team selected ten records of inmates who had been placed on PCO status, and then examined five of those records where the inmate actually was placed on PCO status because of suicide risk issues. One of these inmates had just been discharged from the infirmary, so it was premature to assess compliance with the 24 hour follow-up requirement. In the other four cases, documentation was present that the 24 hour follow-up requirement was met. However, this sample size was small and, as will be noted in the discussion under MOA 51, other observation requirements are not being met at DCC.

D. HRYCI

1. Assessment

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

2. Findings

In the Second Report, the Monitoring Team noted that the initial evaluation form used by the State for purposes of the suicide risk assessment should be modified to include current medication and diagnosis, so that the form will ensure that all information required by the MOA to be recorded actually will be recorded. During its visit to HRYCI, the Monitoring Team found that this form has yet to be modified to include these elements. As a result, the follow-up appointment required by this provision of the MOA is not consistently addressing the factors set forth in this provision of the MOA.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team found that although suicide risk assessments are being performed by the mental health staff, there is often a lack of meaningful psychiatric input due to the previously mentioned psychiatric vacancies.

48. Communication

A. Relevant MOA Provision

Paragraph 48 of the MOA provides:

The State shall ensure that any staff member who places an inmate on suicide precautions shall document the initiation of the precautions, level of observation, housing location, and conditions of the precautions. The State shall develop and implement policies and procedures to ensure that the documentation described above is provided to mental health staff and that in-person contact is made with mental health staff to alert them of the placement of an inmate on suicide precautions. The State shall ensure that mental health staff thoroughly review an inmate's health care record for documentation of any prior suicidal behavior. The State shall promulgate a policy requiring mental health to utilize progress notes to document each interaction and/or assessment of a suicidal inmate. The decision to upgrade, downgrade, discharge, or maintain an inmate on suicide precautions shall be fully justified in each progress note. An inmate shall not be downgraded or discharged from suicide precautions until the responsible mental health staff has thoroughly reviewed the inmate's health care record, as well as conferred with correctional personnel regarding the inmate's stability. Multidisciplinary case management team meetings (to include facility officials and available medical and

mental health personnel) shall occur on a weekly basis to discuss the status of inmates on suicide precautions.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team's review of records indicated that inmates are appropriately assessed for risk of imminent self-harm and placed on a clinically determined level of observation. The policy, which is consistent with the requirements of the MOA, is followed and inmates are stepped down based on a face-to-face evaluation and released from observation only on a psychiatrist's order.

The Monitoring Team discovered some confusion over whether there were multidisciplinary case management meetings taking place as required by this MOA. It appeared to the Monitoring Team that there were no weekly meetings occurring that included staff other than the counselor and psychiatrist monitoring the patient's progress.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team reviewed the minutes of the multidisciplinary case management team meetings and found that they were consistent with the findings of the Second Report.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team found that multidisciplinary case management team meetings are now occurring on a weekly basis. However, these meeting have not included facility level custody staff whose input is important.

E. SCI

1. Assessment

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

2. Findings

The Monitoring Team continued to observe that all inmates on suicide precautions have individualized forms posted on their observation cell door specifying the level of watch and to what property they should have access to. Additionally, the Monitoring Team found that multidisciplinary case management team meetings are occurring on a weekly basis as required by the MOA.

F. Recommendations

At Baylor, the State should establish a process for establishing multidisciplinary case management team meetings as required by this MOA.

At HRYCI, the State should include correctional staff in the meetings currently taking place on a weekly basis.

49. Housing

A. Relevant MOA Provision

Paragraph 49 of the MOA provides:

The State shall ensure that all inmates placed on suicide precautions are housed in suicide-resistant cells (*i.e.*, cells without protrusions that would enable inmates to hang themselves). The location of the cells shall provide full visibility to staff. At

the time of placement on suicide precautions, medical or mental health staff shall write orders setting forth the conditions of the observation, including but not limited to allowable clothing, property, and utensils, and orders addressing continuation of privileges, such as showers, telephone, visiting, recreation, etc., commensurate with the inmate's security level. Removal of an inmate's prison jumpsuit (excluding belts and shoelaces) and the use of any restraints shall be avoided whenever possible, and used only as a last resort when the inmate is engaging in self-destructive behavior. The Parties recognize that security and mental health staff are working towards the common goal of protecting inmates from self-injury and from harm inflicted by other inmates. Such orders must therefore take into account all relevant security concerns, which can include issues relating to the commingling of certain prison populations and the smuggling of contraband. Mental health staff shall give due consideration to such factors when setting forth the conditions of the observation, and any disputes over the privileges that are appropriate shall be resolved by the Warden or his or her designee. Scheduled court hearings shall not be cancelled because an inmate is on suicide precautions.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings. The State has developed a policy that addresses these issues with more specificity. *See* State Policy G-05. The State's policy classifies differing levels of suicide risk as Levels I through III.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team observed in its previous visit that the infirmary at Baylor has enough space to accommodate three inmates on suicide precautions. However, as noted in the discussion of MOA paragraph 36 of this report, the Monitoring Team found there were significant miscommunications between mental health and custody staffs concerning property restrictions and constant observation issues specific to inmates housed in the infirmary and mental health observation cell. These issues had begun to be resolved at the time of the Monitoring Team's visit.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team found no changes from its previous visit during the last reporting cycle. Of significance is the fact that the toilet discussed in the previous report, which essentially is a hole in the ground, is still in use at DCC.¹⁷² However, there are plans being implemented to replace this toilet. The Monitoring Team hopes to see this change fully implemented by the time of its next visit in Fall 2008.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team found no changes from its previous visit during the last reporting cycle. Of significance is the fact that the toilet discussed in the Second Report, which essentially is a hole in the ground, is still in use at HRYCI. The State has used this type of toilet because inmates consistently had removed standard toilets and destroyed them, presenting a safety risk. However, in reaction to the Monitoring Team's recommendations in the Second Report, the State has implemented a pilot program at HRYCI in order to improve the type of toilet being offered to inmates. If the pilot program is successful at HRYCI, the State should consider similar actions at the other Facilities. The Monitoring Team hopes to see this pilot program fully implemented by the time of its next visit in Fall 2008.

E. SCI

1. Assessment

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

¹⁷² As stated in the Second Report, the Monitoring Team believes this type of toilet is both clinically inappropriate and dehumanizing. As is discussed in the Monitoring Team's findings in relation to HRYCI, the State has used this type of toilet with reason, but eh Monitoring Team strongly encourages the State to find another way to address its concerns.

2. Findings

During April 2008, 16 out of the 43 admissions to the infirmary involved inmates on PCO status. Due to the limited number of safety cells, inmates are periodically double celled in cells designed only for single celling. The infirmary safety cell is not designed for double occupancy.

50. Observation

A. Relevant MOA Provision

Paragraph 50 of the MOA provides:

The State shall develop and implement policies and procedures pertaining to observation of suicidal inmates, whereby an inmate who is not actively suicidal, but expresses suicidal ideation (*e.g.*, expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior, or an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, shall be placed under close observation status and observed by staff at staggered intervals not to exceed every 15 minutes (*e.g.*, 5, 10, 7 minutes). An inmate who is actively suicidal, either threatening or engaging in self-injurious behavior, shall be placed on constant observation status and observed by staff on a continuous, uninterrupted basis. Mental health staff shall assess and interact with (not just observe) inmates on suicide precautions on a daily basis.

This provision of the MOA provides a complete general standard against which to assess the State's compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team found that staff at Baylor had conducted an audit of 30 records relevant to this paragraph. The findings of this audit were consistent with the Monitoring Team's review of records and found that the State was in compliance with the requirements of this MOA paragraph.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team found that the problem noted in the Second Report concerning a lack of sound privacy from correctional officers and other inmates continues to exist and significantly hampers the quality of the assessments required by this provision.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team found that the problem noted in the Second Report concerning a lack of sound privacy from correctional officers and other inmates continues to exist and significantly hampers the quality of the assessments required by this provision. The Monitoring Team further bases its assessment on the findings discussed in paragraphs 11 and 36.

E. SCI

1. Assessment

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

2. Findings

Although the Monitoring Team noted that 15 minute checks were being ordered in appropriate circumstances, they were unable to determine whether the checks were actually occurring as the records do not indicate this.

51. “Step-Down Observation”

A. Relevant MOA Provision

Paragraph 51 of the MOA provides:

The State shall develop and implement a “step-down” level of observation whereby inmates on suicide precaution are released gradually from more restrictive levels of supervision to less restrictive levels for an appropriate period of time prior to their discharge from suicide precautions. The State shall ensure that all inmates discharged from suicide precautions continue to receive follow-up assessment in accordance with a treatment plan developed by a qualified mental health professional.

This provision of the MOA provides a complete general standard against which to assess the State’s compliance with this provision of the MOA. To the extent that further clarification of appropriate standards is necessary, such clarification will be stated in the findings.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team found that inmates are routinely stepped down based on a face-to-face evaluation. Inmates are only stepped down on a psychiatrist’s order. The Monitoring Team reviewed records and found 100% compliance with this requirement.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team discovered during its visit in April 2008 that staff was not aware of requirements that post-psychiatric observation of the patient should occur. Specifically, while staff reported being aware of DOC policy that observation occur within seven days of removal (or more frequently if necessary), they were not aware of the requirement that

observation occur within 21-30 days post-removal (or more frequently if necessary). As a result of this confusion, it appears that the required step-down observation is not occurring.

D. HRYCI

1. Assessment

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

2. Findings

The Monitoring Team reviewed the post-PCO log maintained by HRYCI. The Monitoring Team found that except for a small number of inmates discharged after being placed on PCO status, compliance was present for the required follow-up timeframes. However, due to the significant risks associated with not providing follow up observation, there should be 100% compliance with this area.

E. SCI

1. Assessment

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

2. Findings

Although staff reported that the one day follow up was occurring as required, this was not confirmed by a review of the records. This may be a result of the four to six week backfilling of medical records.

F. Recommendations

At DCC, the Monitoring Team recommends that staff be properly trained regarding the suicide prevention policy, with a specific focus on the follow-up requirements. Additionally, the current policy requires that all inmates who are discharged from the infirmary and were on PCO status to receive the required follow-up, which means that virtually all inmates admitted to the infirmary for mental health purposes receive this follow-up. The Monitoring Team recommends the State consider revising the policy to only require follow-up for inmates admitted due to suicide risks. The necessity of follow-up for other inmates should be determined by the treatment planning discharge process.

At SCI, the Monitoring Team recommends that the State conduct a CQI study to examine this issue and determine why the records do not reflect the one day follow-up.

52. Intervention

A. Relevant MOA Provision

Paragraph 52 of the MOA provides:

The State shall develop and implement an intervention policy to ensure that all staff who come into contact with inmates are trained in standard first aid and cardiopulmonary resuscitation; all staff who come into contact with inmates participate in annual “mock drill” training to ensure a prompt emergency response to all suicide attempts; and shall ensure that an emergency response bag that includes appropriate equipment, including a first aid kit and emergency rescue tool, shall be in close proximity to all housing units. All staff members who come into regular contact with inmates shall know the location of this emergency response bag and be trained in its use.

As provided by the MOA, all staff coming into contact with the inmate should be trained in standard first aid procedures and CPR. Further, the “mock drill” training should include training for staff coming into contact with inmates regarding what to do when coming into contact with an inmate engaging in self-harm, or who has engaged in self-harm. Lindsay M. Hayes, *Guide to Developing and Revising Suicide Prevention Protocols*, included as Appendix C to the NCCHC Standards cited above. The staff member coming upon an inmate engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and to start first aid and/or CPR as necessary, even if the inmate appears to have died until relieved by arriving medical personnel. *Id.* The emergency response equipment available to staff should be checked on a daily basis to determine that it is in working order. Finally, all suicide attempts, regardless of their severity should result in an immediate intervention and assessment by mental health staff. *Id.*

B. Assessment

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

C. Findings

The Monitoring Team finds that all relevant staff members have received appropriate emergency response training. The Monitoring Team was not provided with appropriate documentation of emergency drills. Further, the Monitoring Team has not yet reviewed the proposed contents of the First Aid kit.

D. Recommendations

The Monitoring Team recommends that the State submit a list of the contents of the First Aid kit and proposed emergency rescue tool to the Monitoring Team, inform the

Monitoring Team of the proposed location for these items, and ensure that documentation of mock emergency drills are available at each of the Facilities.

53. Mortality and Morbidity Review

A. Relevant MOA Provision

Paragraph 53 of the MOA provides:

The State shall develop and implement policies, procedures, and practices to ensure that a multidisciplinary review is established to review all suicides and serious suicide attempts (*e.g.*, those incidents requiring hospitalization for medical treatment). At a minimum, the review shall comprise an inquiry of: a) circumstances surrounding the incident; b) facility procedures relevant to the incident; c) all relevant training received by involved staff; d) pertinent medical and mental health services/reports involving the victim; e) possible precipitating factors leading to the suicide; and, f) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. When appropriate, the review team shall develop a written plan (and timetable) to address areas that require corrective action.

An appropriate procedure in the event of an inmate death from suicide or a serious suicide attempt is one in which the State determines the appropriateness of clinical care that was provided to the inmate, ascertains whether corrective action in the State's policies, procedures, or practices is warranted; and identifies trends that require further study. J-A-10; P-A-10. If the inmate has committed suicide, the State should immediately notify the State of Delaware medical examiner, and, within 30 days of the suicide, conduct a clinical mortality review¹⁷³ and a psychological autopsy¹⁷⁴ in a manner consistent with this MOA provision, which provides the minimum inquiries necessary for these studies. J-A-10; P-A-10.

The Monitoring Team found that the Mortality and Morbidity review ("M&M") process designed by the State is adequate, and applies to all inmate deaths. The M&M process consists of a review of inmate's record by a physician on site within 24 hours of the inmate's death. In addition, the State refers the inmate's death to the Medical Society, which performs a review of the circumstances of the inmate's death within 30 days. The inmate is sent to the State

¹⁷³ A "clinical mortality review" is "an assessment of the clinical care provided and the circumstances leading up to the death" in order to "identify any areas of patient care or the system's policies and procedures that can be improved." J-A-10; P-A-10.

¹⁷⁴ A "psychological autopsy" is "usually conducted by a psychologist or other qualified mental health professional" and consists of "a written reconstruction of an individual's life with an emphasis on factors that may have contributed to the individual's death." J-A-10; P-A-10.

Medical Examiner for a review of the inmate's body.¹⁷⁵ The next step in the process is that each Facility's M&M Committee, which consists of a physician and nursing staff, and local and regional committee members, convenes a meeting to review the Medical Society report, 24-hour report, and, if available, the Medical Examiner's report and death certificate of the inmate.

B. Baylor

1. Assessment

The Monitoring Team finds Baylor is not in compliance with this provision of the MOA.

2. Findings

The Monitoring Team reviewed the M&M Committee meeting minutes, which included relevant information regarding a serious suicide attempt. Additionally, the State independently notified the Monitoring Team of this M&M and morbidity report at the time of its visit to Baylor because the visit occurred before the entire M&M process had taken place.

C. DCC

1. Assessment

The Monitoring Team defers providing an assessment rating due to the fact that there have been no recent deaths from suicide at DCC.

2. Findings

There have been no suicides at DCC since the Monitoring Team's previous visit in December 2007. The Monitoring Team did review committee reports compiled regarding four instances where inmates attempted serious harm to themselves. In general, these reports were adequate, although there was no attempt to aggregate the findings from the perspective of looking at systemic issues. One of the cases reviewed involved an inmate who had filed multiple grievances regarding the mental health system dating back to December 2007, but the grievances remained unresolved and were not mentioned in the report.

¹⁷⁵ The State Medical Examiner conducts a visual examination of the body, but does not conduct an autopsy. Recently, the Monitoring Team has learned that the State has asked the Medical Examiner to conduct autopsies on inmates who die in custody, and the Medical Examiner has agreed to do so.

D. HRYCI

1. Assessment

The Monitoring Team defers providing an assessment rating due to the fact that there have been no recent deaths from suicide at HRYCI.

2. Findings

There have been no suicides at HRYCI since December 2006.

E. SCI

1. Assessment

The Monitoring Team defers providing an assessment rating due to the fact that there have been no recent deaths from suicide at SCI.

2. Findings

There have been no recent deaths from suicide at SCI.

F. Recommendations

At Baylor, the State must continue to develop its formal process to conduct mortality and morbidity reviews where necessary.

At DCC, the State should reference grievances in these reports where applicable. These reports should also be aggregated for purposes of a CQI study.

QUALITY ASSURANCE

54. Policies and Procedures

A. Relevant MOA Provision

Paragraph 54 of the MOA provides:

The State shall develop and implement written quality assurance policies and procedures to regularly assess and ensure compliance with the terms of this Agreement. These policies and procedures should include, at a minimum: provisions requiring an annual quality management plan and annual evaluation; quantitative performance measurement with tools to be approved in advance by DOJ; tracking and trending of data; creation of a multidisciplinary team; morbidity and mortality reviews with self-critical analysis, and periodic review of emergency room visits and hospitalizations for ambulatory-sensitive conditions.

The Facilities should create a comprehensive CQI program¹⁷⁶ that performs the following functions in a fashion that complements the requirements contained in this provision of the MOA:

- establishes a multidisciplinary quality improvement committee¹⁷⁷ that meets at least quarterly and designs quality improvement monitoring activities, discusses the results, and implements corrective action;
- reviews, at least annually, access to care, receiving screening, health assessment, continuity of care (sick call, chronic disease management, discharge planning), infirmary care, nursing care, pharmacy services, diagnostic services, mental health care, dental care, emergency care, and hospitalizations, adverse patient occurrences including all deaths, critiques of disaster drills, environmental inspection reports, inmate grievances, and infection control;
- completes an annual review of the effectiveness of the CQI program by reviewing minutes of its committee meetings;
- performs at least one process quality improvement study¹⁷⁸ a year; and

¹⁷⁶ A “comprehensive CQI program” is defined as including, “a multidisciplinary quality improvement committee, monitoring of the areas specified in the compliance indicators, and an annual review of the effectiveness of the CQI program itself.” J-A-06; P-A-06. “CQI” means “CQI.”

¹⁷⁷ A “multidisciplinary quality improvement committee” is defined as “a group of health staff from various disciplines that designs quality improvement monitoring activities, discusses the results, and implements corrective action. J-A-06; P-A-06.

- performs at least one outcome quality improvement study¹⁷⁹ a year.

J-A-06; P-A-06.

The Monitoring Team found that there is a Regional CQI Committee, and was able to participate at that committee's first meeting. The Monitoring Team also has been informed that the Regional Medical Director has begun to conduct peer review. The Monitoring Team is encouraged by this process, but encourages greater focus on detailed clinician assessment, and diagnostic and therapeutic plans. The policy that has been enacted requires an annual peer review. The Monitoring Team recommends that for every new clinician, a peer review be conducted within the first three months of his or her start date in order to determine the adequacy of the clinician's performance and provide the clinician with helpful feedback. Once that peer review process demonstrates satisfactory performance by the clinician, then annual peer review would be appropriate.

The Regional CMS office has developed a CQI calendar for the Facilities for 2008. This calendar includes a schedule for reviewing off-site referrals, chronic illness, infirmity care, dental care, emergency care/hospitalization, diagnostic services, medical record format, employee files, employee training, controlled drug, contraband, and sharps content, compliance with OSHA and other inspections, receiving screening, pharmacy/medication services semiannually. Also, the calendar provides for review of medication administration records, review of sick call seven months of the year. In addition, the calendar provides for review of physician sick call, health assessments, discharge planning, segregation rounds, infection control, administrative aspects, and the TB prevention program two times a year. Finally, the calendar calls for a review of medical tools on a monthly basis.

The Monitoring Team reviewed some of the tools to be used for these reviews, and offered technical assistance in the form of suggestions regarding the tools. The Monitoring Team recommends that for each aspect of care, there should be a clear delineation of the methodology to be used for performing the study and collection of data, and particularly to indicate the minimal number of records to be used for each specific indicator. Some indicators look at infrequently occurring items, and if a selective sample for the occurrence of these items is not performed, then the staff will be reviewing a large number of "not applicable" records. Such a record review will not contribute anything to the analysis.

In summary, the Monitoring Team is encouraged by the initial CQI effort both at the regional level and at the institutional level. Much more training is indicated, and regular ongoing meetings should be taking place at least monthly, if not more frequently, as the program gets off the ground. Ultimately, monthly meetings may be all that is necessary, but the State is

¹⁷⁸ "Process quality improvement studies" are studies that "examine the effectiveness of the health care delivery process." J-A-06; P-A-06.

¹⁷⁹ "Outcome quality improvement studies" are studies that "examine whether expected outcomes of patient care were achieved." J-A-06; P-A-06.

working hard on so many issues right now that more frequent meetings might be indicated at this point in time.

B. Baylor

1. Assessment

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

2. Findings

The Monitoring Team found that, at the time of the Monitoring Team's visit, there had been one meeting of Baylor's CQI Committee. The meeting occurred in March 2008, which was the first meeting since the development and implementation of the CQI program at Baylor.

The Monitoring Team reviewed the minutes of the meeting. The minutes reflected the presentation of data, which is appropriate; however, there was an absence of analysis of performance in relation to acceptable standards. Minutes of CQI Committee meetings should be written in manner so that staff members who have not attended the meeting can review the minutes and understand what was evaluated, why it was evaluated, whether the performance was acceptable, and, if not, what the CQI Committee determined to be the cause(s) of the poor performance, and the improvement strategies developed to mitigate the analyzed problem(s).

With regard to the quality assurance of mental health care, the Monitoring Team notes that useful CQI studies were performed regarding suicide prevention practices at Baylor.

C. DCC

1. Assessment

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

2. Findings

The Monitoring Team reviewed minutes of the CQI Committee meetings that had taken place at DCC since January 2008. The Monitoring Team also reviewed the CQI program devised by the CMS regional office with regard to reviewing all major services on a regular basis. The State has made reasonable efforts to initiate the program. The Monitoring Team notes that the implementation of this CQI process is going to be challenging, and that the work required to implement that CQI process will be greater during this initial period because almost all major services are being overhauled. Thus, the Monitoring Team recommends that the CQI Committee meet more frequently than once per month for an initial period of time.

With regard to the CQI Committee meeting minutes reviewed, the Monitoring Team found that, like the minutes at Baylor, they should prove educational for all staff members that have not participated in the actual meeting. Staff should be able to learn from the minutes what topics were reviewed, and with regard to a given process, what was considered to be satisfactory performance, and when performance is not satisfactory, what the causes were for the unsatisfactory performance, and what mitigation strategies the CQI Committee decided to implement. The Monitoring Team believes that it would be useful for all staff to be required to review the CQI Committee meeting minutes.

In addition, the Monitoring Team found that CQI meetings were not always based on only objective data in that the minutes reflected a more anecdotal discussion of problems. Anecdotal information can be useful to determine whether an issue needs to be studied more carefully, but it cannot be the basis for action. The CQI requires study, data collection, data analysis, implementation of improvement strategies and, finally, restudy.

With respect to the quality assurance of mental health care, the Monitoring Team found problems related to the sampling techniques used by the CQI Committee. Specifically, the CQI Committee used random record sampling. This technique often fails to provide an accurate reflection of a system's performance, and therefore, the Monitoring Team recommends that the CQI Committee use more targeted sampling techniques.

D. HRYCI

1. Assessment

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

2. Findings

Although staff indicated that there had been CQI Committee meetings in January, March, and May 2008, the Monitoring Team found that meeting minutes were available only for the January 2008 CQI Committee meeting. It appears that the CQI program at HRYCI is in its infancy and needs to be expanded. Specifically, the staff at HRYCI should implement the program that has been developed by the CMS regional office. In addition, The Monitoring Team strongly recommends that problems identified during the course of normal business that could reflect systemic issues be brought up to the CQI Committee, and considered for possible study initiation. For example, during the monitoring process, the Monitoring Team discovered that DACS is not providing reliable information as was expected. This unreliable information could be symptomatic of poor data entry, and might be a systemic issue appropriate for study.

With respect to time quality assurance of mental health care, the Monitoring Team reviewed CQI Committee studies relevant to mental health issues. These studies were problematic from the perspective of understanding the methodology used and the assessment of the results.

E. SCI

1. Assessment

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

2. Findings

At SCI, the Monitoring Team found that there had been one CQI Committee meeting prior to the Monitoring Team's visit. The minutes of the meeting did not reflect any study data or constructive analysis of the processes being studied. As with the other Facilities, the Monitoring Team is looking for meeting minutes that would inform a person who had not attended the meeting regarding the specific content and outcome of the meeting.

F. Recommendations

At Baylor, the Monitoring Team recommends that the CQI Committee continue to meet regularly and measure performance with regard to key indicators, including timeliness and appropriateness of services provided. Where published performance standards are not met, analysis of poor performances should be documented and mitigation strategies should then be implemented, followed by reassessment to determine the effectiveness of the mitigation strategies.

At DCC, the Monitoring Team recommends that the State:

- Consider more frequent CQI Committee meetings during this early implementation phase;
- Rewrite the regional program in a manner that encourages local staff to suggest areas for study;
- Ensure that the minutes are comprehensible to staff who have not attended the meetings; and
- Ensure that it is clear to the non-attending reader why something is being studied, what the findings are, and what changes are going to be made if the performance has not been satisfactory.

At HRYCI, the Monitoring Team recommends that:

- The CQI Committee meet as frequently as every other week in order to address all the areas that HRYCI is attempting to improve;
- Minutes from CQI Committee meetings be constructed in a way that allows people not attending the meetings to learn what was reviewed, what was found, and what was determined to be changed; and

- Staff embark on a quality improvement project to improve the performance of data entry into DACS.

At all Facilities, the Monitoring Team makes the following recommendations:

- If an area being reviewed semiannually reflects poor performance, more frequent review is indicated until the performance is acceptable;
- At HRYCI and DCC, where different individuals and different staffs are participating in the sick call process based on the geographic area, it is useful to track these things by area and not institution-wide, because it is entirely possible that performance with regard to timeliness or appropriateness may vary by geographic area;
- The TB program has to ensure that all new positives are assessed by a nurse with regard to TB symptoms before the x-ray is taken. If that assessment reveals positive answers to TB symptoms, patients have to be isolated until the x-ray is proven to be negative;
- Training should be provided for *all* staff members who are going to be involved in the CQI program--CQI methodology is not necessarily intuitive, and it is important for people to understand the methodology in order to perform CQI studies adequately;
- Data summarized at the regional meetings should be organized by facility over the course of each year, in order to demonstrate trends in each Facility's performance; and
- With regard to the CQI Committee minutes, the Monitoring Team recommended that the minutes describe precisely what was studied and that the minutes present the percentage of compliance with the expected performance for each area. A staff person who has not attended the CQI meeting should be able to read the minutes and understand what changes need to be implemented and why.

55. Corrective Action Plans

A. Relevant MOA Provision

Paragraph 55 of the MOA provides:

The State shall develop and implement policies and procedures to address problems that are uncovered during the course of CQI activities. The State shall develop and implement corrective action plans to address these problems in such a manner as to prevent them from occurring again in the future.

This provision of the MOA requires that the State develop and implement policies and procedures in response to the uncovering of problems during the CQI activities that are discussed in paragraph 54 of the MOA. In addition, the State is required to develop and implement corrective action plans to address these problems in such a manner as to prevent them from occurring again in the future. The Monitoring Team suggests that an adequate corrective action plan will include a description of the problem that has, the specific steps that the State plans to take to remedy the problem, and a deadline for correction of the problem. Finally, the State should make provisions for a responsible party to follow-up after the deadline to ensure that the corrective action plan was followed appropriately.

The Monitoring Team reports that the State has not created or implemented any corrective action plans pursuant to this provision of the MOA during the past reporting period about which the Monitoring Team has been made aware. The Monitoring Team believes that to be the case because the CQI programs at the Facilities are in the early stages of implementation. The Monitoring Team expects that as the Facilities implement and strengthen their respective CQI programs, the State will have corrective action plans for the Monitoring Team to evaluate. Thus, at present, there is nothing for the Monitoring Team to assess.

CONCLUSION

As discussed in the Second Report, the State is making progress toward substantial compliance with the provisions of the MOA. The State, however, continues to have a great deal more to do to achieve substantial compliance with the MOA. As noted in the Executive Summary, 151 of the 217 compliance assessments contained in this report are partial compliance.¹⁸⁰ As noted earlier in this report, a partial compliance rating can signify that the State has made some progress toward substantial compliance, or it can signify that the State is nearly in substantial compliance with respect to a given provision of the MOA. As shown in the findings and recommendations in this report, the Monitoring Team has attempted to assist the State with determining how to change partial compliance assessments to substantial compliance assessments.

The Fourth Semi-Annual Report will be issued in or about January 2009. The Monitoring Team will continue to provide technical assistance to the State during the next monitoring period. The Monitoring Team also anticipates that the State might implement some of the Monitoring Team's recommendations and, as a result, see additional improvement in its performance.

¹⁸⁰ There are 217 compliance assessments in this report because for DCC, HRYCI, and SCI, there are 54 provisions being rated, and, for Baylor, there are 55 provisions being rated. Further, the Monitoring Team found that 37 of the 217 compliance assessments were substantial compliance, and 22 of the compliance assessments were non-compliance.