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February 8, 2009

The Honorable J. Kelly Arnold
United States Magistrate Judge
U.S. Court House
1717 Pacific Avenue
Tacoma, WA 98402

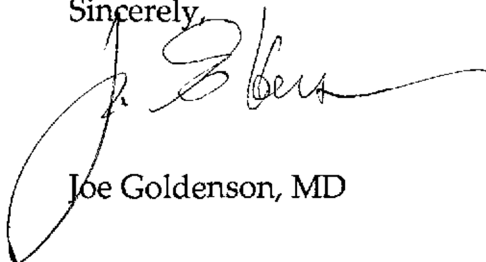
Dear Judge Arnold: C 95-5025

Jo Robinson and I made our third visit to the Pierce County Detention Center on Jo Robinson and I visited the Pierce County Detention Center on December 10-11, 2008, in order to re-evaluate the medical and mental health services. Following completion of a draft of our report, we sent it to the medical and mental health administration at the Detention Center for their review and comments. Attached please find the final version of my report that has incorporated their concerns and suggestions.

Please distribute copies of the report to the parties.

Please contact me if you have any further questions.

Sincerely,



Joe Goldenson, MD

95-CV-05025-RPT

PIERCE COUNTY
DETENTION & CORRECTIONS CENTER
HEALTH SERVICES

Sandra Herrera, et al v. Pierce County, et al
United States District Court
Western District of Washington
Case No. C95-5025FDB

REPORT OF FINDINGS

Submitted by: Joe Goldenson, MD

February 8, 2009

This is the third progress report of Court Monitor Joe Goldenson, MD, on the status of health care services at the Pierce County Detention & Corrections Center (PCDC) in Tacoma, Washington. Jo Robinson, MFT, assisted in the evaluation of the mental health services. Ms. Robinson and I visited PCDC on December 10 and 11, 2008. We toured the facility, reviewed medical records, and interviewed patient-inmates, health care staff, and custody staff.

The audit conducted during our visit was not comprehensive. We primarily focused on those administrative and programmatic issues that we had identified as needing improvement during our prior visits.

This report will address the issues and concerns raised in our prior reports and any new findings that we made during our recent visit. Discussions of areas that were previously found to be in compliance will not be repeated. As noted in our prior report, "PCDC has expressed a desire to use the National Commission on Correctional Health Care (NCCHC) Standards as their guidelines and final goalpost for their health care system." While the standards are not in and of themselves proof of an adequate health care system, they do represent a "well thought out and systematic approach to the difficulties of providing a quality system of health care in corrections, and have consistently shown a high level of concern for inmate welfare." For these reasons, this and future reports will follow the outline of the NCCHC standards, and will comment on progress towards meeting the standards. (NCCHC has recently revised and issued its 2008 Standards. We will continue to use the 2003 Standards as PCDC has expressed a desire to continue using them, and they are the ones that had originally been agreed upon.) Compliance with the standards does not guarantee, however, that the clinical care being provided at a facility is adequate. It is important to note, that while the NCCHC standards are used as a method of organizing the reports, the findings and recommendations related to compliance with the Stipulated Order and Final Judgment are not based on those standards. Our findings and recommendations are based on what changes are necessary, in our professional judgment, for the health services at the PCDC to meet a constitutional level of care.

Prior to submitting this report to the Court, we sent draft copies to the health care staff at PCDC and counsel for their review and comments. We have incorporated many of their suggestions into this final report. The draft copies contained an appendix identifying the patients for the parties. The names of the patients have removed from this final version of the report.

As during our prior visits, the health care and corrections staff graciously assisted us throughout our stay and answered all of our questions. They were completely cooperative with our requests, and we would like to express our appreciation and gratitude for their

support of our monitoring effort. Without their help and cooperation, our task would have been unachievable.

Recognizing that there are areas requiring improvement, we wish to congratulate staff on the progress that has been made since our last visit.

REPORT

The population of the jail was 1,325 on December 11, 2008. There were 643 inmates in the main facility and 682 in the new facility. There were approximately 75 to 80 new bookings per day.

Medical and Mental Health Infirmary/Sheltered Living Level Housing

The policy on *Special Housing* has recently been revised to identify the conditions and circumstances under which the cells in the medical clinic will be used. The revised policy appropriately addresses the concerns raised in prior reports.

Dr. Balderrama reported that 3 men were housed in the medical clinic cells between June and November - a patient who was being treated for alcohol withdrawal, one who was being treated for an exacerbation of chronic pulmonary disease/pneumonia, and one who had a jaw fracture and episodes of difficulty breathing. All of them were housed in the medical clinic for less than 24 hours. Over the same time period, 5 women were housed in these cells. Most of the women were mobility impaired and were housed in the cells for a few days. (PCDC does not have any other general population housing areas for women with mobility problems. These patients are housed either in the medical clinic cells or in the booking area.) We request that PCDC maintain a log of all patients housed in the medical clinic cells and of all inmates with medical problems who are housed in booking because of lack of appropriate housing in general population. The log should include the admitting diagnosis and dates of admission and discharge.

PCDC also needs to develop and implement a log to monitor the pressure in the airborne isolation cells in the clinic. These cells need to be monitored every month when unoccupied, and daily when used for a patient requiring airborne isolation.

As noted below, PCDC should also consider using the cells in the medical clinic for patients who are being monitored for moderate to severe drug and alcohol withdrawal.

Access to Care

My review revealed that patients in general population units, who were referred to a

provider, were being seen within an acceptable timeframe. PCDC conducted a study of access to medical care in the men's special housing units. It appears that patients housed in those areas are also being seen within an acceptable timeframe. (In October, 92% of urgent appointments were being seen within one day, and 92% of follow-up appointments were being seen within 4 days.) However, the required three-times per week nursing rounds in the segregation units are frequently not are being done. (Monitoring reports revealed that checks were done three-times times per week: 100% of the time in July; 50% of the time in June, August, and September; 25% of the time in October; and 0% of the time in November.) We did not review the timeliness of nursing care (i.e., dressing changes, blood pressure checks) in the segregation units during this visit. We recommend that PCDC perform bi-monthly studies of access to sick call and nursing care in both the men's and women's segregation units. We will review these studies during our next visit.

In his final report, Dr. Shelton had recommended that PCDC implement a training program for the nurses on triaging, "including history, exam, findings and what is urgent, what is routine, what can be handled by self care methods." The nursing assessment and skill-training course that had been scheduled for November has been re-scheduled for February 2009.

Our prior reports raised concerns regarding inmates' access to mental health care while incarcerated at PCDC. The system's use of mental health kites (the method inmates use to gain access to the mental health staff), the resulting long delays, and lack of response from mental health were detailed in that report. As a result, we recommended that the mental health program develop a policy and procedure for the timely and appropriate handling of these kites. In response, Mental Health has developed and begun to implement a policy, "Referrals", that addresses these concerns. In part, the new policy states, "At times, a 'Reverse Kite' may be initiated by mental health staff to convey to the patient-inmate such information as the date of their next follow-up psychiatric appointment, information on sleep, relaxation technique, etc." The new policy also spells out "Levels of Priority". They are: immediate, high, moderate and low. The policy assigns timelines to the first two levels – immediate and high. Chart reviews conducted during this visit revealed that this system is problematic in that those patient-inmates with the lower priority levels may get ignored. Both the moderate and low priority levels should have a "no longer than" timeframe added to the policy.

At the time of our visit, we were told that mental health kites were only being reviewed Monday through Friday. In her response to our draft report, Judy Snow, PCDC Mental Health Manager referenced this statement and wrote, "This was stated to both Jo and me by the Direct Services Supervisor, Erika Zimmerman, during one of our meetings. Later,

after Jo's departure, it was further clarified by Erika that the weekend MHPs were reviewing kites on the weekend and did respond to urgent requests. However, those that were deemed routine or requiring only a written response were responded to on Monday. Kites have consistently been screened on a daily basis."

While the average number of mental health kites was approximately 20 per day, there were days when 75 kites were received. During our most recent visit, Jo Robinson reviewed 60 charts of patient-inmates who had submitted kites during the period of time the new policy was in effect. The system has definitely improved. In many cases, mental health staff sees patient-inmates on the same day that the kite was written; in other cases staff is appropriately informing patient-inmates of timely, pending appointments. However, there continues to be significant problems with access to mental care services.

The majority of the kites reviewed during our visit required a face-to-face interaction with a mental health program specialist (MHP). Unfortunately, not all patient-inmates who required this type of contact received it. One notable concern is the practice of advising patient-inmates by reverse kite of pending appointments that are weeks into the future. This was particularly true for patients having problems with psychiatric medications. The failure to address these medication issues in a timely manner can lead to non-compliance with the treatment plan and decompensation in a patient's condition. In order for medication issues to be addressed in a timelier manner, a MHP needs to see the patient and then communicate any concerns to the prescriber.

Another problem found in the responses to the kites was that not all of the issues raised in the kites were being addressed. Additionally, mental health staff was not documenting their responses to the patient-inmates' kites in the medical record. In Ms. Snow's response to our draft report, she advised us that since our visit, mental health staff has begun to conduct face-to-face interviews when the kite indicates issues of "depressed mood, anxiety, other psychiatric symptom or a medication issue where the level of concern is not clear." This new practice will address many of Ms. Robinson's concerns about the mental health system at PCDC. Face-to-face response is the standard of care provided in other jails as evidenced by a recent survey conducted by Ms. Robinson of the mental health programs in six jails (small, medium and large facilities) all of which respond to all mental health "kites" with a face-to-face contact with a mental health provider. We commend Ms. Snow and her staff for their quick corrective actions. During our future visits, we will continue to monitor the provision of mental health services, in order to ensure that there is adequate staff to make the necessary changes and maintain the current appropriate practices.

Review of medical records also revealed that the medical staff is not consistently referring

patient-inmates who require a mental evaluation or care to mental health. Any patient-inmate who has a mental health history or mental heath concern and is not stable requires a referral to a MHP. Chart reviews of kites and patient-inmate interviews found examples where this is not occurring. Ms. Snow informed us that they are initiating training for medical staff regarding the identification of risk factors that would warrant a referral to mental health.

Chart Reviews

In the following cases, issues listed by the patient-inmate on the kite were not entirely addressed on the reverse kite.

Patient A

Kite: "Headache due to anxiety and lack of sleep."

MHP reverse kite: "Please see attached self-help tool to assist with your sleep problems. The mental health unit does not prescribe medication for sleep problems."

The issue of anxiety was not addressed.

Patient B

Kite: "I have extreme anxiety attacks keeps (sic) me awake all night long. I'm looking at a lot of time and can't stop stressing my mind won't stop."

MHP reverse kite: "Please see attached self-help tool to assist with your sleep problems. The mental health unit does not prescribe medication for sleep problems."

The issues of stress and anxiety were not addressed.

Patient C

Kite: "I need to talk to somebody about my stress and anxiety levels. I also can't sleep at night because all I do is think."

MHP reverse kite: "Please see attached self-help tool to assist with your sleep problems. The mental health unit does not prescribe medication for sleep problems."

The issues of stress and anxiety were not addressed.

Patient D

Kite (11/18/08): "Ever since I got here I've been feeling depressed. I keep thinking about my case. My days go by slow, and I have trouble falling asleep. It's very fitful. Someone in my tank told me to kite you guys."

MHP reverse kite: "Please see attached self-help tool to assist with your sleep problems. The mental health unit does not prescribe medication for sleep problems."

The patient had been previously seen by mental health staff on 9/02/08 and advised to kite if he needed to see them again. He was not seen as a result of his 11/18/08 kite and his issue of depression was not addressed.

In the following cases, there were lengthy delays in medication referrals.

Patient E

The patient had initially been referred for medications on 10/16/08. The psychiatric prescriber did not see the patient until 13 days later.

First kite (11/17/08): "Can I please find out my app [appointment] time. I am still here and will be here for a while.

MHP reverse kite (11/19/08): "You have been scheduled to see a psychiatric prescriber on 12/2/08".

Second kite (11/19/08): "I am having very bad mental changes. One minute I am crying the next minute I see myself flipping out for no reason. Bipolar runs in my kids and family so could you please see me sooner than my app. Please."

MHP reverse kite (11/26/08): "You have been scheduled to see a psychiatric prescriber on 12/2/08."

The MHP had not evaluated the patient in response to either of the kites.

Patient F

Chart review shows that the patient was first referred to a psychiatric prescriber on 11/11/08 and not seen for 15 days.

Patient G

The patient had initially been referred for medications on 10/22/08. The psychiatric prescriber did not see the patient until 18 days later.

Kite (11/22/08): "My medication (unreadable) really been helping need a stronger dose."
MHP reverse kite (11/24/08): "You have been scheduled to see a psychiatric prescriber on 12/8/08."

Neither the psychiatric prescriber nor the MHP had evaluated the patient as of 12/11/08.

Patient H

Patient was referred to a psychiatric prescriber on 11/18/08 and was not seen for 10 days.

Patient I

The patient was referred to a psychiatric prescriber by a MHP on 9/30/08. He was not seen by a prescriber and submitted the following kite on 11/7/08.

Kite: "I've been seen by you guys and I've been waiting to be seen again. Things are getting worse. I'm having nightmares of my dad cause his birthday was this month and he just dies its really depressing and I don't want to sleep cause of them. Why won't you come and see me. I'm no able to eat half of the time."

The patient was seen by a psychiatric prescriber on 11/9/08 and medications were ordered.

Patient J

Kite (10/28/08): "Sylvia my mental health person told me to notify her if my dateacyle (sic) or whatever it's called is not working well. I'm still having flashbacks and bad dreams. I'm not sleeping well and I'm starting to grind my teeth as well. Please can I get some help. Thank you kindly God Bless you and your staff."

MHP reverse kite: "You have been scheduled to see a psychiatric prescriber on 11/7/08."

Patient K

Kite (10/28/08): "I was wondering, if I could try the amytriptoline instead of trazadone? Or do I need to wait until I see you again?"

MHP reverse kite: "You have been scheduled to see a psychiatric prescriber on 11/21/08."

Kite (11/24/08): "I'm having some trouble with the new medicine Nortryptoline (sic). My heart races and I have lots of hot flashes. Can we please switch back to Trozadone (sic), maybe a higher dose this time? Sorry to bother you so soon. The med is causing some discomfort and sleeplessness. Respectfully"

MHP reverse kite: "You have been scheduled to see a psychiatric prescriber on 12/15/08."

Patient L

Kite (10/26/08): "This medication does not even scratch the surface, should I even keep taking it?"

MHP reverse kite: "You have been scheduled to see a psychiatric prescriber on 11/14/08."

Patient M

Kite (11/30/08): "I would like to be seen by somebody from Mental Health to find out why my medication is not working for me a lot of the times. I am really depressed, or angry for no reason at all, it's like an up and down everyday. One min I'm happy the next I'm angry or depressed."

MHP reverse kite: "You have been scheduled to see a psychiatric prescriber on 12/12/08."

The following patients submitted kites and either had a lengthy delay or were not seen by the MHP.

Patient N

First kite (11/19/08): "I need to see a psych doctor about some problem I've been having with the racing thoughts and voices in my head please.

MHP reverse kite (11/24/08): "You have been put on the list to be seen by the mental health professional".

Second kite (11/25/08): "Can I please see a Mental Health Counselor of some sorts? I have been very depressed lately I don't even know what to do to handle this depression please can you help me in this request?"

MHP reverse kite (11/26/08): "You have been put on the list to be seen by the mental health professional."

As of 12/11/08, a MHP had not seen the patient.

Patient O

11/21/08 kite – "I really need to be seen by staff (mental health) because the voices are becoming louder and louder & I'm not getting any sleep."

The patient was not seen by a MHP until 12/8/08.

Patient P

Kite (11/21/08): "I would like to stop taking my medication and have indeed stopped for the past 4 days or so."

MHP reverse kite (11/24/08): "You have been put on the list to be seen by the mental health professional."

As of 12/11/08, a MHP had not seen the patient.

Patient Q

Kite (11/28): "I need a grievance form because MHP has not seen me to put me on my meds. I've told them I was on meds here before. Also I was on meds at the Washington State Reformatory/WSF, Monroe. I'm very down and depressed. I have bipolar. Can you please help and or send me a grievance form Thank you"

The patient was not seen by a MHP until 12/8/08.

The following patients were seen by mental health staff and then advised to kite if they were not feeling better in 1 week. Both of these patients showed clinical signs of depression, and positive suicidal risk factors. Patients with symptoms of serious mental illness or risk factors for suicide require active follow-up by mental health.

Patient R

An assessment by a MHP on 10/27/08 described a depressed individual incarcerated on serious charges and had been informed that he was to have no contact with his stepdaughter. The patient was noted to be tearful throughout the interview. The MHP's plan was, "I/M to work on improving self care skills and kite in one week with update regarding mood..."

Patient S

An assessment by a MHP on 10/8/08 described a depressed female with serious charges. This was her first incarceration. She had just been advised by the Court that she was to have no contact with her children. The patient reported a history of depression after the birth of her second daughter. Instead of being scheduled for follow-up with a MHP, the patient-inmate was advised to kite mental health for further care,

Medical staff did not refer the following patients to mental health for appropriate care. Instead, they advised them to submit a kite.

Patient T

The patient had a history of depression and anxiety that was documented on the booking form. At the time of booking (8/4/08), it was noted that his medications were not current by 30 days and they were not ordered. The nurse did not refer the patient to mental health. On 8/6/08, a nurse advised the patient to kite mental health to let them know he had been taking medications on the outside for depression, anxiety and sleep.

Patient U

The screening form documented a mental health diagnosis of depression and current treatment with Citalopram (an antidepressant medication). The patient had been arrested for DWI and this was her first incarceration. Medical staff ordered the medication, but did not refer the patient to mental health despite the fact that she had 3 risk factors for suicide – a prior history of depression, first incarceration, and alcohol intoxication).

Patient V

This patient was new to PCDC. The Receiving Screening Form was not in the medical record; however, it appears that she was booked on 12/9/08. A nursing note stated that

she was "just released from St. Joseph's Hospital psych unit." Medical staff ordered the patient's medications but did not refer her to mental health. On 12/11/08, Jo Robinson interviewed the patient in the presence of Erika Zimmerman, the Mental Health Unit Supervisor. They agreed that the patient showed signs of instability and would benefit from mental health intervention. Patients recently released from psychiatric hospitalizations need to be routinely referred to mental health.

Patient W

The patient entered the jail on 12/10/08. The Receiving Screening Form indicated that the patient was taking Zoloft, with a notation "not filed". There was also documentation that the patient had had a head injury in 2007. There was no further history related to either of these issues. The patient's medication was not ordered and he was not referred to mental health or to medical for follow-up. Jo Robinson interviewed the patient in the presence of Erika Zimmerman. They agreed that Patient W showed signs of instability and would benefit from mental health intervention.

Staffing

At the time of our recent visit, there were 2.5 nursing vacancies – 1 registered nurse position and 1.5 licensed practical nurse positions. These positions have been vacant for 1.5 to 2 years. In addition, there have been 3 LPN's on medical leave for most of the time since our last visit. Two of these nurses are in the process of returning to work and 1 is not expected to return. Medical administrative staff stated that the onerousness, length, and complexity of the hiring process continue to make it difficult to fill vacant positions because qualified candidates take other jobs before the process is completed. As noted in our first report, this has been a long-standing problem. Staff informed us that a new officer, who is experienced with medical issues, has been assigned to do the background checks. Staff was hopeful that this officer would be able to expedite the process. In any event, a process needs to be developed that fulfills the security needs of the facility while allowing hiring to take place in a more timely fashion.

During this visit, I met with Vince Goldsmith, Health Care Administrator, Miguel Balderrama, MD, Medical Director, Mary Scott, RN, Nursing Director, and Judy Snow to discuss the nursing staffing needs. The medical staff agreed that the following positions are needed:

1. A 19 hour/day, 7 days/week RN float position. (Staff felt that this position was not needed between 2 a.m. and 7 a.m.) This nurse would work in the new jail and assist in booking when it gets backed up. The position is necessary because of the unexpected work load that got added to the booking nurse's duties when booking

was moved into the new jail. (See the discussion of receiving screening below for a list of these duties.)

2. A 1.0 FTE triage nurse position (RN). This nurse will perform triage on the weekends and float during the week to cover sick and vacation leave.
3. Two 7 days/week medication nurse positions (LPN). These positions are needed to assist in the delivery of medications on day and evening shifts. They have been identified in the past and are part of the Sheriff's current 5-year-plan.

Prior to writing this report, I summarized the above discussion in a memo to Vince Goldsmith. To my surprise, he responded that I had misunderstood what the health care staff had said to me. At his request, I have attached his letter to the end of this report. At the time of the interview, however, the medical staff, including Mr. Goldsmith, were very clear about the above staffing needs.

At the time of our visit, there were 7 MHPs on the mental health staff. Six MHPs are in the facility during the week and only one MHP provides coverage on weekends. The on-site mental health staff believes this coverage is inadequate. They are all working hard and, on a daily basis, struggling with just, in their words, "putting out fires." With access to care remaining a problem (see above) PCDC's mental health program requires an increase in staffing. In our opinion, at least 2 additional MHPs are required to provide an adequate level of mental health care in the jail. Judy Snow disagreed with the above finding, responding that that the mental health program is currently providing community level of care and that additional staff are not required to comply with the consent decree. We will continue to assess the staffing level during subsequent visits.

The mental health program at PCDC has increased the hours of psychiatric prescribers with the hiring of an Advanced Registered Nurse Practitioner (ARNP). The ARNP works three days a week totaling 19 hours per week. The psychiatrist works four hours on Tuesday, Wednesday, and Thursday and the ARNP works four hours on Monday, ten hours on Friday and five hours on Saturday leaving only Sunday without a prescriber. Even with this expanded coverage, our chart reviews found some lengthy delays in medication referrals (see above). We will continue to evaluate the adequacy of the psychiatric prescriber staffing on future visits.

Receiving Screening

Initial health screening is performed by a health trained correctional officer. New arrestees with any medical concerns are to be referred to the booking nurse who is on duty 24 hours per day for further evaluation. As we found on our prior visits, review of records and discussions with staff revealed that the booking nurses are not evaluating

some incoming patient-inmates with medical problems, not performing adequate assessments on patients they do evaluate, failing to adequately document important information in the medical record, and making medication errors. Medical administrative staff stated that some of these problems are due to the nurses not having enough time to perform their required duties. As noted above, many tasks were added to the booking nurse's duties when booking was moved into the new jail. These new duties, as reported by Mary Scott, RN, include:

- Administering and documenting medications administered to patients housed in booking and in the new jail;
- Doing vital signs checks on patient-inmates housed in booking and in the new jail;
- Monitoring patients who are housed in booking for alcohol/drug withdrawal
- Evaluating patient-inmates involved in altercations;
- Responding to medical emergencies;
- Responding to medical requests of patients in booking and the new jail;
- Responding to family members or friends of patient-inmates who have various questions or who want to just share concerns about specific patient-inmate care;
- Making telephone calls to replace medical staff who call in sick;
- Answering questions and problem solving for custody and medication nurses;
- Looking up information related to patient's orders/ appointments;
- Calling emergency rooms to expedite street officers getting hospital clearances for a person refused at booking;
- Copying paperwork;
- Placing various things in patient-inmates' property bags and retrieving them as needed;
- Getting signed refusal/release of information forms and other paperwork from patients housed in the new jail;
- Monitoring and documenting on patient-inmates in the restraint chair;
- Performing dressing changes;
- Monitoring supplies;
- Tending to needs of females with medical needs who are housed in booking because there is limited medical housing for females in the main jail
- Providing care for inmate workers
- Doing early morning diabetic checks for patients housed in the new jail;
- Completing medical transfers for patient-inmates who are being transferred to another county jail; and

- Assisting police officers in the identification of unlabeled pills.

In our prior reports, we expressed concerns that some patients were not receiving essential medications in a timely manner. Review of medical records during our recent visit revealed medications were being ordered in a timely manner when the booking nurse was able to verify that there was a current prescription. There was still a delay when staff was not able to verify the medication. During our visit, Mary Scott revised the *Medication Continuation in Booking* policy to appropriately address this issue. We will continue to monitor this concern during our future visits.

Intoxication and Withdrawal

Since our last visit, two patients (Patients 1 & 2), who were being monitored for alcohol/drug withdrawal, died in the PCDC. (Patient 1 died on 6/25/08 at 05:26 from complications of alcohol abuse. Patient 2 committed suicide on 8/19/08 at 19:22.) Review of Patient 1's records revealed that monitoring checks had been ordered 3 times per day but that nursing staff did not monitor him for over 15 hours (from 22:59 on 6/23/08 until 14:06 on 6/24/08). Patient 2 was only monitored one time on 8/16/08, one time on 8/17/08, and was not monitored at all on 8/18/08. In addition, Patient 2 refused a clinic visit because he did not want to be placed in leg chains. While, in all likelihood, these problems did not contribute to the patients' deaths, they do highlight deficiencies in how PCDC monitors patients at risk for withdrawal.

Following the deaths, PCDC instituted changes in how such patients are monitored. The protocol was changed so that monitoring would be done four times per day. (Staff reported that the required six-hour checks were often not done because of staffing shortages. In his response to our draft report, Vince Goldsmith stated that "we have come to the conclusion that we should go back to our previous practice of monitoring 3 times per day.) Whenever possible (based on classification), patients at risk for alcohol and/or drug withdrawal are housed in the same area in order to facilitate their monitoring. (Staff reported that while this is occurring, it is not being done on a consistent basis.) In addition, nursing staff is supposed to be asking questions related to risk of suicide as part of their monitoring. Furthermore, custody staff is required to perform welfare checks at a minimum of every 45 minutes on all patient-inmates identified by medical staff as being at risk for alcohol and/or drug withdrawal.

During the current visit, I reviewed the records of 5 patients who were at risk for alcohol withdrawal. There was no documentation that nurses staff was evaluating patients for suicide risk. In addition problems were noted with the care of the following patients:

Patient 3
The patient entered the jail on 11/2/08 at 16:58. The booking nurse noted that the patient had a history seizures, had been intoxicated the prior evening, and that she "sometimes gets the shakes." Prior booking forms from 2005 and 2006 noted that the patient had been monitored for alcohol withdrawal. The nurse did not obtain any further history related to the patient's alcohol consumption and did not place the patient on alcohol withdrawal checks. Following intake, the patient was not seen again by medical staff until the morning of 11/4/08, at which time monitoring was ordered. She was next seen at 13:21 but then not seen again until 11/5/08 at 02:01. This case was reviewed with Dr. Balderrama.

Patient 4
The patient entered the jail on 10/29/08 at 15:16. The booking nurse noted that the patient had a history of alcohol withdrawal, but did not place the patient on the alcohol withdrawal protocol, did not note the date/time of his last drink, did not obtain vital signs, and did not assess for signs/symptoms of alcohol withdrawal. The patient was not seen by medical staff until the following morning. The Physician's Assistant (PA) saw the patient at that time. The PA noted that the patient had a history of alcohol abuse for 30 years, that his last drink had been 2 days before, and that he was complaining of nausea, vomiting and tremor. The PA's assessment was "alcohol withdrawal" for which he ordered medications and monitoring. This case was reviewed with Dr. Balderrama.

Patient 5
The patient was booked into the jail on 11/30/08 at 21:03 with charges of driving while intoxicated. At booking, the patient denied a history of drug or alcohol problems. He was seen by medical staff the next morning after having had a seizure. The PA noted that the patient stated that he had had a seizure disorder for 10 years but had not had any medications for several months. The PA further noted that the patient also stated that he had been an alcohol user for 3 years, that he was a "social drinker", and that his last drink had been that morning but that he had not been drunk for several weeks. The PA's assessment was that the patient had a seizure disorder, for which he ordered medication and follow-up in 3 days. He did not order monitoring for possible alcohol withdrawal. (I discussed this case with Dr. Balderrama. We agreed that alcohol withdrawal was the most likely etiology of the patient's seizure and that he should have been placed on alcohol withdrawal. Dr. Balderrama stated that he had discussed this with the PA.)

At approximately 18:00 on 12/3/08, the patient was noted to be "very agitated and obviously confused, looking around room as though he is responding to internal stimuli." Dr. Balderrama was consulted, and he ordered medication for alcohol withdrawal. Dr. Balderrama also discontinued the medication that had been ordered for the patient's seizure disorder, noting that the patient's seizures were most likely due to alcohol

withdrawal. A nurse administered medication to the patient at approximately 02:00 on 12/4/08, but there is no documentation that she assessed the patient for signs or symptoms of alcohol withdrawal. Later that morning, at 09:30, Dr. Balderrama noted, "Unfortunately, the patient is still not oriented in time and space this a.m. but does not have any other symptoms per nursing report." When the nurse went to monitor the patient that evening at 20:00, she did not check his vital signs because she was not able to "enter [the patient's] cell due to security issues." She noted that he was in his boxer shorts, picking at the wall and that he did not believe he was in the county jail. The nurse who went to monitor the patient at 02:00 on 12/5/08 also noted that she could not enter the cell due to security concerns. (Dr. Balderrama and I agreed that the patient's behavioral changes were related to his alcohol withdrawal and that he should have been transferred to the hospital if he could not be appropriately monitored in the jail.)

Later that morning, at approximately 06:00, custody staff requested that medical staff evaluate the patient. The nurse noted that the patient's pulse was elevated, that he was a little confused, and that he had tremors. The nurse noted that the patient already had an appointment scheduled with Dr. Balderrama that day. Dr. Balderrama saw the patient at approximately 10:00. He noted that the patient had poor improvement and was not responding to the current management. He also noted that the patient was not having adequate oral hydration. Dr. Balderrama sent the patient to the hospital for further care. The patient was admitted to the hospital for treatment of alcohol withdrawal and remained there until 12/8/08.

Patient 6

The patient was placed on the alcohol withdrawal protocol at 13:35 on 12/8/08. The required 6-hour check was done at 20:00 on 12/8/08 but then not again until 08:00 on 12/9/08. This case was reviewed with Dr. Balderrama.

Patient 7

The patient was booked into the jail on 10/25/08 at 14:52. Alcohol withdrawal was noted on the booking form. There was an entry in the medical record later that night at 23:08 from a nurse noting that she had called the patient for a withdrawal check but that he had "refused per CO." At approximately 01:30 on 10/26/08, a nurse noted that the patient's pulse was 130, that he had vomited 5 times, and that he was starting to have hallucinations. The patient was sent to the emergency room at that time for further evaluation and treatment. He was treated in the emergency room for alcohol withdrawal and returned to the jail later that day. The patient was released from custody on 11/18/08 and rearrested on 11/19/08. He was placed back on alcohol detoxification, but there were multiple entries in the medical record stating that he refused to be seen.

Alcohol withdrawal is a clinical syndrome that occurs when individuals who are physically dependent on alcohol stop drinking or reduce their alcohol consumption. Individuals may not initially display signs/symptoms of intoxication and still may be at high risk for withdrawal. Symptoms of withdrawal can begin within 6 hours of the last drink and initially may not be severe (i.e., mild tremors, nausea and anxiety). Medical staff must identify and closely monitor individuals who are at risk for withdrawal, so that early recognition and treatment can occur. Frequent re-evaluation of patients is paramount in the management of alcohol withdrawal. At a minimum, medical staff needs to monitor and document a patient's vital signs, mental status and behavior. The lack of appropriate monitoring of patients at risk for alcohol withdrawal continues to be a problem at PCDC. The plan to house patients who are at risk for alcohol withdrawal in the same area is an excellent idea. We were told, however, that this was not occurring on a consistent basis. In addition, it is not acceptable for a nurse not to monitor a patient because the patient refuses to come to clinic or because of "security concerns." Such concerns may actually be evidence of developing delirium tremens (a severe, potentially fatal complication of alcohol withdrawal).

We recommend that PCDC develop a form that nursing staff can use when monitoring patients who are placed on the alcohol detoxification protocol. (I gave Dr. Balderrama a copy of a sample form.) We also recommend that PCDC consider housing patients at higher risk of alcohol withdrawal in the cells in the medical clinic in order to facilitate their care. In addition, rather than decreasing the frequency of monitoring, consideration should be given to monitoring these patients every 4 hours. Finally, nursing staff can not accept a "refusal" as a reason not to perform the required monitoring.

Nursing Protocols

The nursing protocols have been revised to address the concerns raised in the last report.

Mental Health Services

Since our last visit, the mental health program has made significant changes, including the development and implementation of an updated policy and procedure manual, which have improved the quality of the care provided to the patients at PCDC. While we commend the staff for these positive developments, we still have concerns about the overall level of mental health services.

A series of mental health questions have been added to the forms used by the booking officers and nurses in order to better identify those individual with mental health concerns and needs. While the booking officers are now using the new forms, the booking nurses have not yet begun to use them. Even when this new tool is implemented, we are concerned that many mentally ill patients may not be referred to mental health. During

our recent visit, review of medical records indicated that medical staff was not consistently referring patient-inmates with mental health issues to mental health (see access to care), causing an unnecessary and unsafe delay in evaluation by a MHP. Care must be taken to ensure that all patient-inmates with mental health problems are referred for needed services. This is of particular concern because, due to reorganization of the County's mental health services, mental health staff at PCDC no longer receives the reference list that advises community providers of new arrestees who have a history of receiving mental health treatment in the community. In the past, this had been an important resource to assist mental health staff in identifying new arrestees with mental health problems. We were informed that the mental health program is initiating training for the medical staff regarding the identification of risk factors that would prompt a mental health referral.

Mental health staff is routinely conducting rounds in all the mental health-housing units, both male and female, and have been following their new policy and procedures in these housing areas. This is an improvement over our last two visits. In general, kites are being triaged much faster than on our visit in June 2008, and many of these patients are being seen the same day. However, as stated in our previous reports, the limited number of mental health staff continues to hamper the ability of the mental health program to fully meet the mental health needs of the patient-inmates at PCDC. There are still unacceptable delays in seeing some patients and staff continues to use "reverse kites" at times when a face-to-face encounter is necessary. We also have serious concerns about the overuse of kiting for follow-up and the inability, because of insufficient staffing, to do follow-up care.

It was noted that some patients are still experiencing long waits to see both psychiatric prescribers and MHPs (see access to care). The psychiatrist and psychiatric ARNP are referring some of their patients to MHPs for follow-up between their visits; this practice demonstrates good clinical care and needs to be encouraged and expanded.

MHPs now develop a stabilization plan (SP) for each of their patients. While this is a positive development, the MHPs need to improve the quality of many of the stabilization plans and consistently implement the ones they have developed. A thoughtful, meaningful plan specifies a particular course of therapy and gives guidance and direction to the MHP and the patient. Currently, the most common SPs found in charts read, "MH to F/U" which gives no indication as to what will be done. Others read, "clear per class" or "no changes, MH will continue to F/U", and give no indication as to what mental health care the patient is to receive. One SP, dated 11/24/08, stated, "F/U 2 weeks 12/7." (As of 12/11/08, MH had not seen the patient (Patient X). On 12/5, the same patient submitted a kite, which had not been responded to. Both remained on mental health's follow-up board.) Mental health staff needs training on the development of appropriate stabilizations plans that address specific mental health concerns. Appropriate plans can

help with risk management for patients with histories of suicidal ideation as well as assist patients with symptom management and averting a relapse.

The mental health program has addressed the concerns raised in our prior reports related to the management of suicidal individuals. It has developed a policy on *Suicide Risk Assessment and Precautions* and has implemented a schedule for the follow-up of patient-inmates released from suicide precautions. The new policy states, "Inmates placed on suicide watch by a MHP and subsequently released from suicide precautions will be seen by a MHP within seventy-two hours or sooner if clinically indicted. At the follow-up assessment, a determination is made as to the need for continued mental health intervention."

As we requested in our first report, a joint medical/mental health policy has been developed that specifies the guidelines and limitations of non-psychiatric PA's ordering psychiatric medications and providing follow-up care for many of the mentally ill patients. We suggest that an additional procedure be added to require a referral to a MHP to ascertain the stability of the client. This would help ensure that the PA's follow only stable mental health patients.

Medical Records

The problems related to medical records that were noted in our prior report have not been addressed:

1. The providers do not consistently have access to the medication administration records (MARs) when they are evaluating patients in clinic. The completed MARs are not scanned into the EMR and the paper copies may not be available. As a result, providers are often not able to determine if patients have been taking their medications. (Nursing staff is supposed to notify the providers when a patient has been refusing his/her medication. However, we were informed that, due to staffing issues, this often does not occur.) In addition, while the medical kites are scanned into the medical record, mental health kites are not scanned.
2. Insulin does not appear on the list of medications that a patient has been ordered.
3. Staff has developed and implemented a policy related to the format and contents of the electronic medical record. However, clinical information is still not entered into the electronic medical record in a consistent way. Progress notes from the practitioners and the nurses can be in one of multiple sections – *Synopsis*, *Appointments*, or *Correspondence* (the scanned copy of the booking sheet). In addition, entries in the electronic medical record are not consistently listed in chronological order. This makes it very difficult to review a medical record and increases the likelihood that important clinical information may be missed.

4. Chronic illnesses are not always noted on the Problem List. In addition, mental health problems are not noted on the Problem List.
5. Clinical documentation of patient encounters is often insufficient. Many of the notes from booking and triage are poorly written and do not contain sufficient information about a patient's condition. In addition, when nursing staff provides wound care, the nurse only notes whether the patient was seen or not seen. S/he does not document the condition of the wound or the type of care provided.

Billing/Co-Pay

Discussions with inmate-patients did not reveal any evidence that the current co-pay system deterred individuals from accessing the health care system. We still recommend that staff perform, as part of their quality improvement program, the monitoring studies recommended by Dr. Shelton to track whether or not there was any impediment to access based upon the co-pay.

Dental Care

At the time of our visit, dental care continued to be available only one day per week. In November, contract dentists came into the jail for 6 days and cleared the backlog of patients who had pending dental appointments. At the time of our visit, there were only 6 patients on the urgent list. There were, however, 44 patients waiting for routine dental care. These patients had a variety of dental problems, including pain, dental infections (i.e., Patient 8 (waiting 5 weeks); Patient 9 (waiting 3 weeks); Patient 10 (waiting 3 weeks)) and dental abscesses (i.e., Patient 11 (waiting 3 weeks) Patient 12 (waiting 2 weeks)). These are inappropriately long times to wait for dental care for such serious problems.

On 2/3/09, Vince Goldsmith informed us that PCDC now has a half-time dentist and that, as of 1/29/09, there were no patients on the dental waiting lists.

Chronic Disease Management

PCDC lacks many of the necessary components of an adequate chronic disease program. PCDC has not developed a system for identifying and tracking patients with chronic medical problems. (Dr. Balderrama stated that they were still waiting for the services of a computer programmer to help them develop a system using their electronic medical record.) In addition, guidelines need to be developed for the nursing staff so that they know when to notify a provider about abnormal findings such as elevated blood sugars or blood pressures. Furthermore, as noted above, many chronic illnesses are not currently noted on the problem list.

Dr. Balderrama has distributed copies of the chronic care guidelines from the National Commission on Correctional Health Care to the medical staff. Review of records revealed

that in many cases the guidelines are not being followed and patients are not receiving appropriate care. The examples below demonstrate common problems such as the lack of follow-up and the failure to address abnormal laboratory results. In addition, recommended monitoring and examinations, such as annual tests for urinary protein and annual ophthalmology examinations are not routinely occurring. These concerns were discussed with Dr. Balderrama. He stated that he would follow-up with the nursing and medical staff.

In many of the cases below, the medical records revealed that the patients had multiple "no-shows" for sick call. In such cases, the standard of care is for medical staff to document the reason for the no-show as well as the fact that counseling was provided to the patient. Furthermore, there should be a signed refusal of care when a patient refuses to see a provider for a serious medical problem.

Patient 13
The patient was being treated for HIV. On 6/24/08 he was seen by an infectious disease specialist who recommended follow-up in 9/08. The jail scheduled the follow-up visit for 9/23/08. On 9/12/08, the patient was transferred to Western State Hospital. The patient returned to PCDC on 10/3/08. The jail medical staff did not re-order a referral to the infectious disease specialist until 11/24/08. (The appointment was scheduled for 12/9/08.) This case was discussed with Dr. Balderrama.

Patient 14
The patient has a history of diabetes. She was seen by the booking nurse on the morning of 11/26/08. Her blood sugar at that time was 221. (According to the American Diabetes Association[1], the pre-meal blood sugar for a diabetic patient should be between 90 and 130, and the post-meal blood sugar should be less than 180.) The nurse contacted a provider who ordered the patient's medications. The nurse did not, however, refer the patient to a provider for further care. At 15:00, the patient's blood sugar was 360. The nurse did not contact a provider or refer the patient for an appointment. (A blood sugar of 360 is very elevated. The nurse should have referred the patient to the provider for further evaluation and care.) Over the next 5 days, the patient's blood sugar was consistently elevated in the range of 193 to 255. Despite her elevated blood sugars, staff did not refer the patient to the provider and there were no adjustments to her medications. She was released from custody on 12/2/08 without having seen a provider. This case was discussed with Dr. Balderrama.

Patient 15

[1] *Diabetes Management in Correctional Institutions*, American Diabetes Association, 2007

The patient has a history of hypertension, diabetes, hyperlipidemia, and Crohn's disease. On 10/17/08, his cholesterol was 213 and his LDL cholesterol was 156 (both elevated). As of 12/11/08 this had not been addressed. This case was discussed with Dr. Balderrama.

Patient 16

The patient has a history of diabetes, hypertension, and hyperlipidemia. He was booked into the facility on 11/10/08 and saw a clinician the same day. The clinician ordered the patient's medications. Since that time, his blood sugars had been mostly elevated with a number of readings in the high 200s to 300s. As of 12/11, the patient had not seen a clinician for follow-up and there had not been any adjustments to his medications.

Patient 17

The patient had a history of untreated hypertension. He was seen by the booking nurse on 9/30/08. She noted that his blood pressure was elevated at 183/111. (Normal blood pressure is less than 120/80; values between 120-139/80-89 are considered pre-hypertension; values between 140-159/90-99 are considered stage 1 hypertension; and values greater than 160/100 are considered stage 2 hypertension.[2]) The booking nurse ordered blood pressure checks for 3 days and an urgent appointment with the provider on 10/3/08. On 10/3/08, the patient's blood pressure was 159/105. He did not see the provider until 10/6/08, at which time his blood pressure was 160/110. The provider ordered medication and follow-up on 10/10/08. The follow-up did not occur. The patient was released from custody on 11/5/08, without having seen a provider for follow-up and without having any further monitoring of his blood pressure.

Patient 18

The patient has a history of diabetes and hyperlipidemia. The booking nurse saw the patient on 11/18/08 and noted that his blood sugar was 281 and his blood pressure was very elevated at 180/126. The booking nurse did not contact the provider. (Given the patient's blood pressure and blood sugar, the booking nurse should have contacted the provider.) The patient did not receive any medication and did not see a provider until 11/20/08. At that time, the patient's blood sugar was 236. The provider gave the patient an injection of insulin, and ordered oral medications for his diabetes and hypertension.

Patient 19

The patient has a history of hypertension. On 10/9/08, the booking nurse noted that the patient's blood pressure was 192/108. The booking nurse did not obtain any history related to possible symptoms related to the patient's very high blood pressure. The

[2] *The Seventh Report of the Joint National Commission on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure*, National Institutes of Health

booking nurse contacted a clinician who ordered the patient's medications. The nurse also ordered blood pressure checks for 3 days and follow-up with the clinician the next morning. On 10/10/08, the patient's blood pressure was 180/100. The nurse noted that the patient was complaining of a headache and tingling in her fingers. The nurse did not obtain any further history related to the patient's symptoms. The patient did not see the provider because the patient was in court. On 10/11/08, the patient's blood pressure was 166/108 and she continued to complain of a headache. The nurse did not obtain any further history related to the patient's headache and did not contact a provider for further direction. On 10/12/08, the patient's blood pressure was 179/98 and she continued to complain of a headache. The nurse did not obtain any further history related to the patient's headache and did not contact a provider for further direction. The patient was finally seen by a clinician on 10/17/08. Her blood pressure was 171/112 at that time. The clinician noted that the patient had a long history of headaches and provided appropriate care. (In this case, the nurses should have obtained a history related to the patient's headache and contacted the clinician in a timelier manner.)

Patient 20

The patient has a history of hypertension. On 10/2/08, the booking nurse noted that his blood pressure was 164/120. The booking nurse contacted the clinician who ordered the patient's medications. The patient did not have any follow-up or blood pressure checks until 10/13/08 when he was seen by a clinician. The patient's blood pressure was 175/104 at that time.

Patient 21

The patient has a history of hypertension. On 11/21/08, at 10:38 p.m., the booking nurse noted that the patient's blood pressure was 171/109. The nurse did not obtain any further history. The patient signed a refusal form stating that he did not know his medications and did not want to provide the name of his physician or pharmacy. (In my experience, patients are often embarrassed about being arrested and do not want to provide information about their community providers.) The nurse did not contact or refer the patient to a clinician. (The patient's blood pressure was significantly elevated and the booking nurse should have contacted the on-call provider for further direction.)

On 11/22/08, at 10:00 a.m., another nurse noted that the patient's blood pressure continued to be slightly elevated at 140/98. At 9:30 p.m., on 11/22/08, the patient's blood pressure was 220/124 and he was sent to the emergency room for further evaluation and treatment.

Patient 22

The patient has a history of chronic obstructive pulmonary disease (COPD). A nurse saw him at approximately 10 p.m. on 10/7/08. The patient was having difficulty breathing at

that time. The nurse noted that his oxygen saturation ranged from 78 to 87% (Oxygen saturation is used to assess a patient's respiratory status. Normal oxygen saturation is over 95 %.) The nurse did not contact a clinician. There is an entry the next day at 12:09 p.m. noting that a nurse gave the patient a nebulizer treatment (a method of treating lung disease by having the patient inhale medications). There was no accompanying nursing note documenting the nurse's findings and assessment at that time. At approximately 4:00 p.m. on 10/8/08, the patient was brought down to the medical clinic in a wheelchair due to reports that he was "looking bad." His oxygen saturation was 60% at that time. The patient was sent to the emergency room and admitted to the hospital with a diagnosis of pneumonia and COPD. He was discharged back to the jail one week later. This case was discussed with Dr. Balderrama.

Specialty Care

The jail has arrangements for providing specialized ambulatory care for those patients who require consultations with an outside specialist. Review of medical records revealed that patients were being seen by the specialists in a timely manner. The PCDC providers, however, are not consistently seeing the patients and/or reviewing the consultation reports when patients return from a visit to a specialist. In one case, the patient was seen by an orthopedic surgeon on 11/20/08. The orthopedist recommended a referral to an occupational therapist. The consultation report was not reviewed by a provider at PCDC and the referral was not made. This was discussed with Dr. Balderrama who stated that he would develop a system to address this issue.

Quality Improvement

Continuous Quality Improvement (CQI) is the development and implementation of a program for reviewing the quality of care provided at an institution and, as such, is an essential component of the health care delivery system. Processes and performance must be routinely evaluated and analyzed. Based on the findings of these studies, steps must be taken to improve the outcomes if they fall short of desired goals.

As noted in our prior reports, PCDC has begun to implement a CQI program. Medical staff continues to monitor certain aspects of the health care program such as segregation rounds, tuberculosis skin testing, and booking refusals. Other necessary aspects of a comprehensive CQI program, however, still have not been implemented. PCDC needs to develop a more comprehensive CQI program with both outcome (i.e., the number of diabetic patients whose disease is well controlled) and process (i.e., whether patients who submit health care requests are being seen within the required timeframe) oriented studies being performed. In addition, the March 28, 1996 Order requires that the Quality Assurance and Improvement Committee "includes participation of not less than one

outside physician who is well qualified and familiar with accepted practices and community standards in the Tacoma/Pierce County medical community. Any such physicians shall be identified by an appropriate local medical organization or authority, such as the Washington State Medical Society or the Chief of Staff at major local hospital, accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO). Additionally, the Tacoma-Pierce County Health Department shall be represented on the Committee." PCDC does not have such a committee at this time. On 2/3/09, Vince Goldsmith reported that they are working to reconvene this committee.

Another concern noted during our current visit is related to the death review process. Death reviews are an important part of a facility's health care program. The NCCHC states (*Procedure in the Event of the Death of an Inmate,* Standard J-A-10):

> In all deaths, the responsible health authority determines the appropriateness of clinical care; ascertains as to whether corrective action in the system's policies, procedures, or practices is warranted; and identifies trends that require further study.

At PCDC, when a patient-inmate dies, Dr. Balderrama reviews the case and prepares a summary of the care provided to the patient. His report does not specifically identify areas in which care could be improved and for which corrective action plans need to be developed. In addition to this report, a mortality review is conducted with representatives from medical and custody administrative staff. This review focuses on the response to the incident, not on the clinical care and circumstances leading up to the death. A death review process needs to be developed that identifies system issues that may have affected the delivery of care as well as possible problems in the care provided so that corrective action plans can be developed that will improve future care. This was discussed with Vince Goldsmith and Dr. Balderrama. Vince Goldsmith informed us that PCDC plans on complying fully with the NCCHC's newly revised (2008) standard.

In those cases where the death is a suicide, NCCHC also recommends that a psychological autopsy should be performed. The NCCHC states:

> A *psychological autopsy,* sometimes referred to as a psychological reconstruction and usually conducted by a psychologist or other qualified mental health professional, is a written reconstruction of an individual's life with an emphasis on factors that may have contributed to the individual's death.

The NCCHC further states

> The typical psychological autopsy is based on a detailed review of all file information on the inmate, a careful examination of the suicide site, and

interviews with staff, inmates, and family members familiar with the deceased.

We recommend that the policy and procedure on the *Procedure in the Event of the Death of an Inmate* be revised in order to provide for a more comprehensive review of the clinical care and circumstances surrounding an inmate's death, and the determination of whether corrective action plans need to be developed. We further recommend that a psychological autopsy be conducted in all cases of suicide.

Policies and Procedures

The policies and procedures on Nursing Assessment Protocols (J-E-11) and Health Records (J-H-01) had been revised and updated since our last visit. The medical policies and procedures are now acceptable. They need to be reviewed on an annual basis.

Mental health policy and procedures have been updated. The mental health policies and procedures are now acceptable. They need to be reviewed on an annual basis.

REQUESTS

We request that PCDC provide us with updates on the following areas on April 1, 2008:

1. Progress on filling vacant positions and any changes to the hiring process
2. Nursing skills assessment training
3. Audits of segregation checks
4. Progress on obtaining the services of a computer programmer to address issues with the electronic medical record

NCCHC STANDARDS

We are using the NCCHC Standards as the framework for our opinions. Only the NCCHC Board of Accreditation can officially determine if NCCHC standards have or have not been met.

<u>Governance and Administration</u>

J-A-01 Access to Care
This standard is not being met. See the discussions of access to care, staffing, and mental health services above.

J-A-02 Responsible Health Authority
This standard is met. PCDC has a qualified full time Health Authority and a full-time Medical Director.

J-A-03 Medical Autonomy
This standard is met. Decisions and actions regarding health care services provided to inmates are the sole responsibility of qualified health care personnel and are not compromised for security reasons.

J-A-04 Administrative Meetings and Reports
This standard is met. Administrative meetings are being held. Monthly statistical reports are being produced that include data on areas such as the number of bookings; medical, nursing, mental health, and dental encounters; emergency room and specialty referrals; prescriptions; the number and types of medical grievances; the results of skin testing for tuberculosis; and deaths.

J-A-05 Policies and Procedures
This standard is met.

J-A-06 Continuous Quality Improvement Program
This standard is not being met. See the discussion of CQI above.

J-A-07 Emergency Response Plan
This standard was not evaluated.

J-A-08 Communication on Special Needs Patients
This standard was not evaluated during this visit.

J-A-09 Privacy of care

This standard is met.

J-A-10 Procedure in the Event of an Inmate Death

This standard is not met. A procedure needs to be developed and implemented to provide for a more comprehensive review of the clinical care and circumstances surrounding an inmate's death, and the determination of whether corrective action plans need to be developed.

J-A-11 Grievance Mechanism for Health Complaints

This standard is met. There is a mechanism in place for allowing inmate grievances and then for reviewing and responding to these grievances both on an individual and an aggregate basis to look for patterns of complaints.

Managing a Safe and Healthy Environment

J-B-01 Infection Control Program

This standard is being met. PCDC has developed a policy for the use of the airborne isolation rooms that includes procedures and logs for monitoring the pressure. In future visits, we will review the logs to ensure that the necessary monitoring is occurring.

J-B-02 Environmental Health and Safety

This standard was not evaluated during this visit.

J-B-03 Kitchen Sanitation and Food Handlers

This standard was not evaluated during this visit.

J-B-04 Ectoparasite control

This standard is met. PCDC has written a policy and procedure to establish active parasite (lice, scabies) control that is appropriate in that it is applied only to infected patients, and not to all inmates upon entering jail. Qualified Health staff is used to identify infection and authorize treatment. Pregnant women are referred to a providerfor further evaluation and treatment.

Personnel and Training

J-C-01 Credentialing

This standard was not evaluated during this visit.

J-C-02 Clinical Performance Enhancement
This standard was not evaluated during this visit.

J-C-03 Continuing Education for Qualified Health Services Professionals
This standard was not evaluated during this visit.

J-C-04 Training for Correctional Officers
This standard is being met. Mental health advised us that they have reinstated their training of PCDC's officers on the identification of mental health problems and suicide prevention. We will review the training records during our next visit.

J-C-05 Medication Administration Training
This standard is met. Permanent and agency nurses receive adequate training and orientation before they are given responsibility for administering medications.

J-C-06 Inmate workers
This standard is met.

J-C-07 Staffing Plan
This standard is not being met. See the staffing discussion above.

J-C-08 Health Care Liaison
This standard does not apply.

J-C-09 Orientation Health Staff
This standard is met.

Health Care Services and Support

J-D-01 Pharmaceutical Operations
This standard is met. The current contracted off-site pharmacy is doing well to fill the needs of the patients of PCDC. There is a stock of "emergency" medications for off-hours and there is 24 hour availability from local pharmacies or the hospital if medications are needed that are not kept on site.

J-D-02 Medication Services
This standard is met.

J-D-03 Clinic Space, Equipment and Supplies
This standard is not being met. This standard requires that there is sufficient and suitable

space, equipment, and medical supplies for the adequate delivery of health care. At this time, the clinic area in the booking area is not adequately equipped.

J-D-04 Diagnostic Services
This standard is met.

J-D-05 Hospital and Specialty Care
This standard is met. The jail has arrangements for providing hospital and specialized ambulatory care for medical and mental illnesses.

Inmate Care and Treatment

J-E-01 Information on Health Services
This standard is being met.

J-E-02 Receiving Screening
This standard is not being met. See the discussion of receiving screening above.

J-E-03 Transfer Screening
This standard is not applicable.

J-E-04 Health assessment
This standard is not being met. Required medical and mental health assessments are not being done.

J-E-05 Mental Health Screening and Evaluation
This standard is not being met. While, a series of question have been written by mental health to be added to the custody and nursing booking forms, the new form has not been implemented by medical.

J-E-06 Oral Care
This standard is not being met. See the discussion of dental care above.

J-E-07 Non-Emergency Health Care Requests and Services
This standard is not being met. See the discussions of access to care, mental health services, and dental care above.

J-E-08 Emergency Services
This standard is being met.

J-E-09 Segregated Inmates
This standard is not being met. See the discussion of access to care above.

J-E-10 Patient Escort
This standard was not evaluated.

J-E-11 Nursing Assessment Protocols
This standard is met.

J-E-12: Continuity of Care during Incarceration
This standard is not being met. Continuity of essential medications for newly arrived inmates needs to be improved. See the discussion of receiving screening above.

This standard is being met for mental health.

J-E-13 Discharge Planning
This standard is being met. Mental health begins planning for re-entry from the beginning of incarceration and reviews the client's community resources with each inmate contact. Discharge medication is provided until a follow-up appointment is made in the community. The mental health staff works with the mentally ill client to inform them of housing options if homelessness is an issue. Discharge planning for patients with medical problems is also occurring, although in a less organized manner. Mental healh has reinstate the court diversion specialist.

Health Promotion and Disease Prevention

J-F-01 Health Education and Promotion
This standard was not evaluated during this visit.

J-F-02 Nutrition and Medical Diets
This standard is being met.

J-F-03 Exercise
This standard is being met. Discussions with staff revealed that all inmates were allowed at least the minimum number of hours for recreation.

J-F-04 Personal Hygiene
This standard met. PCDC has changed its practice of having inmates in segregation take showers while in restraints.

J-F-05 Use of Tobacco
This standard is being met. PCDC is a non-smoking facility.

Special Needs and Services

J-G-01 Special Needs Treatment Plans
This standard is not being met. Inmates identified with special needs requiring close medical supervision or multi-disciplinary care including the chronically ill, those with communicable diseases, physically handicapped, frail, elderly inmates, the terminally ill, inmates with special mental health needs, and the developmentally disabled, should have special treatment plans listed in their medical charts. The treatment plan should include instructions about diet, exercise, medication, type and frequency of diagnostic testing, and frequency of follow up for medical evaluation. These patients are being identified on a case-by-case basis by the practitioners, and appropriate medical care ordered. There is no automatic system for insuring on-going and timely follow up on a regular and routine basis for patients with identified special needs.

Mental heath is now writing stabilization plans on all of their clients, but many are not meaningful. Staff needs training on how to write a care plan (see Mental Health).

J-G-02 Management of Chronic Disease
This standard is not being met. See the discussion of chronic disease management above.

J-G-03 Infirmary Care
This standard is not applicable.

J-G-04 Mental Health Services
This standard is not being met. See the discussions of mental health services and staffing above.

J-G-05 Suicide Prevention Program
This standard is being met.

J-G-06 Intoxication and Withdrawal
This standard is not being met. See the discussion of intoxication and withdrawal above.

J-G-07 Care of the Pregnant Inmate
This standard is being met.

J-G-08 Inmates with Alcohol and Other Drug Problems
This standard was not evaluated during the recent visit.

J-G-09 Procedure in the Event of Sexual Assault
This standard was not evaluated during the recent visit.

J-G-10 Pregnancy Counseling
This standard was not evaluated during the recent visit.

J-G-11 Orthotics, Prostheses, and Other Aids to Impairment
The standard is being met.

J-G-12 Care for the Terminally Ill
This standard does not apply. Terminally ill patients are transferred to the local hospital.

Health Records

J-H-01 Health Record Format and Contents
This standard is not being met. See discussion of health records above.

J-H-02 Confidentiality of Health Records and Information
This standard is being met.

J-H-03 Access to Custody Information
This standard is being met.

J-H-04 Availability and Use of Health Records
The standard is being met.

J-H-05 Transfer of Health Records
This does not apply to PCDC as they have only one facility and a shared electronic health record.

J-H-06 Retention of Health Records
This standard is being met.

Medical-Legal Issues

J-I-01 Use of Restraint and Seclusion in Correctional Facilities
This standard is being met. Staff advised us that restraint, as part of a treatment

program, is not used for medical or mental health patients. PCDC sends patients with this type of medical need to the hospital. The custody staff solely orders restraints at PCDC. In future visits, we will monitor the use of the restraint chair and the "bolts" in the DTO and DTS cells that are used by custody staff to restrain inmates.

J-I-02 Emergency Psychotropic Medication
This standard is being met.

J-I-03 Forensic information
This standard is being met.

J-I-04 End-of-life Decision Making
Not applicable to PCDC.

J-I-05 Informed Consent
This standard is being met.

J-I-06 Right to Refuse Treatment
This standard is not being met. The policy on *Medical Refusal* (J-I-06) states that patients with emergent or urgent problems who refuse care will be brought to the clinic and the practitioner will explain the consequences of refusing. If the patient continues to refuse, "s/he must sign a refusal form..." Staff stated that this often does not occur and "refused per CO" is written in the chart.

J-I-07 Medical and Other Research
This standard is being met. PCDC does not use inmates for medical research. (Inmates may stay on an appropriately established research protocol if they were placed on it while in the community prior to incarceration.)

Summary

The following NCCHC accreditation standards are not being met:

J-A-01 Access to Care
J-A-06 Continuous Quality Improvement Program
J-C-07 Staffing Plan
J-D-03 Clinic space, Equipment and Supplies
J-E-02 Receiving Screening
J-E-04 Health assessment
J-E-05 Mental Health Screening and Evaluation

J-E-06 Oral Care
J-E-07 Non-Emergency medical requests
J-E-09 Segregation Inmates
J-E-12: Continuity of Care
J-G-01 Special treatment plans
J-G-02 Management of Chronic Disease
J-G-04 Mental Health Services
J-H-01 Health Record Format and Contents
J-I-06 Right to Refuse Treatment

The following NCCHC accreditation standards were not fully evaluated:

J-A-07 Emergency Plan
J-A-08 Communication on Special Needs Patients
J-B-02 Environmental health and safety
J-B-03 Kitchen Sanitation and Food Handlers
J-C-01 Credentialing
J-C-02 Clinical Performance Enhancement
J-C-03 Continuing Education for Qualified Health Services Professionals
J-E-10 Patient Escort
J-F-01 Health Education and Promotion
J-F-02 Nutrition and Medical Diets
J-G-08 Inmates with Alcohol and Other Drug Problems
J-G-09 Procedure in the Event of Sexual Assault
J-G-10 Pregnancy Counseling

Attachment

Pierce County Sheriff's Department
Corrections Health Clinic
910 Tacoma Ave South
Tacoma, Washington 98402
(253) 798-4033 or fax (253) 798-4043

Vincent P. Goldsmith
Health Services Manager

January 7, 2009

Joe Goldenson, MD
Medical Director
San Francisco Department of Pubic Health
650 5th ST Suite #309
San Francisco, CA 94107

RE: Response to Staffing Needs Memorandum

Dear Dr. Goldenson:

I hope you and your family had an excellent time during this past holiday season. Thank you for your patience, if I never shovel snow again it will be too soon. I'm responding to your letter dated 12/17/2008, "staffing Needs."

Previously you have provided us a detailed report for our comments, and I assume you will do this in connection with your December 10th visit. For present purposes, I want to respond to your recent memorandum, and in particular to the assertion that Dr. Balderrama, Mary Scott and I had stated that additional nursing positions are needed to meet the conditions of the settlement agreement. The discussion to which you refer involved hypothetical situations, e.g., more staff would be hired as more of the jail is opened. County staff did not agree that additional nurses are necessary to meet the terms of the settlement agreement.

With regard to the proposed float nurse position, it is true that the booking nurse is not able to screen every prisoner into the jail, the reason being that there were other duties infringing on the booking nurse time. During our meeting with you I stated that this position was not needed because we don't believe that we need to have a nurse screen everyone into the jail.

Current staffing levels are fully adequate to provide necessary medical services for inmates. I did not attend the whole meeting, but I have spoken with my staff and they all agree that we do not need the proposed new positions to meet the conditions of the court order. It is our opinion that we are providing the community standard of care and we are meeting the requirements of the consent decree.

If you include in your next report a statement that county staff somehow have agreed with your staffing proposal, please also include the text of the preceding three paragraphs of this letter verbatim.

Respectfully,

Vincent P. Goldsmith, M.H.A., C.C.H.P.