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January 26, 2008



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

Dear Judge Arnold:

Jo Robinson, a mental health expert, and I visited the Pierce County Detention Center on November 15-16, 2007, in order to 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. After receiving their response, we have had several subsequent conversations with them. 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

# 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

January 26, 2008

This is the first 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. In preparation for this report, we reviewed reports from Steve Shelton, MD, the prior Court Monitor, the staffing report from Kathryn Knox, RN, the September 1997 report from Bonnie Norman, RN, the *Health Services Policy and Procedure Manual*, and the *Nursing Guidelines and Protocols*. Ms. Robinson and I visited PCDCC on November 15 and 16, 2007. We toured the facility, reviewed medical records, and interviewed health care and custody staff.

The audit conducted during our first visit was not comprehensive. We primarily focused on those administrative and programmatic issues that Dr. Shelton had noted as needing improvement. We did not have the opportunity to fully evaluate the quality of the clinical care. We will look at this area during future visits through a more extensive review of medical records.

As noted in Dr. Shelton's 2005 report, many of the concerns raised by the Court in the stipulations have been adequately addressed. These include housing, administrative and medical leadership, mental health housing, availability of over the counter medications, and identification of a referral hospital. In addition, PCDC has finalized the development of an appropriate set of policies and procedures that are based on the standards of the National Commission on Correctional Health Care. Some of these policies and procedures will need to be revised (as discussed below) to either reflect current PCDC practice or to address deficiencies.

Dr. Shelton also noted that 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." We agree that 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. Compliance with the standards does not guarantee, however, that the clinical care being provided at a facility is adequate. As indicated above, future reports will also evaluate the quality of care based upon a clinical review of selected medical records.

Prior to submitting this report to the Court, we sent a draft copy to the health care staff at PCDC for their review and comments. We have incorporated many of their suggestions into this final report.

We would like to express our gratitude to all the staff (health care and corrections) that graciously assisted us throughout our stay and answered our never-ending questions. They were completely cooperative with our requests, including a large list of documents we had asked for, and we would like to express our appreciation for their support of our monitoring effort. Without their help and cooperation, our task would have been unachievable.

REPORT

The population of the jail was 1,458 on November 15, 2007. There were 655 inmates in the main facility and 803 in the new facility. There are approximately 75 to 80 new bookings per day.

Central Health Services Area

The clinic on the third floor of the main jail is clean, well equipped and lighted, and provides an appropriate environment in which to evaluate patients. The original design did not allocate sufficient space for administrative offices. Staff has addressed this deficiency by converting some of the cells into office space. This appears to have been a successful solution to the problem.

Clinics in the New Jail

The clinics in the housing areas of the new jail are small and do not have medical equipment. When nurses evaluate or treat patients they must bring their equipment and supplies with them. Patients who require a more comprehensive examination or who need to be seen by a practitioner must be transported to the clinic in the main jail.

Medical and Mental Health Infirmary/Sheltered Living Level Housing

The cells in the health services area of the main jail that are designated to be medical and mental health beds are not being utilized due to a lack of necessary custody and nursing positions. The exceptions to this are: (1) patients who are being evaluated for suspected tuberculosis disease are occasionally housed in the negative pressure airborne isolation rooms; and (2) patients who require a higher level of medical care than is available in general population are sometimes housed in the medical beds. In those cases, custody and medical staff is increased in the clinic area. In addition, such patients can be admitted to the hospital for care or sent to another facility that has an infirmary.

PCDC has stated that it will develop a policy and procedure for the use of the medical rooms. In addition, it will begin tracking the number and reason that patients are put into the airborne isolation, infirmary, and sheltered living rooms. We also recommend that PCDC conduct a survey of incoming and long-term inmates to determine the number who

would benefit from sheltered living or infirmary housing, such as high risk diabetic, cardiac, or asthmatic patients, high risk pregnant women, post-operative patients, and patients requiring observation. During future visits, we will examine this issue more fully.

Access to Care

An inmate can access routine health care services by submitting a kite to the medical staff. The same forms as are used for these kites as are used for all other types of kites. The inmate then places the kite in a locked box that is only for health care services. Nursing staff picks up the kites at night and sorts and reviews them. Patients with medically related complaints (approximately 70 to 80 per jail per day) are then referred to the triage nurse the next morning. There are two triage nurses positions assigned to each of the facilities.

However, one of the positions in the main jail has been vacant since last March. In addition, there is no coverage when one of the triage nurses is sick or on vacation or education leave. Mary Scott, RN, the Nursing Supervisor, stated that during times of high absenteeism, this level of staffing was almost "disabling." On November 15, there was only one triage nurse on duty for both facilities and on November 16, there was only one on duty in each facility. (One of the triage nurses informed us that he could usually evaluate 20 to 25 patients per day). Furthermore, the triage nurses only work five days per week. On weekends, the medical kites from the main jail are reviewed by a nurse in the clinic and those from the new jail are reviewed by the nurse at intake. Patients with "urgent" complaints are to be seen over the weekend. Those with "non-urgent" complaints are deferred until Monday. Many inmates, however, are medically unsophisticated and have poor writing skills, and therefore, the kites may not accurately reflect the urgency of their medical problems. In many cases, such as patients complaining of headaches or abdominal pain, more information than is written on the request is required before the immediacy of need can be determined. A nurse needs to interview such inmates in order to determine the urgency of their problem. Given the responsibilities of the booking and clinic nurse, it is not clear that they have enough time to adequately screen the medical kites on the weekends. PCDC should conduct a quality improvement study to evaluate the process by which inmates access care. This is also an area that we will review during future visits.

After evaluating the patient, the triage nurses can address minor medical complaints through the use of protocols, consult with Dr. Balderrama, the Medical Director, or one of the Physician Assistants, or refer the patient to the medical clinic in the main jail for further evaluation and care. In his final report, Dr. Shelton recommended that PCDC implement a well prepared 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." While the triage nurses currently undergo training and are closely monitored by Dr. Balderrama, we recommend the implementation of a more formalized and documented training program such as the one recommended by Dr. Shelton. We did not formally evaluate how long it took for patients to be seen by a practitioner following referral, but it appeared that those in general population units were being seen within an acceptable time frame. We will review this in more detail during future visits.

Access to medical care in special housing units (such as the administrative segregation units) also occurs through submission of a written kite that the inmate can place directly in a locked medical box. The kites are picked up and addressed seven days per week in the same manner as those from the other housing areas in the jail. In addition, per the *Segregated Inmates* policy, nursing staff is to conduct rounds in these units three times per week and perform "visual checks, e.g., "How are you doing?"" According to audits conducted by PCDC medical staff, this was only occurring approximately 60% of the time. In addition, staff reported that patients from these units who were referred to a practitioner by the triage nurse were often not seen in a timely manner. For example, Patient 1 was seen by the triage nurse on October 17 for a complaint of abdominal pain due to trauma that he sustained during his arrest. The nurse referred the patient to the practitioner as a "First-up" appointment. He was not seen by the practitioner until October 22. The practitioner scheduled follow-up in 2 weeks, but the patient was not seen until 4 weeks later. (By that time his discomfort had resolved. This does not change, however, the fact that he was not seen in a timely manner.)

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. (The booking nurse is also often called on by the custody staff to evaluate the medical complaints of inmates housed in the new jail). Staff reported that it is not uncommon, especially during busy times, for inmates with identified health concerns to be housed prior to being seen by the booking nurse. PCDC stated that it would begin tracking the number of daily bookings, the time of day that they are occurring, and the number of new arrestees that the booking nurses are screening. We recommend that it also conduct a study to determine if all new arrestees with medical or mental health problems are being evaluated by the booking nurse.

The booking nurse is also responsible for contacting outside medical providers and pharmacies in order to verify current prescriptions for newly arrived inmates who state they are taking medications. Once verified, the nurse contacts a PCDC practitioner to obtain orders for the medication. If the nurse is unable to verify a current prescription, the patient is referred to see a practitioner at sick call. It was reported that at times, if the

patient appears knowledgeable about his/her medications, the booking nurse will contact the practitioner for orders even if they can not verify the medication.

The purpose of receiving screening includes the determination of whether newly arriving arrestees have any urgent or emergent health care needs, have medical conditions that require referral for follow-up, are receiving medications that must be continued, or may be suffering from a potentially communicable disease. This screening should include both a face-to-face interview and, whenever possible, a review of the prisoner's medical record. In addition, potential for suicide or for withdrawal from alcohol or other drugs must be addressed. The NCCHC standard on *Receiving Screening* (J-E-02) states, "In all facilities where health professionals are available, it is expected that they conduct the initial screening." The standard does allow for health-trained correctional staff members to perform the screening in facilities where medical staff is not on site at all times. However, given the staffing and the number of daily bookings conducted at PCDC, we would expect that a health professional perform the initial screening. This would ensure that all newly arrived arrestees are appropriately evaluated. This would also allow the nurse to review the electronic medical records of all incoming inmates.

Furthermore, the current system for continuing outside medications needs to be reviewed. We are concerned that some patients may not receive essential medications until days after they have been arrested. For example, a 54-year-old man who had been taking Coumadin since he had had a pulmonary embolus in 2003 (Patient 11) was booked into the jail on October, 26, 2003. The booking nurse was unable to verify his medication and referred him to a provider on an urgent basis. There was an entry in the medical record later that morning that the patient had "refused to the CO." (There was no refusal form in the medical record). The patient was not seen until October 29. At that time the provider noted that the patient received his medication from a pharmacy in Canada. He further noted that the patient was very knowledgeable and that he would start the Coumadin that day. There had been, however, a three day delay before the patient received an essential medication. In those cases where medications for serious medical problems, such as diabetes, hypertension, and HIV disease, cannot be verified, the nurse should consult with a practitioner about those patients who give a reliable history or have physical findings consistent with their illness, so that the medications can be ordered pending verification. We recommend that PCDC conduct a quality improvement study to evaluate the timeliness with which patients receive essential medications when they first enter the jail.

Finally, there is no examination table or electrocardiogram (EKG) machine in the medical clinic in the booking area. The booking nurse is called on to evaluate both newly arriving arrestees who may have acute medical problems, as well as inmates housed in the new jail with acute problems. In order to adequately assess patients, such as those with abdominal

or chest pain, an examination table and EKG machine need to be available.

Staffing

The current medical program at PCDC is budgeted for 28 nursing positions (14 LPN and 14 RN), a full time physician, 3 full time physician's assistants (PA), a health services administrator, and support staff (clerical, medical records, contract x-ray). As of November 2007, there was 1 RN vacancy. As noted above, no coverage is provided when one of the triage nurses is absent from work. In addition, the staffing plan does not include a relief factor to provide coverage for nurses in other positions (such as booking or clinic) who are on sick, vacation, or education leave. PCDC uses overtime, per diem, and agency nurses to cover these shifts. Staff informed us that it is not always possible, however, to find coverage, and they have to work short handed. PCDC stated that it would begin tracking the number of open shifts per month.

As noted above, there is a need for additional nursing positions in order to implement a system where receiving screening is performed by a registered nurse. Additional staff may also be needed if it is determined that they are required to ensure that health care requests are appropriately addressed seven days per week or if studies reveal that there are enough patients who require a higher level of care to warrant opening medical beds in the clinic area. In addition, staffing needs will have to be re-assessed as PCDC implements a chronic disease management program and begins performing health assessments.

At the time of our visit, mental health staffing consisted of 5 Mental Health Program Specialists (MHP) who provide seven-day per week coverage, from approximately 7 am to 9 pm. The MHPs also provide emergency night coverage on a rotating basis. There were two MHP applicants who were going through the comprehensive clearance process. In addition, a clerical position was open. With this position unfilled, the MHPs have to do the work usually done by this assistant. (Since our visit one of the two MHPs and the clerical assistant have been hired.) In addition, there was psychiatric coverage on Tuesdays, Wednesdays, and Thursdays. (Since our visit psychiatric coverage has been expanded to 4 day per week, though the total number of hours per week of psychiatric coverage has not changed).

PCDC has a very large number of patients with mental health needs. Dave Stewart, Acting Director of Human Services, advised us of a study conducted in the 1990's to determine the percentage of serious mentally ill prisoners housed at the facility. The study concluded that between 25% and 28% of the inmate population had a serious and persistent mental illness. This percentage is significantly higher than the 16% suggested by the 2002, Council of State Governments' *Criminal Justice/Mental Health Consensus Project.* Mr. Stewart states that PCDC's percentage is high because of the multitude of mental

health institutions within the county. These include a state hospital, two prisons housing mental health facilities, and a seven-state VA hospital, all of whom release to this county increasing the concentration of mentally ill people in the county. Staff also reported that there has been an alarming trend over the last 5 years of increasing numbers of individuals, who have had prior contact with the community mental health system, coming into PCDC. Despite this, the number of inmates seen for mental health services has decreased by over 1,000 inmates over this same period.

In light of PCDC's significant need for mental health screenings, suicide evaluations, and scheduled rounds in the higher security level mental health housing units, we are concerned that there may not be enough MHPs to provide adequate mental health care to the mentally ill inmates housed in lower level psychiatric housing and general population areas. Even if all of the positions were filled, staffing may still not be adequate to provide an appropriate level of mental health care. We will further review the adequacy of the mental health staffing during future visits.

In addition to concerns regarding the adequacy of MHP staffing, we are also concerned that the psychiatric coverage may be insufficient. The mental health program has had a fulltime, psychiatric nurse practitioner position open for approximately two years. As noted above, currently there is psychiatric coverage four days per week, leaving no scheduled psychiatric coverage for three days. Mental Health has a priority list of inmates (high, medium, and low) to see the psychiatrists for an evaluation for psychiatric medication. Because of constant additions to the list, it is very rare that inmates with a low priority are seen by a psychiatrist to receive a medication evaluation. This is of concern because inmates are told that they will be receiving this evaluation. It is advised that mental health conduct a review of the low priority list with one of their psychiatrists and an MHP to determine if the referrals on this list are clinically indicated. If so, the patients should be seen by a psychiatrist. If not, a different system of care for addressing the needs of the patients on the low priority list should be developed. We will also review the level of psychiatric coverage during subsequent visits.

Medical staff informed us that the hiring process is an impediment to hiring health services staff. This is largely attributed to the amount of time applicants must wait before they can be hired. Health care personnel in the community can be hired within two to four weeks. Currently, the hiring process at PCDC takes three to six months. As a result, filling any vacancies is a long process. Much of this delay is due to the background checks performed by the Sheriff's Department. This has been a longstanding problem at the PCDC. In her November 1997 report, Bonnie Norman noted,

> It will be very difficult to hire qualified professional staff unless PCDC is able to streamline the process of hiring. Sheriff French needs to review

options to the current prolonged hiring process, especially for highly skilled professional personnel whose state or professional licenses are already carefully and strictly regulated, and do everything he can as soon as he can to streamline the health services hiring process.

PCDC stated that it would prepare a report of the last year documenting:

- The length of time from when a healthcare position became vacant to when it was filled.
- The number of healthcare professionals who submitted applications.
- The number who were hired.
- The length of time from submission of the application to hiring.
- The number of applicants who withdrew their applications before completing the background process.
- The number of applicants who withdrew their applications before they were contacted.
- The number of applicants who took other jobs before completing the background process.

If the background procedures are contributing to the difficulty in hiring healthcare staff, a process will need to be developed that fulfills the security needs of the facility while allowing hiring to take place in a more timely fashion.

Intoxication and Withdrawal

The protocols for identifying and managing inmate-patients who are at risk for alcohol withdrawal are not adequate. Alcohol withdrawal is a clinical syndrome that occurs when individuals who are physically dependent on alcohol stop drinking or reduce their alcohol consumption. If not managed appropriately, alcohol withdrawal can result in severe complications such as withdrawal seizures, delirium tremens, and possibly death. 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.

Benzodiazepines, such as Librium, are used to prevent progression from minor withdrawal to more severe manifestations of withdrawal. It is common practice to monitor patients for the symptoms of alcohol withdrawal and to dose the benzodiazepines based on the level of symptomatology. Alternatively, minor withdrawal symptoms may be treated with fixed regimens (i.e., giving medication at specified intervals). When this is

done, patients must be closely monitored and given additional medication if progression to higher stages is observed. With appropriate and timely care, the serious consequences of alcohol withdrawal can be avoided.

The PCDC policy and procedure on *Intoxication and Withdrawal* (J-G-06) correctly notes that, "Inmates at risk need to be identified and appropriate treatment initiated." The procedure states that the booking officer is to refer any inmates with a history of substance abuse to the booking nurse. It further states that the booking nurse needs to promptly contact a provider if any of the following are present: severe tremors, seizure or history of same, abnormal vital sings, irregular heart rate, abnormal postural vital signs, vomiting or pregnancy. The PCDC *Guide for Booking Nurse* states that individuals who are at high risk for alcohol withdrawal (not defined) should have vital signs checked two times per day for three days and be placed on the urgent list to see the practitioner, and that the provider should be called if there are signs of current alcohol withdrawal. There are no guidelines for identifying patients who are initially asymptomatic but who are at risk of developing signs and symptoms of alcohol abuse, or for appropriately monitoring and treating these patients.

PCDC needs to revise its current alcohol withdrawal protocol to provide for a better method of identifying, monitoring and treating those patients at risk for alcohol withdrawal.

Nursing Protocols

PCDC has developed a set of nursing protocols that address the nursing response to and management of many common medical problems. These protocols provide clinical criteria on when to send patients to the emergency room, when to refer them to the practitioner, and when only nursing intervention is required. The protocols do not, however, provide guidance as to when a provider should be contacted immediately and when it is acceptable to refer the patient to the clinic. For instance, the protocol for abdominal pain states that a patient with severe pain, rebound tenderness, and localized right lower quadrant pain should be referred to a practitioner. The protocol for dandruff also advises the nurse to refer the patient to the clinic if the problem has failed to respond to prior nursing intervention. Clearly, in the first scenario, an immediate call to the provider is required, whereas in the latter example, it is appropriate for the patient to wait until he is seen in clinic. An example of this problem is Patient 2, is an 80 year-old-man who has a defibrillator and pacemaker and has had several heart attacks and bypass surgery. On September 9, 2007, custody staff brought him to the booking nurse because he was complaining of shortness of breath and chest pain. The nurse noted that the pain radiated to the patient's neck and across his upper back, and that he reported that his fingertips felt numb. She also noted his prior cardiac history. The patient's history and symptoms were

of great concern for a possible heart attack. However, instead of sending the patient immediately to the emergency room or calling the provider on-call for further guidance, the nurse sent the patient to the main jail clinic for an electrocardiogram. It was not until almost one hour after the patient had initially presented that the on-call provider was contacted and the patient was sent to the emergency room via ambulance. Fortunately, he had not sustained a heart attack.

The nursing protocols need to be revised to differentiate between those situations which require immediate consultation and those where it is acceptable to wait for the patient to be seen in clinic. In addition, the policy and procedure on *Nursing Assessment Protocols* (J-E-11) needs to be updated to address the use of the nursing protocols.

Mental Health Services

The mental health staff is knowledgeable about the mentally ill inmate population and expressed commitment to the work they do. Referrals for mental health come from multiple sources: correctional officers, medical staff, self-referrals, attorneys, and families. Due to staffing shortages, the mental health court-screening program referenced in the last monitoring report was abated and only recently re-established in mid-November. The staff provides a significant number of assessments and coverage with limited resources. In addition, the MHPs work closely with community mental health treatment providers to assist with continuity of care and discharge planning and have an innovative electronic system that encourages community involvement when clients are incarcerated.

Even with a dedicated mental health staff, however, we have serious concerns regarding the mental health program at PCDC. (See the discussion of mental health staffing above.) PCDC's mental health staff currently conducts monitoring rounds with mental health inmates housed in the danger-to-self (DTS) observation cells and the danger-to others (DTO), level-one security cells. The DTS cells are monitored daily by mental health staff and the level ones are monitored three times a week. Those housed in lower level mental health housing or in general population do not receive monitoring rounds by a Mental Health Professional (MHP). We were not able to fully evaluate the adequacy of the types of treatment and level of care available to mental health clients. This is an area that we will concentrate on during our next visit to PCDC.

Some of the mental health staff expressed particular concern regarding the housing for mentally ill women. According to these staff, while some of the mentally ill women who are housed in the level one security housing area are not appropriate for general population, they do not need to be housed in such a restrictive environment. Such housing severely limits the time out of their cells and can be harmful to their mental health. If an inmate is not classified as a danger-to-self or danger-to-others, they need to

be housed, with the input of mental health staff, in a less restrictive environment. We did not have a chance to look into this concern during this visit. We will examine it during future visits.

The PA's continue psychiatric medications that have been verified from the community and provide the follow-up care for many inmates on psychiatric medications during their incarceration. It does not appear that a psychiatrist sees or reviews the medication while the inmates are in jail. No policy was located describing this practice. Mental health and medical staff need to create a policy that addresses this practice. The policy needs to include both guidelines and limitations.

Medical Records

PCDC has implemented the use of an electronic medical record (EMR). Clinical documentation is directly entered into the EMR by the clinical staff. Other information such as laboratory results, x-ray reports and records from outside providers is scanned into the system. Medical information that predates the EMR was not scanned and is available in the form of a paper chart. One concern is that medication administration records are not scanned into the EMR and may not be available when the patient is being evaluated. In addition, it is possible to view a list of the medications that have been ordered for a patient. Insulin, however, does not appear on this list, so one would not know that a patient is receiving insulin unless they looked elsewhere in the medical record. The medication list should include all medications that a patient is receiving.

Another concern is the fact that there is no consistent way of entering information. 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). This makes it very difficult to review a medical record and increases the likelihood that important clinical information may be missed. In addition, chronic illnesses are not always noted on the Problem List. Our concerns were shared by some of the clinical staff that we interviewed. PCDC needs to develop a policy and procedure for the EMR that delineates where information should be entered. In addition, many of the notes from booking and triage are poorly written and do not contain sufficient information about the patient's condition.

Billing/Co-Pay

As noted by Dr. Shelton, the co-pay policy for inmates at PCDC appears to be appropriate and adequate to meet the constitutional requirements for access to health care. Inmates are assessed a $5.00 charge, subject to leaving a balance of $4.50 in his/her book account for certain medical encounters, such as an initial visit for a minor complaint that is not referred to a provider. A fee is not imposed for most health care services, including intake

screening, communicable disease screening, mental health services, emergency care, and any visit that results in a referral to a practitioner. In addition, no inmate is denied services based on a lack of funds. However, any co-pay system can have an adverse impact on access to care. Dr. Shelton had recommended certain monitoring studies to track whether or not there was any impediment to access based upon the co-pay. Staff had not performed these studies, but was fairly certain that the co-pay had not deterred patients from accessing the health care system. We recommend that this be documented using the measures suggested by Dr. Shelton. In addition, during future visits, we will be interviewing inmates to assess the impact of the co-pay system.

Medical Diets

PCDC offers the standard range of medical diets. Staff reported, however, that the diets supplied by the food services company were often unsatisfactory in terms of both quality and quantity. They stated that this was also true for the regular diets supplied by the company. Since this is an issue that has been raised in prior reports, PCDC should contract with a dietician to perform a study of the food services at the facility.

Dental Care

Dental care is available only one day per week. This is totally insufficient to meet the dental needs of the jail population. On November 16, 2007, there were 21 patients on the dental priority list. According to the policy on *Oral Care* (J-E-06), dental priorities are to be seen at the next dental clinic. Many of these patients had been on the list for over 3 weeks. One patient with a broken tooth (Patient 3) had been on the priority list for 44 days, and another with a cracked molar and exposed root (Patient 4) had been on the priority list for 10 days. (PCDC informed up that Patient 4 refused care when he saw the dentist. This does not, however, alter the fact that he was not seen in a timely manner.) In addition, 155 patients were on the waiting list for routine dental care. Many of these patients had been waiting over 4 to 5 months to see the dentist. Statistical reports indicated that the dentist was only seeing about 30 to 40 patients per month.

Chronic Disease Management

The sick call process is primarily designed to address acute, self-limited medical problems. Since a significant proportion of prisoners suffer from diseases, such as hypertension, diabetes, asthma, seizures and HIV/AIDS, facilities must have a mechanism for monitoring individuals with chronic health conditions. The development of a chronic care program helps to ensure routine follow-up and appropriate treatment of patients with serious medical problems. Such programs serve to identify and monitor patients with chronic illnesses in order to initiate appropriate therapeutic regimens that will promote good health and prevent complications, and provide patient education and counseling in order

to encourage patients to practice healthy behaviors. In contrast to visits for episodic care of self-limited problems, the chronic care visit should address all issues related to the patient's illness since the last visit. In addition, there should be a registry that lists by disease all the patients in custody with chronic illnesses and a method of tracking those patients to ensure that they are being seen on a routine basis (a minimum of every three months) and that appropriate monitoring is occurring.

PCDC has not developed or implemented an adequate chronic care program. A disease registry needs to be developed and training of the practitioners in the chronic disease model needs to occur. In addition, disease specific chronic care guidelines should be developed and in-serviced with the staff.

Medications/Pharmacy

Pharmacy is being handled by contract from an outside pharmacy. Staff report that medications are delivered the same day or the next day more than 90% of the time. There is also a stock of on-site medications for immediate delivery and usage. PCDC continues to use a Keep-on-Person (KOP) medication program in the new jail and for the inmate workers housed in the main jail. We agree with Dr. Shelton's recommendation that this program be extended to the main jail as it can result in reduced nursing and custody labor and improved patient care.

Quality Improvement

Continuous Quality Improvement (CQI) is the development and implementation of a procedure for reviewing the quality of care provided at an institution and, as such, is an essential component of the health care delivery system. CQI is accomplished through a combination of studies, audits, record reviews, peer review, mortality reviews and other quality improvement activities. 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 time frame) oriented studies should be performed. It is through these activities that important problems and concerns with the health care system can be documented, factors leading to suboptimal performance can be identified, and strategies for improving care can be developed. Once changes have been implemented, follow-up studies need to be done to determine the effectiveness of the corrective actions. According to the NCCHC aspects of care that must be reviewed annually include: access to care, reception screening, health assessment, continuity of care, emergency care and hospitalizations, mental health services, chronic disease management, discharge planning, infirmary care, and adverse patient outcomes, including deaths. [*Standards for Health Services in Jails*, NCCHC, 2003, page 153]

PCDC has begun to implement a CQI program. Medical staff is currently monitoring certain aspects of the health care program such as segregation rounds, tuberculosis skin

testing, and booking refusals. Staff is also conducting death reviews. Other aspects of a comprehensive CQI program have not been fully implemented. The policy and procedure on *Continuing Quality Improvement Program* (J-A-06) states that the physician will perform monthly chart reviews "of at least 5% of the inmate current health encounters during the month..." While chart reviews are being done, they are not being done to the extent specified in the policy and procedure. Furthermore, the types of CQI studies described above are not being performed by either the medical or mental health programs.

A more comprehensive CQI program needs to be developed at PCDC.

Policies and Procedures

As noted above, the policies and procedures on Nursing Assessment Protocols (J-E-11) and Health Records (J-H-01) need to be revised and updated.

Mental health policy and procedures have not been revised for approximately ten years. Many of their practices have changed and the new facility has opened. The policies and procedures need to be updated. In addition, the medical program has policies regarding mental health practices that mental health staff has never seen. A system needs to be in place for review and approval of shared policies.

# 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.*

***Governance and Administration***

**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 not met. See the discussion of policies and procedures above.

**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 met. Physician review of each death is occurring. In addition, a review of each death is being done by a committee that includes the appropriate individuals. Issues that represent possible systems errors are being identified and addressed. In addition there is a system for notifying an inmate's family in case of emergency such as serious illness or injury.

**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 not being met. PCDC has an adequate program for screening incoming inmates for tuberculosis. Appropriate monitoring and guidelines for the treatment of skin and soft tissue infections have also been established.

There is a problem, however, with the airborne isolation cells that are used to house patients who are being evaluated for suspected tuberculosis disease. These cells are not being properly monitored. Guidelines from the Centers for Disease Control recommend that room pressures be confirmed daily while the rooms were occupied by patients with known or suspected tuberculosis and at least monthly at other times. Monitoring of these rooms was not occurring and on the day of our visit we checked the room and it did not appear that negative pressure was being maintained. This was discussed with the medical and engineering staff. PCDC needs to develop a policy for the use of the airborne isolation rooms that includes procedures and logs for monitoring the pressure. The cells should not be used for patients who may have infectious tuberculosis until an adequate monitoring system is established.

**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 not being met. Mental health staff no longer offers refresher courses to PCDC's Correctional Officers on the identification of mental health problems and suicide prevention. Such a refresher course has not taken place in three years. To meet this standard, these topics must be reviewed, at a minimum, every two years.

**J-C-05 Medication Administration Training**
This standard is not being met. Due to the staffing problems described above, agency nurses, who do not receive sufficient training and orientation, are often used to pass out 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. Mental health continues to have an impressive electronic system that automatically identifies those new arrestees who have received mental health services in the community. As noted above, increasing numbers of individuals who have had prior contact with the community mental health system are coming into PCDC; however, the number of inmates seen for mental health services has decreased. It is unlikely that the number of mentally ill inmates has diminished. It is more probable that these patients are not being identified or that the capacity to evaluate them has diminished.

A screening tool, in addition to the correctional officer's intake screen and the community reference list, needs to be utilized to assure inmates with mental health needs are referred to mental health. To satisfy this requirement, a series of approved mental health questions could be asked by nursing staff.

**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. In addition, we recommend that different forms or colors be used to distinguish medical from other kites.

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

**J-E-09 Segregated Inmates**
This standard is not being met. Required rounds in the segregation units are not occurring 3 times per week. In addition, staff reported that access to care is delayed for inmates in segregation.

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

**J-E-11 Nursing Assessment Protocols**
This standard is not being met. See the discussion of nursing protocols above.

**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. Continuity care is a priority for the PCDC mental health staff. An electronic list is generated daily advising both jail mental health of new arrestees' community mental health history as well as providing a list to community mental health centers advising the center of their client arrest. Jail mental health continues verified community psychiatric medication upon admission to the jail.

**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.

***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 was not evaluated during this visit. As noted above, staff voiced concerns about the regular and medical diets. We recommend that PCDC contract with a nutritionist to evaluate the diets.

**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 is not being met. Inmates in segregation are forced to take showers with their hands are cuffed in front of them. It is not possible to adequately clean oneself under these circumstances.

**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.

While all of the mental health charts reviewed had a "P" for plan and addressed the re-entry or discharge plan into the community, few had developed a treatment plan for the course of therapy during incarceration. Mental health treatment plans need to include both short and long term goals.

**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 currently not applicable. However, as noted above, PCDC needs to conduct a survey to determine how many infirmary/sheltered living beds are needed to address the needs of the patients housed in the jail.

**J-G-04 Mental Health Services**

This standard was not fully evaluated. See the discussions of mental health services and staffing above.

**J-G-05 Suicide Prevention Program**

This standard is not being met. PCDC has a system for identification, referral, evaluation, housing, monitoring, and reviewing of suicides or serious attempts. The PCDC's initial Jail Health Receiving Screen Form asks, "Suicide Attempt in Last 2 Months." Past suicide attempts are the best predictor of suicide attempts both in and out of jail. Two months is a low standard for a referral for a mental health assessment. Any inmate that has a history of in-custody suicide attempts should be referred to mental health for evaluation. Mental health's computer system will pick up inmates that have made attempts in PCDC; however, it will not advise of suicide attempts made in other detention centers or mental

health system outside of Pierce County mental health. An initial training is provided to all staff; however, a biennial refresher course is not being taught.

**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. The PCDC policy on *Use of Restraint and Seclusion in Corrections Facility* (J-I-01) has a confusing statement that needs correcting. In the statement, "Medical staff will do a health assessment *no more* than two hours after initial placement, ""no more" needs to be replaced with "within". 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 not being met. The policy for involuntary medications is unclear and ambiguous. The requirement of the second practitioner's endorsement is written in a confused manner and needs clarification. This policy must also clearly spell out at what point the first dose of forced, longer-term, on-emergency medications are administered. It is likely that the practice meets the standard, but the policy needs to be clarified.

**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. The case of Patient 11, whose care is discussed above in the section on Receiving Screening, is an example of this. He was referred from booking to the practitioner in the medical clinic on an urgent basis. He was, however, not seen that day. The only note states, "refused to the CO." As a result, he did not receive his essential medication until he was seen by the practitioner 3 days later.

**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-05 Policies and Procedures
J-A-06 Continuous Quality Improvement Program
J-B-01 Infection control of communicable diseases
J-C-04 Training for Correctional Officers
J-C-05 Medication Administration Training
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-11 Nursing Assessment Protocols
J-E-12: Continuity of Care
J-F-04 Personal hygiene
J-G-01 Special treatment plans
J-G-02 Management of Chronic Disease
J-G-05 Suicide prevention program
J-G-06 Intoxication and withdrawal
J-H-01 Health Record Format and Contents

J-I-02 Emergency Psychotropic Medication
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-04 Mental Health Services
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

Other Issues

1. Staff expressed concerns about the nutritional adequacy of both the regular and the medical diets. We recommend that PCDC contract with a nutritionist to evaluate the diets.
2. The following areas require further study through quality improvement activities or other studies:
    a. The need for infirmary/sheltered living housing
    b. Access to care
    c. The priority list for psychiatric care
    d. The hiring process
    e. The intake screening process