

Exhibit J

Monterey County Jail Health Care Evaluation

Prepared by
Mike Puisis DO
November 29, 2013

Introduction

In conducting this I reviewed essential components to an adequate health care system. These include organizational structure, health care infrastructure (e.g. clinical space, equipment, etc.), health care processes, and the quality of care.

Methods of assessment included:

- Interviews with health care leadership, health care and custody staff;
- Tours and inspection of the jail and medical clinics, the Outpatient Housing Unit, pharmacy, and medical records;
- Reviews of reports, tracking logs and health records;
- Observation of health care processes (e.g. medication administration);
- Review of policies and procedures;
- Review of staffing patterns

With respect to the assessment of adequacy, I seek to determine whether any pattern or practice exists that presents a serious risk of harm to detainees, which is not being adequately addressed.

Executive Summary

On October 21 to October 23, 2013 I toured the Monterey County Jail to evaluate health care services. This report describes my findings and recommendations. I want to thank the Sheriff, his staff and the staff of California Forensic Health Group (CFHG) for their cooperation in conducting the review. Everyone was fully cooperative and helpful during my visit.

After passage of Administrative Bill 109, the composition and size of the Monterey County Jail (MCJ) has changed significantly. The jail is growing larger and according to custody leadership there are a greater percentage of sentenced inmates creating a crowded and more difficult security environment. The health services program which may have been adequate in a smaller jail with a larger population of misdemeanor inmates is now struggling to provide adequate services. It is not performing at an adequate level.

While the existing hard working staff is the strength of this facility, they are impaired by the evolving changes at the jail. Staffing is inadequate. Because there are limitations with respect to officers transporting inmates for their scheduled appointments, officer staffing should be evaluated along with medical staffing. Required services are not accomplished and a new staffing plan should be developed that allows for completion of required assignments as stipulated in policies. Staffing should include a relief factor so that staff absences do not affect performance.

Clinic space, equipment and supplies are inadequate. None of the existing clinical space was built or designed as clinical space. Clinical activities should be performed in space designed, equipped and supplied for clinical activity. Policies and procedures need to be revised as well so that adequate care can be provided in the new and larger jail environment. Monterey County is constructing a new \$40 million 288 bed addition to the jail. The project is currently in the design phase. The design¹ includes one clinic examination room and one dental procedure room immediately adjacent to an inmate living area. This does not address existing clinical space inadequacies and is designed on the same model of existing clinic space which is inadequate. I strongly recommend that Monterey County include in this new jail addition, a replacement health care unit properly designed to accommodate existing needs at the jail. If possible, capital funds for that building project should include funding to rehabilitate the inadequacies of the existing intake area.

Clinical care is inadequate in most areas of service as will be detailed in this report. Clinical care needs to be re-designed to ensure that sick patients and patients with chronic illness are identified at intake and then appropriately managed. This is a multi-faceted problem involving intake screening, identification and management of persons with chronic illness, provision of necessary medication, and provision of adequate access to services through nursing sick call procedures. All areas should be improved. It appears that staffing issues are a major

¹ County of Monterey Jail Housing Addition; Establish Project Scope, Cost, and Schedule: Project Number 8819, June 2013

contributor to deficiencies. However, in some areas policy directives and defective system processes are barriers to adequate care. I am confident that the existing leadership can overcome these difficulties.

Existing relations with the local medical center are a strength that could be improved by ensuring that medical records of hospitalized inmates are provided to the jail medical staff. The local health department can be a significant resource in establishing infection control measures at the jail that protect both staff and inmates.

Due to time constraints, this report does not include findings with respect to credentialing, nursing and provider supervision, or specialty care referrals. Also, while there is existing policy on quality improvement, I was not provided information with respect to ongoing quality improvement activity and this area will need further review.

This report includes an executive summary, a findings section, a series of recommendations, and chart reviews that form part of the basis of my opinion. The chart reviews have redacted names which I will provide to medical leadership so that they can re-review the material if they desire. Also, the finding section includes a description of what I reviewed to form my opinion for that item.

Findings

Facility Description

The Monterey County Jail (MCJ) is located in Salinas, California. It serves pretrial detainees and an increasing number of sentenced inmates. According to information obtained from custody leadership, since Assembly Bill 109 (AB 109) was passed in 2011 the number of sentenced inmates has increased. Sentenced inmates remain incarcerated at the jail for a longer period of time. The jail, therefore, is less of a detention facility and more of a prison with longer length of stays and significantly more convicted felons. According to custody leadership, one of the side effects of this is that there are almost no misdemeanor detainees and there are higher classification inmates. The length of stay in 2009 prior to AB 109 was 162 days. Custody officials could not provide the current length of stay but thought it was considerably longer. Between January 2013 and June of 2013 the average daily population was 1126 inmates. The rated capacity of the jail is 825. The jail is filled to 136% of its rated capacity.

The jail is old. The initial jail structures were constructed in the 1970s. The main jail is a rotunda having multiple tiers of mostly single cells and houses higher security level inmates. The female jail is a smaller rotunda arrangement housing approximately 140 females. Another older part of the jail called the rehab jail was built around 1973 and contains large dormitories of triple bunks. This part of the jail is used to house minimum to medium classification inmates and inmate workers. A newer part of the jail was built in 1995 and contains 5 dormitories housing 50 to 70 inmates each of mostly medium classification inmates. These dormitories are located on a large central corridor at the end of which are several safety cells used for the purpose of mental health and medical housing for disturbed inmates. These cells are remote from medical and mental health clinical areas. Nearby this part of the jail is the intake area. This is a very small unit with a counter next to the sally port where officers perform medical intake screening. This unit has a sobering cell which is used to detoxify inmates who are undergoing withdrawal.

There are plans for building an additional 288 jail beds. This will reduce overcrowding at the jail.

Organizational Structure and Health Care Leadership

Methodology: I interviewed facility health care leadership and reviewed the table of organization.

Findings: Health care is provided by California Forensic Medical Group (CFMG), INC. a private for profit entity that provides health care to incarcerated populations in 65 jails and juvenile facilities in 27 counties of California. CFMG has been the medical vendor at MCJ since 1983.

The CFMG Program Manager is David Harness. He has been Program Manager for the medical program for over 30 years. Mr. Harness, in addition to his function as Program Manager at MCJ, is also Program Manager at another smaller jail and a juvenile facility, also contracted to

CFMG. He is therefore not full time at the jail. The Nursing Supervisor is Lola Bayer who, in addition to covering the jail program, also supervises the Youth Facility and the Juvenile Hall. The Medical Director is Dr. Garcia. Dr. Garcia also has supervisory responsibility at other facilities. In addition, Dr. Garcia is responsible for addressing administrative medical concerns at the MCJ including attorney requests for information, legal matters, and inmate health grievances. He is present on site at the jail 4 days a week. The table of organization is organized with nursing reporting to the Program Manager. The only direct reports of the Medical Director are the physician assistant and the part time physician. At this facility, given the extensive self directed nurse protocols, there should be some direct supervision of nursing by the Medical Director.

Staffing

Methodology: I interviewed facility health care leadership and reviewed the current staffing plan.

Findings: The MCJ medical program has insufficient staffing. It was apparent in chart reviews that required assignments are not performed or are incompletely performed. As well, the staffing plan does not appear to have sufficient staffing. Areas of assignment that were not performed consistently or were performed poorly included evaluation of health requests, chronic illness care, evaluations in sobering and isolation cells, management of patients on the OHU, and intake assessments. Segregation rounds and infection control surveillance are not performed.

The staffing plan consists of approximately 23 full time equivalent positions or 936 hours of service. For all of these positions, there is no relief factor assigned. As a result, there is no coverage assigned when an employee takes a day off or is on vacation. Typically, a relief factor is anywhere from 1.4 to 1.7 for each full time equivalent position. This means that even given the current staffing plan, the staffing is 40% to 70% less than necessary just on the basis of relief factor.

Even if relief factor was included, the numbers of staff are insufficient to accomplish the assigned duties. For example, for each shift there is only 1 Registered Nurse (RN) assigned. This RN must evaluate all inmates required to be seen in intake. Approximately 30 people a day are incarcerated. A smaller number of these are identified by custody staff as needing a medical screening. That number is probably less than 10 a day divided by 3 shifts. In addition, there are 30 health care requests a day. An RN evaluates all sick call requests except for those in the A clinic which are evaluated by the physician assistant (PA). In addition, health care emergencies occur. In addition all inmates in the sobering cell and isolation cells must be evaluated every 4 hours. In addition, on some shifts, the RN must supervise the Licensed Vocational Nurses (LVN). This is not possible for a single RN to perform in an 8 hour day. In chart reviews, it was clear, that many evaluations (sobering cell, detoxification assessments, health request reviews) are not happening or were not performed appropriately or in accordance with policy requirements. For health requests, nurses appeared, most often, to

merely send the request to the provider without evaluating the patient. This has resulted in missed care.

LVN staff is responsible for administration of all medication and for that purpose there is at least 1 LVN per shift. The day and evening shift has an additional LVN for purposes of assisting in the clinics. The numbers of medications is not large at this jail but the jail is spread out and a single nurse is responsible for dispensing medication into individual packets for each patient, writing patient specific identification on each envelope, going to each housing unit throughout the jail and then documenting passage of medication in a medication administration record. This is difficult to perform accurately for the number of inmates involved. The remaining LVNs perform other duties including reading tuberculin skin tests, taking off orders, scheduling patients and assisting RNs on patient specific duties in the clinics.

There are 2 certified nurse assistants (CNA) assigned to each shift. During the daytime shift, 1 CNA works with the nurse performing clerical duties during sick call. Another works with the physician assistant, assisting during clinics. The evening shift CNAs perform a combination of clerical and nursing assistance duties. At night one of the CNAs works in medical records and another assists the nurse.

In my opinion, this staffing pattern is not capable of accomplishing all assigned duties; this was evident in chart reviews.

The Director of Nursing fills in when other nurses are off. Given that there is no relief factor, this must be a routine occurrence. This detracts from supervision and oversight. Chart reviews demonstrated many instances of failure to perform evaluations according to policy, failure to perform vital signs, and abrupt evaluations of poor quality. In part these are probably a result of insufficient staffing. The Director of Nursing also needs time to review the quality of nursing work so that performance can improve.

The Medical Director evaluates patients or reviews charts for about 20 people a day. Much of the Medical Director's work consists of addressing grievances, attending to attorney complaints, and other administrative matters. Based on chart reviews, most of the care provided to patients, is provided by the Physician Assistant (PA). The PA committed many lapses of care and clinical errors that should result in some supervision which does not appear to be happening. Many patients should be evaluated by a physician but are not. Based on chart reviews, it does not appear that there is sufficient physician time at this facility. There does not appear to be an effective chronic care program at the jail and patients with chronic illness are not regularly seen in accordance with acceptable community standards. In my opinion, this is evidence of lack of physician staffing. This was evident in chart reviews.

The PA is responsible for evaluating all health requests from the main clinic, providing a female clinic Monday, Wednesday, and Friday, and seeing all walk-in patients and chronic illness patients in the main clinic. This can be as many as 20-40 people a day. Given this volume of

patients, it is not surprising that the evaluations performed by the PA are generally not thorough.

Officer staffing with respect to medical care should be evaluated as well. Even if medical staffing were appropriate, without adequate officer staffing, inmates will not arrive for their scheduled appointments if there are insufficient officers to transport and guard inmates in health care clinics. Approximately 1 officer provides escort to the main clinic for several health care staff. As a result, if the PA is seeing patients, the physician can not see patients. For other clinics, there are no specific officer assignments for moving patients for scheduled appointments and health care staff negotiates these transports on an ad hoc basis which is not functional. The requirement for escort officers and officers to maintain a secure environment in the health care unit and during medication administration should be assessed and augmented.

The program should evaluate time studies of expected duty assignments based on existing procedures and work loads and then readjust staffing. A relief factor should be included so that scheduled and unscheduled time off does not impair duty assignments.

The Program Manager, Director of Nursing and the Medical Director, given the size of this jail should be full time employees. Supervision and review of clinical work of nurses and the PA should be a routine part of the duties of the Director of Nursing and the Medical Director.

I did not review credentialing, nursing supervision or provider supervision during this visit.

Health Care Operations, Clinic Space and Sanitation

Methodology: I toured the jail and all medical clinics including the main clinic and the Outpatient Housing Unit (OHU). I also toured the medication room and the medical records area in the main clinic.

Findings: Health care space, both for clinical care and administrative support, is inadequate. The part of the jail housing the main medical clinic was built in 1995, but the majority of the jail beds are in structures that were built over 45 years ago in the 1970s. I was told that none of the clinical space was originally constructed for its intended purpose. All of the clinical space is reconfigured from other types of space. This results in design features that are mostly not appropriate for clinical care.

The main clinic is extremely cramped. Inmates wait with their escort officers in a small lobby waiting area immediately adjacent to two examination rooms. There is no reception area for nursing staff to prepare patients for clinical evaluation by performing vital signs, blood sugars or peak expiratory flow rates. In the main clinic, the physician examination room does not contain an examination table. The doctor evaluates the patient in a chair and moves to another room if a physical examination is necessary. This discourages proper examinations. The medication room is open 24/7. Many times during my tour, I walked past this room without anyone in the

room. This room has a narcotic cabinet within the room that is locked. However, all medication rooms should be locked with permission to enter restricted to authorized personnel. The narcotic cabinet by being in a room that is continuously open is therefore only secured with a single lock. Narcotics are to be stored in a double locked arrangement; in a locked cabinet in a secure lock room. This should be remedied.

The main clinic area with two examination rooms, a nurse station, a medical records room, a medication room, and several offices has no toilet. In order to use a rest room staff must exit the area go into a corridor, pass through two secure doors, and enter a custody staff toilet in their locker room area.

The medical records room is small and provides almost no space in which to file records. Staff works in ergonomically challenging conditions and file paperwork on a very small counter with very little space to work. This room is also open 24/7. Medical records can not be released without authorization yet this room is basically open without any security.

Administrative space in the main clinic is confined to a single room for the Director of Nursing who has to vacate the office several times a week to permit a mental health counselor to have work space. The Program Manager has office space and the dentist has an operatory located in an inmate tier. The dentist office is adjacent to the Program Manager's office. When the Program Manager enters his office, he walks through the day room of the inmate tier, with inmates occupying it, enters the dentist's operatory (which is adjacent to the inmate living area), and walks through the operatory into his office. The dentist's office and administrator's office are inadequate. Unsupervised inmates who might break into this operatory could have access to a wide variety of dental probes and tools that could be used as weapons.

The examination room for nurses in intake is approximately 70 square feet which is significantly undersized for an examination room. The room contains only a desk and two chairs along with a cabinet for supplies. The room has no examination table and lacks typical equipment necessary for assessments. The room is also immediately across from a room where incoming inmates undress and change clothes. On the day of my visit, this room was open and partially clothed individuals were visible. This is an inappropriate setting for examinations. Not unsurprisingly, I was told that nurses evaluated inmates in the room used by officers to complete a health inquiry or on a bench in a nearby hallway. These hallway-type evaluations are unacceptable for any clinical evaluations.

Officers perform intake health screening standing up in a room. Inmates are brought in from the sally port and wait in a room adjacent to the room where officers perform medical screening. There is no door and I was told that inmates sometimes line up within hearing distance from the officer performing the intake medical screening. There is no privacy. At times when only one inmate requires screening, the screening is private. Nevertheless, this arrangement lacks privacy and dignity.

Within the intake area there is a sobering cell. This cell has rubberized walls, floor and ceiling. There is no toilet in this room. Instead, there is a grated drain in the center of the floor which inmates can urinate and defecate into. This drain is flushed from outside the room. This room smelled of excrement and was not sanitary. Several charts reviewed included sobering cell nurse evaluations in which inmates were sleeping. It is unsanitary to sleep on a floor in this room. Also, this room is used to hold inmates who are either intoxicated or under watch for expectant delirium tremens. This room is far from nurse observation and is therefore inadequate for its stated purpose.

Near to the intake area through several locked doors are several "isolation cells" which are used for custody purposes to segregate unruly inmates or to house persons suspected by officers to be a potential harm to themselves or to others. These determinations are made by officers. However nurses evaluate inmates placed in these cells at specified intervals. These cells are far from the main clinic and there is no equipment in the room to perform an adequate assessment. These rooms as currently configured are unacceptable for the purpose of housing inmates requiring medical monitoring. In chart reviews, an inmate in delirium tremens was housed in one of these cells and his diagnosis was delayed.

There is a medical examination room not far from the intake area in a corridor. This clinic has an examination table, a desk and a chair but no other equipment for clinical care (otophthalmoscope, blood pressure cuff, etc.). There is no waiting room and the room and the clinic is remote from the medical records room.

In the old jail, there is a clinic for examination of female patients. One enters the clinic by walking through an inmate laundry which appeared to be the waiting room. The spatial layout was not intended for medical care. The examination area is narrow.

Also in the main jail there is a room used by nurses for nurse sick call. This room is extremely small. There is a single desk and 2 chairs. There is no examination table or equipment. All equipment is brought in by the nurse. Any examination of inmates is done in chairs. It is not surprising that the quality of nurse evaluations is poor given the equipment and space they have to work with.

All clinic examination areas were not hygienic or clean. All clinics had clutter. There is no standardization of equipment, furnishings, and supplies. There are no periodic automatic replacement (PAR) levels for supplies; nurses restock supplies. For several examination areas there were no supplies. I observed nurses performing sick call who carried supplies with them in a small bag. One nurse carried supplies in her personal handbag.

Examination rooms did not all have examination tables, some otophthalmoscopesophthalmoscopes were not working, some rooms had no equipment, and none were standardized. Every clinical area where clinical staff sees patients should be standardized, should include an examination table with sufficient space to perform evaluations, should include equipment necessary for examinations and should have proper lighting. An

appropriate benchmark for office space and fixed equipment is the U.S. Veterans Administration Office of Construction and Facilities Management Design Guides which can be found at <http://www.cfm.va.gov/til/dGuide.asp>.

MCJ is planning a new jail addition. The design plans for the new jail include 1 examination room and 1 procedure room which may be used as a dental operator. These clinical rooms have no waiting room or reception area for nursing to triage patients. Also, the rooms are located immediately adjacent to an inmate tier making it difficult to operate as a clinic. This is inadequate as a design except for use as a nurse triage room. This is a lost opportunity. There are significant deficiencies of clinic space throughout the jail. This capital improvement project could include a redesign and construction of adequate clinic space for the medical program. The planned addition is not satisfactory for that purpose.

Cleaning of clinical space is performed by inmate porters. Clinic space was not well sanitized. Health care management did not have a procedure or schedule of cleaning. I was told that inmate porters sweep, mop floors, and remove trash. Clinical examination areas should be cleaned according to a schedule appropriate for health care institutions or hospital clinics. This is not now occurring.

Policies and Procedures

Methodology: I interviewed health care leadership and staff, and reviewed selected policies and procedures to determine whether policies were adequate, whether they were periodically reviewed, and whether policy was consistent with jail practices.

Findings: Policy and procedure at MCJ are generic corporate policies which have little specific direction for staff at MCJ. Important policies are listed below with comments.

1. *Daily Triage of Complaints* This policy does not include directions on how nurses document their reasoning in triaging of health requests. The nurse is only required to date the day they triaged the slip. I could not find consistent documentation of why nurses did what they did with respect to triaging. Tracking of health requests is not required by policy but should be. Performance of vital signs for symptomatic requests is not required but should be. There is no direction on what is to be done with dental or mental health requests. The clinical requirements for when a nurse is to use a nursing protocol are not specified. It appears that nursing management of health requests is not standardized but it should be.
2. *Emergency Services* This policy on how nurses respond to emergencies does not address when a nurse is required to consult a physician. On multiple occasions in chart reviews, nurses did not consistently consult with a physician during emergency evaluations.

3. *Privacy of Care* MCJ does not have a policy on privacy of care. This should be done. Correctional officer health screening is not governed by policy with respect to privacy.
4. *Tuberculosis Screening* This policy should be re-written to be consistent with recommendations from the Centers for Disease Control and Prevention². The MCJ policy requires symptom screening for tuberculosis at the 14 day health inventory. 14 day symptom screening is not recommended; symptom screening should be performed by health care personnel immediately upon arrival in the facility. In practice, officers perform this function upon arrival but it is not governed by policy. CDC does not recommend officer screening except for small jails. MCJ is not a small jail. The MCJ policy recommends tuberculin skin testing at 14 days. The CDC recommends 7 days. The MCJ policy does not include isolation procedures for persons with positive symptoms. The MCJ policy does not specify a time frame for completion of a chest x-ray after identification of a positive tuberculin skin test. This should be completed within 72 hours. Persons with positive chest x-rays should be placed immediately in isolation or transferred to a hospital. This is not addressed in the policy.
5. *Preparation of Medication Prior to Administration* In my opinion, nurses dispense medication as they prepare for medication administration which may not be legal. The process of nurses preparing their medication should be established in procedure. Currently, there is no policy or procedure to guide nurses in preparation of medications for delivery.
6. *Medication Administration* The MCJ policy on medication administration does not reflect current practice. MCJ administers medication at 3 am, 9 am, 4 pm and 9 pm but the policy directs that medication will be administered at intervals 12 hours apart. The policy should state the times medication will be administered. A 3 am morning medication pass is likely to increase noncompliance with medication. The policy is generic and not specific for this facility. The policy does not distinguish between how medication is administered in dormitories and cells. It also does not describe the responsibilities of custody staff. When inmates are in court or miss a dose of medication, there should be guidance to nurses with respect to follow up attempts to administer the medication. The collaboration between officers and the medication nurse are not established in policy. I would recommend an interagency medication administration procedure on how medication is to be administered that includes the responsibilities of nursing to administer the medication and the responsibilities of custody to maintain a secure environment and make inmates available to nursing staff.
7. *Renewal of Medication* The MCJ addresses medication renewal in their policy titled *Discontinuation of Medication*. This policy states that nurses who administer

² Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC; Endorsed by the Advisory Council for the Elimination of Tuberculosis, the National Commission on Correctional Health Care, and the American Correctional Association; MMWR Recommendations and Reports July 7, 2006 / 55(RR09);1-44

medication will pull charts and schedule the inmate for sick call prior to the discontinuance or renewal date for the MD/DNP/PA to review. However, staff I talked to did not give a consistent response on how medication renewal occurred. The procedures described to me were not consistent with policy. The practice of medication renewal should be clearly stated in policy. That practice should ensure continuity of necessary medication.

8. *Continuation of Medications Begun Prior to Incarceration* This policy should be re-written. The policy restricts medications that should be continued after incarceration thereby creating a barrier to receiving necessary medication. This is inappropriate. All necessary medication should be continued upon incarceration. Nurses are required to verify all medications at intake which is an excellent process. However, if inmates state that they take medication but do not know the name of their medication or the pharmacy where they obtain medication, the nurses do not call a physician for a medication order. MCJ must ensure that when necessary medication can't be verified, a physician must timely evaluate the patient to ensure continuity of necessary medication. Some inmates will require medication but do not have a prescription with a local pharmacy. This policy does not ensure continuity of medication.

9. *Individualized Treatment Plans* This policy is a generic policy that does not specify how specific types of conditions will be handled at the MCJ. For example, it isn't clear how the following types of conditions are handled in terms of housing and follow up:
 - Developmentally disabled
 - Patients on dialysis
 - Elderly patients or patients with dementia
 - Patients requiring wheelchairs or who have physical disabilities
 - Housing for pregnant women
 - Housing for persons with communicable disease
 - Housing for mentally ill
 - Housing for terminally ill

The existing policy implies that treatment plans are developed ad hoc. Housing and care for the above common conditions should be established in advance.

10. *Chronic Illness* This policy is adequate with two major exceptions. One is that the policy does not ensure that necessary medication is continued during incarceration. At intake, a nurse is to verify necessary medication and continue those medications that can be verified. For medication that can't be verified at a pharmacy, the follow up with

a physician is to be at the next available sick call. In practice follow up with a provider does not consistently occur. Certain medication must not be stopped. Even when verification can't be accomplished there must be communication between a provider and nurse to bridge the patient with medication until the physician can see the patient. Necessary medication should be continued within 24 hours regardless of whether it can be verified or not.

A second problem is with the application of this policy with respect to the time intervals of visits. The policy establishes that patients are seen every 90 days or at the discretion of the provider. Patients should be seen as frequently as indicated based on the status and degree of control of their illness. Patients with uncontrolled diabetes, hypertension, or asthma, for example, should be seen earlier than every 90 days. This is particularly true early in the course of incarceration. In practice, even the 90 day visits are not consistently occurring. Chronic care visits do not appear to be occurring as recommended.

11. *OHU Care* This is the highest level of acuity housing at MCJ. The policy allows this unit to be managed entirely by nursing by virtue of physician delegation of admission and discharge responsibilities to a physician designee, which can be a nurse. With the exception of nursing observation for a shift, all admissions and discharges should be the responsibility of a physician. Physicians should perform a history and physical examination for all admissions and discharges. Also, physicians should examine patients as frequently as indicated based on their conditions but at a minimum no less than every 2 weeks for regular admissions and no less than every 3 months for borders. Physicians are required to make daily rounds on this unit by policy. There is no requirement of documentation of these rounds. Therefore, this effort can't be verified and may not occur. Requirements for physician documentation should be included in the policy. The procedure does not state how often vital signs are to be taken by nurses. The procedure states, "Vital signs shall be taken and recorded as follows". However, nothing follows this statement and it is not clear what the vital sign intervals are supposed to be.

12. *Care of the Pregnant Female* The policy on *Reproductive Services* is mostly adequate but does not address housing, diet or timing of the first provider visit after identification of pregnant status at intake. Although, the policy does state that an appointment with an obstetrician will be made, the timing of the appointment with an MCJ provider and with an outside obstetrician should be stated. Also, housing and diet is not described in the policy. This should be done. The policy does not address whether pre-natal vitamins are to be given; this should be done. The policy does address treatment of the opiate addicted pregnant female but time frames for evaluation are not clear. Symptoms of opiate withdrawal can occur as soon as 6 hours after cessation of using opiates. Therefore, nurses should contact physicians during the intake process for directions on withdrawal procedures. The existing policy states that

patients will be seen at the next sick call. In practice, based on review of records, the next sick call may be an extended period of time.

13. *Health Records* The policy on health records is extremely brief and generic. It states that health records are to be secure and that access is limited to health personnel. However, the current practices of transportation of charts to clinics and how current staff takes medical records from medical record shelves are not consistent with a secure medical record environment. The existing practices should be described with respect to security of the record.
14. *Intake Health Screening* The current policy does not provide for accurate or appropriate medical intake screening and therefore does not protect incoming detainees from harm. The responsibilities placed upon correctional officers in this policy are well beyond their ability to perform. Officer screening is also complicated because for many conditions, inmates will be reluctant to reveal their status to a correctional officer. This is particularly true for substance abuse issues. Detainees who have not yet had a Court hearing will be reluctant to reveal illegal activities to a sworn criminal justice officer. More importantly, officers have no training for this function. For a jail of this size, intake screening should be performed by nurses. The current policy does not include the responsibilities of nurses with respect to intake screening. The policy also does not include where intake screening is to occur, how privacy is ensured, the timeliness of initiation of necessary medication and other therapies, timeliness of physician evaluation of detainees with illness, and protection of detainees with disabilities or other conditions from harm with respect to housing or need for urgent treatment.
15. *Chemically Dependent Inmates* This policy and procedure permits nurses as well as physicians or mid-level providers to diagnose chemical dependency. This is inappropriate. All patients identified as chemically dependent and thereby placed in detoxification should be diagnosed by a physician or mid-level provider. In practice, nurses use a poorly written detoxification protocol which is inconsistently followed. This has the appearance, based on chart reviews, of nurses making up rules as they go along.
16. *Alcohol Intoxification and Detoxification (Sobering Cells)* This policy does not specify who is responsible for placement of detainees in sobering cells and initiating detoxification. In practice officers do this which is not clinically appropriate as this assumes a diagnosis which physicians or mid-level providers should make. The policy and procedure is vague with respect to nursing and physician responsibilities in this process. This should be clarified. RNs may be permitted to initiate this process but this should be under physician supervision by virtue of consultation. All persons in detoxification should be examined by a physician as soon as possible after placement in a sobering cell for detoxification.

17. *Sobering Cells-Custody's Role* This medical policy directs officers to house persons in sobering cells deemed by custody to be intoxicated on alcohol or other drugs or a threat to themselves or others. In practice, officers place detainees in sobering cells and in isolation cells. Based on chart reviews officers appear to have placed a person in isolation who was undergoing alcohol withdrawal. Placement in these cells should be a medical responsibility and include a medical evaluation and physician consultation prior to initiating placement in the cell.
18. *Clinic space, equipment, and supplies* There is currently no policy addressing provision of adequate clinic space, equipment or supplies. There are also no procedures for cleaning of clinical space. There were significant deficiencies in this area and procedures should be developed.
19. *Segregation* All detainees placed in isolation or segregation must have access to care normally afforded to other detainees. Because there is no access to placement of a health request while a detainee is in segregation, there must be a way to address new health complaints. In addition, placement in segregation or isolation may be detrimental to certain types of detainees, particularly those with mental illness or significant medical illnesses. For that reason, there is typically a medical review of detainees entering segregation by medical staff to ensure that it is safe to segregate a detainee. Officers control placement of individuals in sobering cells for intoxication and withdrawal and also place individuals in isolation cells when they have a concern that a detainee may be at risk for harm to himself or others. This is a dangerous practice. The current policy does not describe use of isolation or segregation for medical purposes. This should be done. The current policy also does not include a medical or particularly mental health screening prior to placement in isolation. The policy states that nurses document all segregation contacts in the patient's medical record. This is not the current practice. The policy should state how detainees in segregation have access to the existing health request process.

Medical Reception

Methodology: I toured the intake area, interviewed facility health care leadership and reviewed health records.

Findings: I was told that on average, 963 detainees were booked per month at the MCJ in the prior year. This is approximately 11,500 bookings a year or about 31 detainees a day. Correctional officers perform medical screening for detainees incarcerated in the MCJ. While this may be appropriate for a very small jail where health care staff is not present at the jail on a continuous basis, it is not appropriate for a jail of 1200 individuals, the approximate size of the MCJ.

Officers are not trained health professionals. They are not trained to perform medical assessments or perform medical evaluations. As a result, there is a higher likelihood that officers will miss medical conditions of incoming inmates. By policy³, officers are expected to be able to identify persons who have recently had convulsions, have signs of head injury, have any type of serious injury or illness, display signs of alcohol or drug withdrawal, or have symptoms of internal bleeding. They are not trained to do this. On chart review, I notice several examples of individuals with identified disease at the MCJ missed by officers during screening.

It appears that chronic illnesses are significantly under-identified at MCJ. Based on review of medication records, I identified that over the prior 3 months there were only 23 prescriptions for either a steroid or beta agonist inhaler for asthma. Even if all of these individuals remained in the jail until the time of my visit, this would yield a prevalence of asthma of only 2 %. 62 (5.5%) individuals were on medication for high blood pressure. 26 (2.3%) individuals were on medication for high blood lipids. 22 (1.9%) individuals were on medication for diabetes. Only 18 (1.5%) other individuals were on medication for chronic illness. Some of these individuals were on more than 1 medication. If they are all counted individually, there were only 13% of individuals on medication for chronic illness. This number is significantly below the expected numbers of individuals who should have chronic illness.

In 2002, the National Commission on Correctional Health Care (NCCHC) prepared a report⁴ to Congress on estimated prevalence of various illnesses in correctional populations. The NCCHC estimated that 8-9% of inmates had asthma, 5% had diabetes, and more than 18% had hypertension. The California Diabetes Program⁵ reported that 8.1% of adults in Monterey County have diabetes. Since the MCJ probably has a younger population their prevalence is likely to be less than 8.1%. The Centers for Disease Control and Prevention⁶ reported that the unadjusted prevalence of hypertension amongst United States adults was 31%.

The prevalence, particularly of asthma and hypertension are significantly below correctional estimated prevalence and below California and national prevalence rates. In my experience, more than 20% of a correctional population will typically have a chronic illness. At MCJ only 13% of individuals are on medication for a chronic illness, well below expectations and below estimated prevalence in a correctional population. In my opinion, this is in part due to officer screening and missing patients by virtue of inadequate history. In part, individuals with identified chronic illness are not being treated for their conditions with medications. This will be shown in chart reviews.

³ Pre-Detention Medical Evaluation/Intake Health Screening, California Forensic Medical Group, INC. Policy and Procedure Manual, Monterey County Adult Detention Facility

⁴ The Health Status of Soon-To-Be-Released Inmates; A Report to Congress, Volume 1; National Commission on Correctional Health Care, March 2002.

⁵ Diabetes in California Counties; California Department of Public Health & University of California, San Francisco; April 2009

⁶ Control of Hypertension Among Adults – National Health and Nutrition Examination Survey, United States, 2005-2008; Morbidity and Mortality Weekly Report (MMWR) *Supplements* June 15, 2012 / 61 (02); 19-25

The Director of Nursing estimated that about 3 detainees a day will have chronic illness identified at intake screening. This is an extremely low number of inmates identified with chronic illness. It was not possible to verify the exact numbers of evaluations performed by nurses in intake on a daily basis as no statistics on this are maintained. The Monthly Workload Statistics includes all statistics maintained by the health program. However, this does not include the numbers of detainees evaluated in intake by medical staff for chronic illness.

In my opinion, intake is therefore a deficient process in which incoming inmates with chronic illness are either not identified or are not adequately treated.

Tuberculosis screening is also an integral part of intake screening. This is done to prevent individuals with tuberculosis from infecting other detainees. Because of congregate living arrangements, tuberculosis is a substantial health concern in correctional centers and outbreaks are common in correctional centers.⁷ The Centers for Disease Control (CDC) and Prevention⁸ recommends symptom screening immediately upon booking. If screening identifies positive symptoms, the individual is to be placed in isolation until tuberculosis can be ruled out. The CDC recommends that health care professionals perform initial screening. They do acknowledge that officers will sometimes perform screening in detention centers housing minimal numbers of inmates. MCJ does not house minimal numbers of inmates; over 1100 detainees are housed in MCJ. Nurses should perform symptom screening.

Also, if tuberculin skin testing is used, the CDC recommends placement of the tuberculin skin test within 7 days of entry into the facility. If positive, they recommend a chest x-ray within 72 hours of the positive skin test.

The MCJ screening consists of officer performed symptom screening at intake with a tuberculin skin test performed at day 14 of incarceration. Officer screening and follow up of persons with symptoms identified by officers is not governed by policy. Follow up x-rays did not appear to be done within 72 hours of a positive test. Policy on tuberculosis screening does not specify a timeline for follow up chest x-ray. Isolation procedures are also not present in the policy.

I was told that approximately 963 inmates are incarcerated per month. Based on the Monthly Workload Statistics 2013, for the first 9 months of 2013, 249 persons received a tuberculin skin test to screen for tuberculosis. Thus, only 26% of incoming detainees were screened. This may be due to incomplete screening combined with detainees leaving jail before the 14 day skin test can be done. In any case, the majority of inmates are not screened. This places other inmates exposed to these individuals at risk for exposure to tuberculosis. MCJ does not keep statistics to verify that all detainees are screened for tuberculosis.

⁷ Tuberculosis Transmission in Multiple Correctional Facilities--- Kansas, 2002-2003; MMWR August 20, 2004 / 53(32); 734-738

⁸ Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC Endorsed by the Advisory Council for the Elimination of Tuberculosis, the National Commission on Correctional Health Care, and the American Correctional Association; MMWR July 7, 2006 / 55(RR09); 1-44

Infection Control activity, including tuberculosis surveillance, is managed by the Director of Nursing. However few statistics are maintained. Nursing maintains a tuberculin skin test (PPD) log. This log contains a sheet for every day. On each sheet are the PPD tests which were applied for that day. In a column to the right of each patient listed is the reading for that skin test. Mostly, positive results are recorded in millimeters but sometimes nurses record the test as positive. All skin test results should be recorded in millimeters of positivity. Many patient entries have a notation stating "PPD not given". For example, on 10/17/13, nine individuals are listed. Seven of these had documentation "PPD not given". One was listed as 0. Another was listed as being discharged. The meaning of "PPD not given" is not clear and is not stated in policy.

If all the patients on this list in the PPD log book for September 2013 are counted the number equals 213. However, ten patients were either noted to be discharged or documented as not having received a PPD. So the actual number of persons who received a TB skin test was 203. However, the number of patients listed who received TB screening in September on the Monthly Workload Statistics 2013 is 239. I could not reconcile this discrepancy with leadership staff.

With respect to results of testing, for September 2013, there were nineteen positive skin test results noted in the TB log of which two were positive by history. Using the number of tests performed in the log for September as a denominator and the number positive in September as the numerator, the prevalence of skin test positivity at the jail is nine percent.

I reviewed five patients who had significantly abnormal PPD tests to assess follow up procedures. All of these charts demonstrate a deficient tuberculosis screening process. In one chart reviewed, it appears that the patient may have acquired tuberculosis at the jail. Other chart reviews showed delayed screening, delayed follow up chest x-rays, failure to isolate and immediately evaluate a patient with symptoms of tuberculosis, and ineffective tuberculosis screening. These chart reviews are at the end of this report.

The tuberculosis screening program should be re-evaluated with respect to CDC guidelines and current process deficiencies.

Drug and Alcohol Withdrawal Screening at Intake

Findings: Officers perform intake medical screening to identify those who might be at risk for alcohol or other withdrawal syndromes. Also, it appears that officers are responsible for making decisions with respect to isolating detainees for alcohol withdrawal or intoxication (sobering cells) or for placement of detainees in isolation who might be a danger to themselves or others (isolation cells).⁹ Policies on this matter do not clearly state who is responsible for placement of detainees in isolation or in sobering cells. In practice, while nurses evaluate detainees once officers place detainees in these cells, officers are responsible for assigning

⁹ Sobering Cells- Custody's Role; Monterey County Adult Detention Facility Policy and Procedure

detainees to these cells. Officers are not trained to identify persons at risk for withdrawal, to evaluate persons who appear to be intoxicated, or to make medical decisions with respect to isolation for this purpose. This should be done by medical professionals not custody officers. This places detainees at risk for harm. Smell of alcohol can be confused with diabetic ketoacidosis. The altered mental status of alcoholism or drug withdrawal can mask serious injury or other medical conditions.

The intake screening procedure¹⁰ requires that officers who identify detainees displaying alcohol or other withdrawal symptoms are to immediately refer these detainees for medical evaluation. However, the requirements of medical staff are not documented in the intake procedures. Other procedures on alcohol intoxication¹¹ and alcohol withdrawal are vague. The responsible party for placement in a sobering cell is not named. The role of physicians in this policy is not clear. The policy appears to allow nurses to manage withdrawal by virtue of using a protocol which, in practice, is not strictly followed. The policy requires nurses consult with a physician for any one of 8 abnormal signs. Based on chart reviews, it does not appear that this is happening. I was told that all persons at risk of withdrawal see a physician within 24 hours of incarceration during week days. Based on chart reviews, I could not see evidence that this is occurring. As a result, alcohol and other drug withdrawal syndromes are managed by officers and nurses without physician supervision.

The policy on Alcohol Intoxification and Detoxification includes an Alcohol Withdrawal Scale (AWS) Flow Sheet. The policy implies that this flow sheet is the CIWA –revised assessment form. It is not. The Clinical Institute Withdrawal Assessment for alcohol scale revised (CIWA-Ar)¹² is a 10-item scale for clinical assessment of alcohol withdrawal. This scale was validated and found reliable in the format originally used. CFMG INC modified this scale so that its items and scoring are not similar to the validated scale. The reliability of the CFMG scale is unknown. Risk factors and treatment protocols in the CFMG procedure are not consistent with contemporary standards¹³ for outpatient alcohol detoxification. When nurses evaluate detainees in sobering cells, the AWS Flow Sheet is sometimes used and sometimes not used. When used, the form is not always completed. The use of an un-validated form by nurses, who incompletely follow policy, and perform without proper physician oversight results in nurses managing withdrawal in a serendipitous fashion based on individual nurse practice rather than a clinically based consistent practice.

Detoxification procedures at MCJ should be reviewed, policy should be clarified and practice should be strengthened so that detainees who are intoxicated and withdrawing from alcohol or other substances are protected and appropriately managed.

¹⁰ Pre-Detention Medical Evaluation/Intake Health Screening; Monterey County Adult Detention Facility Policy and Procedure

¹¹ Alcohol Intoxification and Detoxification (Sobering Cells); Monterey County Adult Detention Facility Policy and Procedure

¹² Sullivan JT, Sykora K, Schneiderman J, et al; Assessment of Alcohol Withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar); BJA (1989) 84, 1353-1357

¹³ Volpicelli JR, Teitelbaum SA, Ambulatory alcohol detoxification, in UpToDate at www.uptodate.com, an online clinical textbook

Several examples of problems with this process are provided in chart reviews at the end of this report.

Access to Care

Methodology: To evaluate access to care, I toured clinical areas to review how inmates can place health requests. I interviewed health care leadership and reviewed the process of evaluation of health requests. I also performed chart reviews.

Nursing Sick Call and Triage

Findings: The health request process is a fundamental way that detainees gain access to medical care. I toured the jail and in almost all areas, secure boxes were available for detainees to place a request for medical care. Some boxes are located outside of detainee housing units in the hall; these should be moved inside the housing unit. All boxes have dual purposes. Detainees used these boxes for both grievances and health requests. As a result, officers handle all requests which should be confidentially placed and handled only by medical staff. Separate boxes should be used for medical requests. The boxes should continue to be secure but should be managed by health care staff.

On one of the days of my tour I counted 37 health requests placed on a single day. This amounts to about 3% of the inmates placing requests on a daily basis. 7 of the 37 requests were written on small pieces of paper. There appear to be insufficient paper request forms in all housing areas. This can be easily corrected.

Policy¹⁴ on handling health requests is extremely brief and does not address how nurses are to manage health requests. As a result, it appears, based on chart reviews, that nurses develop individual practices for addressing complaints. All nurses do appear to document the date of triaging in the upper left corner of the health request. The signature of the staff and disposition, as required by policy, are not done. Typically nurses place initials on the form but no disposition is provided on health requests in charts I reviewed.

Timeframes for evaluation of health requests are not included in policy. Health requests should be triaged within 24 hours. In practice, health requests are inconsistently triaged within 24 hours. Vital signs should be performed for all symptomatic complaints. There is no policy requirement for this and in practice vital signs are seldom performed for symptomatic complaints. I attribute these deficiencies to nurse staffing issues. In addition, nurses evaluate detainees in settings that do not have an examination table, sufficient space, equipment or lighting that characterize appropriate clinical examination settings. Few health requests that I reviewed actually included a documented nurse evaluation and assessment. This is consistent with inadequate staff performing evaluations in inappropriate space.

¹⁴ Daily Triaging of Complaints; Monterey County Adult Detention Policy and Procedure Manual

Some requests are requests for medication. Because of a defective chronic illness program, detainees use the health request process to seek medication, medication renewal, or chronic illness evaluation. These requests are not channeled into a chronic disease management process.

I was provided with a large number of standardized nursing procedures which ostensibly are used by nurses in their evaluation of health requests. Because of the brevity of documented nurse evaluations in evaluation of health requests, it was clear that these protocols were not consistently used during nurse evaluations of detainee complaints. Nurse protocols should not include independent diagnosis and treatment of detainees. The protocols give wide latitude to nurses. In practice, physician oversight is not consistently evident.

On one of the days of my tour, I was told that there were 207 detainees in segregation; 164 males in the main jail and 43 females. There is no policy to address how detainees in segregation have access to the health request process. Typically, the correctional standard¹⁵ is that when detainees are segregated health staff monitors their health. Detainees in MCJ segregation are not evaluated by health staff and it is not clear how they have access to care. Policy¹⁶ describes that nurses conduct rounds on a limited number of isolation cells 3 days a week, observe, and speak with all inmates in isolation. However, all detainees in segregation should be observed and assessed 3 times a week as well. This observation can be recorded on a log in the segregation unit.

Health Care Appointment Scheduling

Findings: Follow up of health requests was not consistently timely based on chart reviews. I did not review health care appointment scheduling. However, the numbers of people who place a medical request are not tracked. So the medical program has no information on how many people place requests, how many are seen, or whether their care was timely. I was told that all medical health requests are seen during daytime hours. Evening nurses only address emergencies. During the day shift the doctor sees all emergencies. Without tracking health requests and the timeliness of review and evaluation the health program is unable to evaluate its own performance with respect to detainee access to care.

Chronic Disease Management

Methodology: I interviewed facility health care leadership and staff involved in management of chronic disease patients and reviewed medical records of patients with chronic illness.

Findings: The MCJ does not have a roster of persons with chronic illness. As previously stated in this report, I estimated the numbers of persons with chronic illness by identifying detainees on medication for chronic illness. The numbers of chronic illness patients was low based on estimated chronic disease prevalence rates previously cited. The low numbers of chronic illness

¹⁵ Segregated Inmates; Standard J-E-09, Standards for Health Services in Jails, National Commission on Correctional Health Care 2003

¹⁶ Inmates in Isolation; Monterey County Detention Facility Policy and Procedure Manual

patients is most likely, in part, due to officer screening as opposed to medical professional screening. In part, patients appear to not be treated for their chronic diseases even when identified.

I was told that all newly incarcerated detainees who are identified with a chronic illness are to be evaluated within 24 hours by a physician 5 days a week. For Friday and Saturday newly arrived inmates with chronic illness are evaluated by on-call physicians with a Monday morning physician visit. This is consistent with the policy¹⁷ on chronic care. In practice, based on chart review, this does not typically occur.

By policy, all patients with chronic illness are to be scheduled every 90 days, but this is not consistently documented in the medical records. The PA actually re-schedules chronic illness patients for "as needed" (PRN) appointments and does not create a follow up chronic illness visit for them.

There is a significant difference in the quality between the mid-level provider and the physician with respect to chronic illness evaluation and follow up. If the mid-level provider continues to evaluate patients with chronic illness, additional physician supervision should be put into place. Based on chart reviews, the mid-level provider evaluated most detainees with chronic illness. Because of this, care was inconsistent and the quality could significantly improve.

Most notably, several patients in chart reviews were not treated for their chronic medical conditions. This was particularly evident for persons with asthma and hypertension. It is critical that patients who have chronic illness have continuity of medication from the community to the jail. At the MCJ if a detainee does not remember the name of his medication or if the health staff can not verify a prescription of medication at a local pharmacy, no medication is provided even when medication is medically necessary. MCJ has a responsibility to treat persons with chronic illness with necessary medication. When the patient does not have health coverage in the community, medical providers must evaluate detainees and provide necessary medication for their chronic illness. This is not occurring at MCJ. This will be evident in chart reviews. Based on chart reviews, it appears that MCJ is systematically denying necessary medication to patients with chronic disease. This is especially true for medication for asthma.

Vital signs are not consistently recorded for chronic illness evaluations. This is required by policy and is consistent with good practice.

There is no infection control program at MCJ. Tracking of methicillin resistant staphylococcus aureus (MRSA) is not done even though this is a major problem in correctional centers.¹⁸ Tracking of tuberculosis screening is not performed. The medical program therefore is unaware

¹⁷ Chronic Care; Monterey County Adult Detention Facility Policy and Procedure Manual

¹⁸ Methicillin-Resistant Staphylococcus aureus Infections in Correctional Facilities--- Georgia, California, and Texas, 2001-2003; MMWR October 17, 2003 / 52(41); 992-996

of whether it has a problem in these areas or whether their existing programs are successful in managing these conditions in the jail. Both tuberculosis and MRSA can spread to employees and from there to the community. MCJ should take advantage of the local health department to develop appropriate surveillance programs for tuberculosis and MRSA to ensure that care is appropriately delivered and that outbreaks are not affecting the jail population. The Centers for Disease Control has an excellent guideline for tuberculosis screening for correctional facilities and MRSA guidelines for corrections can be crafted using Federal Bureau of Prison guidelines.¹⁹ I would recommend that the local health department review surveillance procedures and tracking at the jail and make recommendations based on local conditions.

Pharmacy and Medication Administration

Methodology: I interviewed the nurse who administers medication during the day shift, toured the medication room, observed medication administration, and reviewed medication administration records.

Medication Room

Findings: I was told by staff that the medication room is open 24 hours a day. Medication rooms should be secured by a locked door with access available to those nursing staff or pharmacy staff authorized to enter the room. Also, within the medication room is a locked narcotic cabinet. Because the medication room door is not secure, the narcotic cabinet is not within a double locked arrangement. This should be corrected.

Medication Administration

Findings: Stock medication is used for almost all medications delivered to detainees. Nurses used the medication administration record as verification of a prescription, remove medication from stock medication bottles, and re-package the medication in an envelope with the patient's name, medication name, and directions hand written on the envelope. In my opinion, this constitutes dispensing which may not be legal for nurses to perform and, in any case, is not good practice.

The actual practice of the re-packaging included the nurse removing the cover of a stock medication bottle; pouring a number of pills into the medication container cover; and with a gloved hand removing pills one by one and placing them into patient specific labeled envelopes. This is also not hygienic as individual pills should not be handled directly.

Medication administration records are not used to record administration of medication at the time medication is administered. Instead, the nurse takes the individual labeled envelopes to the housing units to administer medication. Recording medication administration is performed at a later time by virtue of evaluating the envelopes after return to the medication room which may be a few hours after starting medication administration. The nurse records an empty envelope as a successful medication administration. Envelopes which still contain medication

¹⁹ Management of Methicillin-Resistant *Staphylococcus Aureus* (MRSA) Infections; Federal Bureau of Prisons, Clinical Practice Guidelines, April 2012 found at <http://www.bop.gov/news/PDFs/mrsa.pdf>

are recorded as not given. The reason for not administering medication is recollected from memory. This is not good nursing practice. Medication administration should be documented at the time it is performed.

Some medications are not included on the medication administration record. All asthma inhalers are intentionally excluded from the medication administration record. Asthma medications are tracked on a "controlled substance count sheet". It was not clear when patients with asthma received inhalers and it is my opinion that there is a significant barrier to receiving medication for asthma. Medications used for detoxification did not appear to be recorded on a medication administration record and it was not clear where they are recorded as given. Insulin is also not documented on the medication administration record. All medications prescribed by providers should be included on the medication administration record so that there is a unified record of a patient's medication. This is a patient safety issue.

Medications are administered at hours that promote non adherence. Medications are administered at 3 am, 9 am, 3 pm, and midnight. The main morning medication pass is at 3 am. I reviewed a patient record in which on the same day the patient was said to refuse his morning medication but took the afternoon medication. When observing a medication administration, I witnessed a detainee explain that he had difficulty getting up at 3 am for the morning pass. The health program should study the time frames of medication administration and re-adjust so that compliance can be improved. It may make sense to make the main administration at 9 am. Also, when medication administration failed either because the detainee did not get up or was at court, I did not see evidence of making a second attempt at a later medication administration time to pass the medication. In one chart reviewed, the patient did not take 3 am medication but took medication at 3 pm. However, the nurse did not make an attempt to pass the missed morning medication.

Laboratory/Radiology

Methodology: I interviewed the Program Manager

Findings: Laboratory and radiology services are provided by contracted services. These services appear to be working well.

Health Records

Methodology: I toured the health records unit, interviewed the medical records supervisor and reviewed many charts.

Findings: The medical records supervisor is not licensed. However, it is clear that she works very hard to accurately file and make available medical records to clinicians. Charts I reviewed were orderly. Paperwork appeared to consistently be in the correct location. I commend staff for their work in a challenging environment.

The medical records unit is extremely small. There is almost no space in which to do the work of filing paper into charts and counter space is inadequate for this purpose.

The medical records room is open 24/7 and all staff has access to records. Because all custody and civilian staff have access to the medical area, medical records are not secure. At night and even during the day, any staff member can remove a medical record. There was no evident procedure for signing out a record and establishing security of the medical record which is a fundamental element of maintaining a medical record. Medical leadership may want to consult with a licensed medical records consultant to re-design the program so that records remain secure at the jail.

I was told that the medical program is intending to purchase an electronic medical record. This will be a significant improvement.

Night time clerical staff obtains a list of next day clinics and pull records to have them available for the next day. I was not able to review clinics in operation in all areas. However, when nursing staff go to the nursing clinic to evaluate health requests they should have the medical record with them when they evaluate the patient. I was not confident that this occurs. All evaluations should take place accompanied by a medical record. This is not established in policy²⁰ and does not appear to occur in some clinical settings such as isolation room evaluations.

Pregnancy Care

Findings: Policy on care of the pregnant woman is part of the policy on reproductive services²¹. That policy should include diet and housing recommendations as well as the timing of first visits to the onsite provider and offsite obstetrician.

All pregnant women are managed by a local obstetrical service. Based on review of records, care appears appropriate. A copy of the obstetrician's evaluation should be maintained onsite in the detainee's medical record. In the event the detainee has a complication, it is important that the onsite provider is aware what the complication may be.

Urgent/Emergent Care

Methodology: I reviewed charts of detainees who were hospitalized and assessed the emergency response

Findings: MCJ has an arrangement with a medical center which is a few blocks away from the jail. This is an excellent arrangement. Access to that medical center was good. I did not identify problems in the transportation of inmates for offsite visits.

Nurses respond to most onsite emergencies. Their practices are not always consistent. Documentation is not consistently on the emergency response form. Communication with a physician or mid-level provider is not consistent. It appears that nurses, at times, make their

²⁰ Health Records; Monterey County Adult Detention Policy and Procedure Manual

²¹ Reproductive Services; Monterey County Adult Detention Policy and Procedure Manual

own decisions with respect to emergency referral. This is appropriate if it results in a nurse sending a patient to a hospital for evaluation without calling the on-call provider. Although, this is not cost effective, it is safe for the detainee. However, when a detainee has an urgent problem and the nurse sends the detainee back to housing without consulting a provider, the detainee may be placed at risk. This was evident in several charts reviewed. MCJ should evaluate this process to ensure that procedures and practices are appropriate.

When detainees are hospitalized, there is no established procedure for what is to occur when they return from the hospital. All detainees who go offsite for specialty appointments or for hospitalization should be immediately evaluated by medical staff upon return from outside care to ensure that necessary therapy is initiated and follow up is scheduled as recommended. All inmates who receive specialty consultation or are hospitalized should have a follow up physician visit to review the specialty or hospital report with the patient.

Specialty Services/Consultations

Methodology: I reviewed the policies and procedures and reviewed charts.

Findings: There are no policies on referral to a specialist. The process of obtaining specialty care should be codified in policy and procedure. In practice, based on chart review, obstetrical care consultation appears to occur timely. I did not have an opportunity to review specialty care referral.

Outpatient Housing Unit (OHU) Care of Patients Needing Skilled Nursing

Methodology: I toured the OHU and reviewed a chart of a patient who had an extended stay on the unit.

Findings: There is a small OHU in the MCJ. This unit is next to the nursing station. I was not able to verify whether the unit has a call system. The unit is close to the nursing unit but from the nursing station, nurses can not see into each cell. Patient evaluations can be easily accomplished by walking a few steps onto the unit. The policy²² stipulates that detainees are to be within sight and sound. Without a call system, inmates are not within sound of a nurse and not compliant with policy. I agree with the existing policy with respect to being within sight and sound of a nurse.

By policy a nurse, mid-level provider or a physician can admit a detainee to the unit. Admission privileges should be restricted to physicians with the exception of a brief nursing observation admission. Nurses are approved to perform the admission history and physical examination. These should be performed by a physician.

I was unable to review charts of detainees admitted to the unit as medical admissions. So, I don't have an opinion of the quality of care. I did review a detainee admitted on sheltered

²² Outpatient Housing Unit; Monterey County Detention Facility Policy and Procedure Manual

living status. His care was not good and he appeared to be ignored. I recommend that the medical program review his care and ensure that all detainees on the unit have access to needed medical care.

Internal Monitoring and Quality Improvement Activities

Methodology: I reviewed policy and procedure.

Findings: There is a policy and procedure on Quality Management²³. The Medical Director and Program Manager are responsible for quality management activity at the MCJ. Given the time constraints of administrative leadership, as well as their additional assignments at other facilities, it is hard to imagine that they have time for quality management work. The policy requires both an internal and external peer review. I did not have an opportunity to review these. This is a good practice when well done.

The Quality Management Committee by policy is to meet quarterly to discuss service delivery issues at the jail. I did not have an opportunity to review those minutes. After the tour, I did ask for these minutes but did not receive them. The Quality Management Committee is the vehicle to correct deficiencies in practice at this facility. Meeting minutes are the evidence of performance in this area.

Recommendations

Organizational Structure

1. MCJ leadership should dedicate full time to MCJ jail.
2. For purposes of clinical care, and especially for purposes of nursing protocols, the Director of Nursing should clinically report to the Medical Director.

Staffing

3. The medical program should review staffing requirements. Staffing should be based on revisions of policy. The medical program should establish adequate staffing in order to perform assignments required by policy.
4. Staffing levels should include a relief factor.
5. Custody should evaluate their staffing with respect to ensuring adequate staffing to transport inmates for scheduled medical appointments, collaborating with nursing on medication administration, and securing the medical environment for required services.

Operations: Equipment, Space, Supplies, Scheduling, Sanitation, Health

6. All clinical evaluations should be performed in a clinical setting.
7. All clinical examination space should be of adequate size, properly equipped and supplied, lighted, and sanitized at a community health care standard. I recommend using the Veterans Administration guidelines as a benchmark as found at <http://www.cfm.va.gov/til/dGuide.asp>.

²³ Quality Management Program; Monterey County Detention Facility Policy and Procedure Manual

8. A medical intake area should be configured so that nursing personnel can perform adequate physical assessments in a private and secure environment.
9. Each of the 3 separate parts of the jail should have an adequate clinic examination room with a waiting area and a small space for equipment and supplies.
10. The Sheriff should consider creating a new health care clinic of adequate space and design in the new jail construction.

Records, Laboratory, Radiology

11. I recommend using a licensed medical records consultant to establish procedures for ensuring security of paper medical records. This should include sign out of records, establishing rules for who is permitted to handle and access the medical records room, and procedures for ensuring confidentiality of the medical record.
12. Medical records should obtain all provider notes for specialty care visits and complete discharge summaries from all hospital visits, including emergency room encounters. These should be reviewed by a physician, signed as reviewed and placed into the medical record.

Policies and Procedures

13. Policies and procedures should be revised to apply specifically to the MCJ.

Intake

14. Nurses should replace officers in performing medical intake screening.
15. All inmates booked into the jail should have vital signs performed by a nurse. Persons with diabetes should also have a capillary blood glucose test. All persons with asthma should have a peak expiratory flow rate. All persons with emphysema should have a pulse oximeter for oxygen saturation.
16. Appropriate nurse intake screening should result in physical examination by a physician of all those identified by a nurse with a chronic or current medical problem. The timeliness of the physician evaluation should be governed by an acuity scale pegged to the severity of the patient's illness.
17. Medical staff should be responsible for initial evaluations and placement of persons into sobering cells, detoxification cells, and medical isolation.
18. The medical program may consider ways to identify blood alcohol levels of suspected intoxicated individuals.
19. The sobering cell should be sanitized appropriately.
20. Detoxification procedures should be revised. Alcohol procedures should be separated from opioid withdrawal procedures. Benzodiazepam procedures should be included if these are common in the community.
21. The alcohol detoxification procedure should include proper use of a CIWA scale.
22. Physicians should be involved as early as possible in evaluation of all detoxifying inmates.
23. Medical isolation and detoxification processes should be revised so that appropriate medical evaluation in a clinical setting can occur for persons undergoing withdrawal. In-cell evaluations should be prohibited.
24. Medical intake screening should take place in an appropriate clinical setting that ensures privacy and appropriate medical screening.

25. Tuberculosis screening should follow Center for Disease Control guidelines which have already been cited.

Access to Care: Nursing Sick Call

26. Documentation procedures for triaging and nurse sick call should be standardized.
27. All health requests with a symptom should include nursing vital signs.
28. All health requests should be tracked so that the health program can internally monitor their performance. Tracking should include date of submission, date of triage, date of nurse evaluation, disposition, and date of provider follow up if indicated.
29. All health requests with a symptom should include a nurse or provider face to face evaluation within 72 hours. Health requests of an urgent nature (e.g. chest pain) should be evaluated the same day. If the PA evaluates health requests, the timelines of evaluation should be the same as if a nurse were performing the assignment.
30. Sufficient health request slips should be available to inmates.
31. Nursing leadership should develop requirements for nurse documentation with respect to evaluation of health requests. These should include vital signs and minimal history and assessment requirements based on the type of complaint.
32. The Director of Nursing should regularly and systematically review the quality of nurse assessments of health service requests. This should be performed for each nurse performing this assignment.

Chronic Disease Management

33. Sufficient physician staff needs to be hired to ensure adequate chronic disease management.
34. If the PA is to manage the chronic illness program, sufficient physician supervision must take place to ensure that community standard of care is provided.
35. Chronic care must be provided at a community standard consistent with national guidelines. Three examples are:
 - a. For asthma the standard should be the National Heart Lung and Blood Institute Guidelines for the Diagnosis and Management of Asthma²⁴
 - b. For hypertension the standard should be The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure²⁵
 - c. For diabetes the standard should be Diabetes Management in Correctional Institutions by the American Diabetes Association.²⁶
36. A roster of persons with chronic illness should be maintained so that adequate and timely scheduling of appointments can occur.

²⁴ Expert Panel Report3: Guidelines for the Diagnosis and Management of Asthma, Full Report 2007; National Heart, Lung and Blood Institute, National Asthma Education and Prevention Program found at: <http://www.nhlbi.nih.gov/guidelines/asthma/index.htm>

²⁵ The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure; National Institutes of Health, National Heart Lung and Blood Institutes NIH Publication No. 02-5215 September 2002 found at <http://www.nhlbi.nih.gov/guidelines/hypertension/index.htm>

²⁶ Diabetes Management in Correctional Institutions, American Diabetes Association; Diabetes Care, Vol 35, Supplement 1, January 2012 found at: http://care.diabetesjournals.org/content/35/Supplement_1/S87.full.pdf+html

37. Continuity of necessary medication for all persons with any chronic illness should be ensured. Verification of medication with a local pharmacy should be continued. However, persons whose medications can not be verified must be evaluated by a provider to ensure continuity of medication within 24 hours. Bridging medication by virtue of phone consultation with the intake nurse and a provider is acceptable.
38. Systemic barriers to obtaining necessary medication to treat chronic illness should be eliminated.
39. The medical program should consult with the Monterey County Health Department to review their surveillance of tuberculosis and Methicillin Resistant Staph Aureus (MRSA). Surveillance should include tracking logs.

Pharmacy and Medication Administration

40. The practice of nurse dispensing from stock bottles should be reviewed with a representative of the California Pharmacy Board to ensure that the practice is legal.
41. Transfer of medication from stock bottles to individual labeled containers should be standardized, hygienic, and in line with pharmacy standards for re-packaging medication.
42. Medication administration times should be adjusted so that the main medication delivery is at a time when most inmates are available to accept medication.
43. The medical program and custody should develop a standardized inter-agency procedure for medication administration.
44. Documentation of medication administration should take place at the time medication is administered.
45. All medications should be included on the medication administration record including insulin and asthma medication.
46. The current practice of prescription of asthma medication should be reviewed to ensure that all persons with asthma receive medication in accordance with community standards of care.

Urgent/Emergent Care

47. Requirements for nurse consultation with providers, including nurse documentation of provider recommendations, should be instituted. Nurses must document the contents of the consultation in the record. An alternative is to have providers document their phone consultation with a nurse on a form that can subsequently be placed in the medical record.
48. Inmates having urgent problems should be seen the day of the complaint.

Outpatient Housing Unit

49. With the exception of brief nurse observation stays, all admissions to the infirmary should be under direct physician orders.
50. Physicians should perform all history and physical examination and discharge summaries for patients on the OHU unit.
51. Care on the OHU should be monitored for quality.

Chart Reviews

Patient #1

Patient #1 was booked 8/22/13 and a custody officer performed a booking screening on 8/22/13. The officer noted that the detainee was taking high blood pressure medication and was under physician care for high blood pressure.

Later that day, a nurse performed a medical intake triage of the detainee and documented that the patient took Norvasc and a diuretic. The blood pressure was 148/108, which is high and merited treatment. The nurse did not take a history of when the patient last took medication. The nurse completed the formatted questionnaire but took no additional history. The nurse documented that she would verify medication and ordered BP checks every day for 5 days and scheduled the patient for nursing sick call on an as needed (PRN) basis. The nurse did not call a physician for a prescription and the patient did not receive medication. The results of the blood pressure checks were not filed in chronological order but were located in the progress note section. Blood pressures were all abnormal and were 146/108; 168/104; 167/104 from 8/23/13 through 8/25/13. 8/26/13 the blood pressure was 148/100. The pressure was not taken on 8/27/13. The nurse performing these evaluations didn't document any action based on the elevated blood pressure. On 3 of these days the patient complained of headache which he associated with elevated blood pressure but the nurse took no action.

At about 10:30 pm on 8/31/13 an LVN performed an assessment of the patient emergently for a blood pressure of 180/120. Aside from documenting a headache, the nurse took no history. An RN called a doctor and the nurse took a telephone order from a physician for Norvasc, enalapril and Tylenol. The patient had elevated blood pressure but did not receive an order for his usual medication for 9 days after incarceration. The process does not ensure continuity of medication for persons with chronic illness.

The patient received the first dose of medication at about 6 pm on 9/2/13 approximately ten days after incarceration. Patients should receive their usual medication within 24 hours of incarceration.

Before the patient actually received his first dose of medication, on site emergency responders evaluated the patient for elevated blood pressure, headache, blurry vision, and vomiting. A nurse described the patient as drooling. The blood pressure was 190/126. The patient was transported to a local hospital. This was probably an unnecessary hospitalization and could have been prevented if the patient had received medication timely.

A nurse saw the patient after returning from the hospital on 9/2/13 and noted his blood pressure of 162/102. The nurse documented that an appointment would be made for the physician. I could not locate a discharge summary from the hospital in the medical record so it is not clear what diagnostic testing the hospital performed.

Later the same day on 9/2/13 at 7:30 pm a nurse evaluated the patient for headache, vomiting, and light sensitivity. The blood pressure was 174/128. The nurse called a PA. The nurse gave the patient a stat dose of clonidine by protocol. This was not a typical episode of elevated high blood pressure as the patient had associated symptoms (headache, vomiting, and light sensitivity) that might have been associated with complications of hypertension or another disease (e.g. migraine). The nurse should have called a provider.

On 9/3/13 a physician evaluated the patient. Although the physician noted that the patient had intermittent migraine headaches, he did not take further history of migraines which the patient appeared to have the previous days. The physician noted that the patient went to a local hospital and had a normal CT scan of his brain and that his blood pressure was elevated (158/100). The doctor added atenolol. The doctor did not note the problem with migraines in the assessment but documented "Request that patient be brought medication for his headache". Migraine headaches are a condition for which medication should be provided to the patient. It appeared that the patient was required to provide his own medication for this condition.

The doctor saw the patient again on 9/30/13. The blood pressure was 156/93 which is elevated. The doctor did not note the compliance with medication. No heart or lung examination was performed. The September medication administration record documented that the patient received enalapril and Norvasc every day except for 9/28/12 but the atenolol was documented as not being given 9 different days. 4 of those days when medication was not given, the patient was at court. The atenolol was prescribed for a morning medication pass (at 3 am) and the other medications were ordered for the 3 pm medication pass. Nurses did not make an additional attempt to pass the missed morning medication at the 3 pm medication pass even though the patient was present at that time. The current system of preparation of medication does not include assessing missed medication and does not appear to include a 2nd attempt to pass medication if an inmate is unavailable.

A physician saw the patient on 10/15/13 for allergic rhinitis. The doctor did not evaluate the blood pressure.

On 10/19/13 a nurse documented a note stating

"CNA prepared BP of 160/110 this afternoon. Pt had denied chest pains, headache/dizziness. Will monitor BP for 24 HR Q shift."

The patient had been in the jail for almost a month. He did not receive an initial order for his medication at intake and did not receive his known medication for over a week. One nurse evaluation by a nurse exceeded scope of practice. The patient's hypertension was not controlled and there was no indication that the patient was enrolled in a chronic disease management program.

Patient #2

Patient #2 was incarcerated on 6/8/15. An officer who performed medical intake screening identified no problems. The officer checked the box asking the question "Do you have a drug or alcohol habit that could cause withdrawal problems?" as negative. Because the officer screening was negative, medical staff did not see the patient.

On 6/10/13 at 1:15pm a nurse evaluated the patient. The nurse took a history that the patient drank alcohol daily for years. This was not consistent with the custody officer screening. The nurse described the patient as "jittery". The nurse also described the patient as part of an army detoxification program. The nurse history was not thorough; the officer intake history was inaccurate. The pulse was 78, the temperature was described as afebrile, and the blood pressure was documented as 136 /90. Temperatures should be recorded as the number of degrees Fahrenheit not at "afebrile" or "normal". The nurse recommended placing the detainee in detoxification. Within an hour another nurse evaluated the patient in a sobering cell. The blood pressure was 152/79, pulse was 114 and temperature was described as "afebrile". The nurse documented that the patient was placed in a safety cell for bizarre behavior. Another nurse assessed the patient again at 4:20 pm. Blood pressure was 118/84, pulse was 80 and again the patient was described as "afebrile". The nurse noted that the patient was feeling better. The nurse approved the patient to be sent back to his cell. The nurse did not provide a CIWA score using the AWS Flow Sheet.

On 6/11/13 the patient was back in a safety cell. A nurse assessed the patient at about 2:30 am on 6/11/13. The nurse did not perform vital signs. These safety cells are not safe as they are out of site of medical providers, have no space to conduct a physical assessment, and are not located near a health care unit so that nurses do not have access to equipment to perform vital signs. The nurse documented that the patient was, "yelling that custody kidnapped and killed his sister, Pt speaking rapidly and topics are nonsensical word salad". The nurse notified a physician that custody placed the patient in a safety cell for being dangerous to himself and others. This patient was released too early from detoxification by the intake nurse. When he began developing alcohol withdrawal symptoms and early delirium tremens, he was in population and apparently sent by custody into a safety cell under assumption that he was mentally ill. The nurse performing this evaluation did not refer to the patient's medical record and notice that the patient had a significant risk for alcohol withdrawal. It couldn't be determined if the nurse evaluated the patient with a medical record.

Three hours later, at 5:45 am on 6/11/13, a nurse documented that the patient continued to be uncooperative, threatening to harm the nurse and custody staff. The nurse did not perform vital signs. Vital sign assessment should be part of any nurse assessment of a symptomatic patient.

At 12:30 pm, on 6/11/13, a nurse gave the patient haloperidol and Ativan and Cogentin based on a telephone order by a psychiatrist without documenting the conversation with the psychiatrist in the progress note. The nurse also did not document an assessment. The only

documentation in the progress note was a list of medications given. All evaluations by nurses should include an assessment. Nurses should also document the contents of the conversation with the on-call physicians and psychiatrists. It appeared that the nurse believed that the patient had mental illness.

At 6:30 pm on 6/11/13 a nurse evaluated the patient who was rambling incoherently and trying to escape out of the window of the safety cell "picking at wall and door". The pulse was 71 and the blood pressure was 114/88. Temperature was not taken. The psychiatrist gave another phone order for Ativan 2 mg as a stat dose. The Ativan was given at 8 pm. At 9 pm the nurse called the psychiatrist because the patient continued to act bizarrely by trying to escape in front of staff. The patient also had diaphoresis and tremors. The nurse did not take vital signs. The psychiatrist ordered the patient sent to a hospital. According to a nurse note, the patient returned to the jail on 6/18/13 and had severe delirium tremens, myocardial infarction, and hypertension. I could not locate a hospital discharge summary in the medical record to substantiate the nursing documentation of a heart attack. A nurse obtained a telephone order for amlodipine, a blood pressure medication on 6/18/13. A physician saw the patient on 6/19/13 the day he was discharged from the jail. The patient received one dose of this medication on 6/19/13.

Officers missed the history obtained by a nurse that would have identified this patient's risk for alcohol withdrawal. A nurse did not perform a thorough alcohol withdrawal assessment using an AWS Flow Sheet. As a result this patient had unrecognized delirium tremens for at least a day before transfer to a hospital. Whether the patient had a myocardial infarction and whether this might have been prevented can't be assessed; hospital records were not present.

Patient #3

Patient #3 was 64 years old and was incarcerated on 5/11/13. An officer performed an intake health screening questionnaire at about 8:30 am but identified no medical problems. The officer sent the patient to general population. At about 11 am on 5/11/13 a nurse evaluated the patient for chest pain. The patient had blood pressure of 180/110. The nurse sent the patient to a hospital without documentation of consultation with a physician. Whether the patient had a history of hypertension is not clear. However, if nurses performed intake screening with vital signs this detainee's problem would have been identified at intake screening.

The patient was having a stroke in progress and was transferred from Natividad Medical Center to Stanford Medical Center after TPA was administered. The patient was released from custody, apparently before he arrived at Stanford.

Less than a month later, on 6/7/13 the patient was re-incarcerated. An officer performed an intake screening at about 5 pm documenting that the patient had hypertension and had a stroke about a month previous. A nurse did not see the patient in follow up and the patient did not receive medication.

At 9 pm on 6/7/13 a nurse obtained an order to send the patient to a local hospital but there were no notes associated with this order. All medical encounters should result in a documented note in the medical record. It wasn't clear from the record that the officer identification of a medical condition resulted in a nursing evaluation.

The patient appeared to be back at the jail within a day but there was no documentation recording what happened at the hospital. Hospital discharge summaries should be available in the medical record. Upon return from a hospital, all inmates should receive an immediate medical assessment to assess for any therapeutic changes. Just after midnight on 6/8/13 a nurse at the jail evaluated the patient for chest pain. The nurse documented that the patient was short of breath and had left chest and arm pain. The patient was not diaphoretic but the nurse did not ask about any other associated symptoms. The nurse consulted a physician and documented that the patient had been at the hospital that day and "cleared". The meaning of "cleared" was not obvious. No treatment was provided. The blood pressure was 132/84. The physician should have obtained an electrocardiogram.

About an hour later on 6/8/13 at 1 am a nurse documented that a report was received from the local hospital that the patient was seen for chest pain and had a urine toxicology screen positive for methamphetamine. The nurse documented a normal electrocardiogram at the hospital.

A half hour later at 1:30 am on 6/8/13 a different nurse evaluated the patient for left sided numbness and discoloration of his hand. The blood pressure was 192/121 with a pulse of 81. The nurse documented that the patient denied pre-existing cardiac conditions despite the patient having had a prior stroke. The pulse was described as irregular. The nurse did not take a history of medications and did not note that the patient had recently been hospitalized for a stroke even though this information was on the officer's health screening. The nurse did not consult with a physician for the elevated blood pressure. The irregular heart beat should have resulted in a physician consultation and an electrocardiogram. This was an unsafe emergency nurse evaluation as the patient had a very high blood pressure, a recent stroke, and was not being provided with his medication for high blood pressure. This portrays a failed intake process. This patient should probably have been placed in observation on the OHU until a physician could examine him the following day.

On 6/8/13 a nurse documented a late entry at 4:30 am. This nurse documented a blood pressure of 171/110 and gave clonidine based on protocol. History and physical assessment were not performed. This is a dangerous protocol as used. This patient had a recent stroke, hypertension, and was not receiving his necessary medications. The nurse performed an inadequate history, little physical assessment and dispensed medication to a patient without understanding the condition of the patient except that his blood pressure was high.

On 6/8/13 at about 5 am, a nurse rechecked the blood pressure which was 167/112. No other history was taken. Although the officer's intake screening indicated hypertension this was not

noted by the nurse. The nurse did not document a call to a physician in the medical record but at 5:30 the nurse took a telephone order for aspirin, lisinopril and a diuretic. If a nurse consults with a physician, that conversation and its essential contents should be documented in the record. The nurse should also have completed a history and physical assessment for this patient.

On 6/9/13 at about 11:30 am a nurse evaluated the patient on an emergent basis documenting that the patient was lying on the floor. The nurse documented that the patient experienced dizziness and fell. Lisinopril is a medication that when first started may cause dizziness. It is recommended to start with a low dose, advise the patient about potential for dizziness and take necessary precautions. There is no evidence in the medical record that this advice was given to the patient. The nurse documented slurred speech. The pulse was 90 and the blood pressure was 115/79. The nurse consulted a physician who ordered the patient sent to a local hospital. Apparently the patient was discharged from the jail sometime after this event. During this incarceration the intake screening process failed, the patient did not receive his typical and necessary blood pressure medication, and the patient was placed at risk of harm due to failure to adequately assess and treat his hypertension. These inadequacies resulted in two hospitalizations.

The patient was incarcerated again on 9/18/13. On the officer health screening, the officer noted that the patient took medication for his heart but did not document the medication. The officer also noted that the patient had unspecified heart disease and hypertension. A nurse evaluated the patient about a half hour after the officer screening on 9/18/13. The nurse documented that the patient had a prior stroke in June of 2013 with residual left sided weakness and hypertension. The nurse documented that the patient was on 10 mg lisinopril, aspirin, and 40 mg pravastatin. The blood pressure was 140/80, the pulse 88. The nurse history was poor. The assessment was basically checking the boxes on the form as "no" or "normal". The nurse obtained a physician telephone order for the medication. There was no medication administration record in the patient's chart so I couldn't verify whether the patient received medication.

This patient was discharged on 9/18/13. There is no evidence that this detainee was enrolled in a chronic illness program. 2 of 3 intake screenings were defective and the detainee did not obtain necessary medication upon arrival at the jail. Nursing evaluations were poor. There was an absence of physician evaluations. Medical records did not have copies of hospital discharge summaries so clinical care at the hospital could be evaluated.

Patient #4

Patient #4 was incarcerated 1/10/11 and the officer screening was negative and the patient was placed in a single cell. The first medical note was a physician assistant (PA) note on 2/22/11 when a physician assistant evaluated the patient for a sore throat. The patient had a temperature of 99.8. The lungs were clear. The PA ordered ibuprofen, an antihistamine and fluids and an as needed (PRN) follow up.

On 9/8/11 a PA saw the patient for a rash on his chin consisting of vesicles. The PA thought the rash was herpes simplex and treated the patient with acyclovir for 5 days; no follow up was ordered. This PA typically orders as needed (PRN) follow up for all patients even when a follow up should be ordered. Anyone with a recently diagnosed condition of uncertain etiology or for patients with a chronic illness should have a follow up appointment scheduled.

On 5/14/13 the patient placed a health request stating that he felt sick and thought he had a fever. A nurse evaluated the patient on 5/15/13. The note was extremely brief. The only history was "c/o cold". This was an inadequate history. The patient had fever of 100.2 F. The nurse evaluated the patient's ears. The tympanic membrane was described as bulging. The nurse documented nausea, vomiting and diarrhea in the objective findings. The nurse also documented "ache in chest" and a red throat. The assessment was fever. The nurse ordered clear liquid diet after consultation with a physician. The nurse did not document the content of the consultation with the physician. Fever with chest pain, nausea, vomiting and diarrhea should result in a physician evaluation.

On 5/16/13 a nurse evaluated the patient in the infirmary for vomiting and diarrhea. The nurse took vitals which included temperature 100.8 and pulse of 110, which are both abnormal. The nurse did not consult a physician but requested a clear liquid diet for lunch and dinner. This nurse should have taken a better history and performed a more thorough assessment and should have consulted a physician. On 5/16/13 at 3:30 pm the nurse checked vitals again and the patient had fever of 101.2 and pulse of 118. The nurse took no action. The nurse should have consulted a physician. On 5/17/13 a nurse took vitals again and the patient had fever of 100.8 with a pulse of 121. This sequence demonstrates poor judgment on the part of multiple nurses. Fever with other symptoms should prompt a physician evaluation. The nursing notes were poor and did not reflect why no action was taken.

On 5/17/13, about 3 days after initially complaining of fever, at about 1 pm a physician saw the patient who had a fever of 101.3 with a pulse of 127. The physician took a history of 5 days nausea, vomiting and diarrhea with fever. He was not able to drink because he vomited. The doctor examined the patient and diagnosed dehydration and probably gastroenteritis and ordered a chest x-ray, labs and intravenous fluid. By about 3 pm the patient received 2 liters of intravenous fluid and his pulse was 115 and he had a fever of 103. A nurse consulted a physician who sent the patient to a local hospital.

The patient was diagnosed with bilateral pneumonia and treated with intravenous vancomycin, levaquin and zosyn, all antibiotics. This detainee was placed at risk because of inadequate evaluations and failure of evaluation by a physician. He returned to the jail on 5/23/13.

The first physician visit after hospitalization was 5/24/13. The physician noted that the patient had pneumonia with possible coccidiomycosis. The patient was on fluconazole an antifungal pending testing for coccidiomycosis.

A chest x-ray on 5/28/13 was normal which is inconsistent with pulmonary coccidiomycosis.

On 6/3/13 a physician saw the patient and documented that the patient wasn't getting the fluconazole as ordered. Fluconazole is used to treat coccidiomycosis. It wasn't clear if the physician noted the normal chest x-ray. The doctor did not document any testing for coccidiomycosis but did refer the patient to an infectious disease physician. The infectious disease physician said that the patient was doing better on fluconazole but that the initial coccidiomycosis titers were negative. He gave recommendations for additional testing and ordered a decrease of the fluconazole.

On 6/13/13 a PA saw the patient and noted that the patient weighed 185 pounds in March of 2013 but weighed 165 pounds in the clinic. The PA noted that the patient possibly had valley fever. The PA noted that the patient was following in the communicable disease clinic and that labs were ordered. A follow up chest x-ray was not ordered.

Coccidiomycosis titers at the state laboratory were negative on 6/19/13.

On 7/3/13 someone wrote a note but did not list their title stating that they spoke with the infectious disease doctor who indicated that the cocci serology was negative. The infectious disease doctor recommended discontinuing the fluconazole. A physician wrote a brief note in review of the 7/3/13 note and agreed. The doctor stopped the fluconazole. The doctor did not note the 6/19/13 negative chest x-ray.

Patient #5

Patient #5 was incarcerated on 5/16/13 and an officer identified no medical problems including that the patient had no drug or alcohol habit that could lead to withdrawal. However, the medical record documents that the patient received opiate detoxification in October of 2011 at the jail. Because the officer medical screening was negative and inaccurate, medical staff did not evaluate the patient. Part of the problem with custody officer performing intake medical screening is that their function as part of the criminal justice system makes it less likely that an inmate will reveal possible criminal activity (drug or alcohol use) to them.

A nurse completed a TB assessment form on 5/30/13. On 6/1/13 a PPD was documented as 0 mm. On 6/1/13 emergency responders evaluated the patient because he was found on the floor. His pulse was initially 143 and he had pinpoint pupils. A nurse gave the patient oxygen and the patient gradually revived and his pulse decreased to 83. The nurse performed no history and performed minimal assessment. His level of consciousness was documented as "came around slowly". The emergency response note did not document a disposition. However, a progress note written at the same time documented that nurses responded to a "man down" call. The inmate was unresponsive and "cyanotic". The nurse documented the other inmates said they gave the inmate cardiopulmonary resuscitation but this wasn't verified. The nurse noted that the patient became responsive but took no history. The nurse documented that the patient didn't remember what happened. The nursing documentation of

care for this patient was very poor. The patient was taken to a local hospital. There was no follow up note to the hospitalization. The patient remained in the hospital from 6/2/13 until 6/13/13 but there are no hospital records or any documentation in the medical record regarding what occurred. There was no follow up of the hospitalization. Data from the hospital list provided to me indicated that the patient was hospitalized for opium poisoning.

On 6/13/13 a nurse completed a health appraisal which consisted of completing vital signs, taking a history of previous treatment by a physician, and a sexually transmitted disease history. The nurse performed vital signs and the blood pressure was 130/90 which is borderline abnormal but no action was taken.

The medical problems of this patient could not be determined from review of his medical record. The nurse evaluation on 6/1/13 did not include details of what actually happened. I could find no hospital discharge summary in the medical record. The patient was not seen after return from the hospital by a provider and therefore necessary follow up may not have taken place. The medical record should not leave room for speculating on what the patient's condition is.

The next progress note was on 8/12/13 when a PA saw the patient for dental caries. The PA didn't address the hospitalization in June.

On 9/19/13 the patient placed a health request slip for a blister on his foot which he said was infected from the shower. There was no evidence of a nurse evaluation. It appears that this patient was not evaluated for his health request for 4 days. A PA evaluated the patient on 9/23/13 and documented that the patient said he developed a blister that had become infected. The PA documented a discolored callus with scant dried blood without signs of infection. The PA cleaned the lesion with betadine and applied antibiotic ointment.

A PA saw the patient again on 9/24/13 and the patient said he couldn't walk because of pain in his foot. The PA documented thickened callus on 3 metatarsal joints which was yellow. The PA noted no fluctuance or pus. The PA attempted to incise the area and white discharge was expressed. The PA started 3 antibiotics: a single dose of a parenteral antibiotic and two oral antibiotics (sepra and Keflex) along with diflucan, an antifungal agent. The indication for the diflucan was not given and the only assessment was "wound evaluation, sole of left foot, callus ulceration". The patient refused to be seen on 9/25/13. The antibiotic regimen, particularly with the diflucan did not appear clinically appropriate.

The PA saw the patient again on 9/26/13. The patient now had an ulcer on the foot of approximately 1 centimeter. The PA noted no signs of infection. The antibiotics were continued. This detainee had a delayed evaluation based on a health request and the quality of care was questionable. Documentation of the indication for the antifungal agent was not provided.

Patient #6

Patient #6 was incarcerated on 6/16/13 at 11:30 pm. The officer performing medical screening noted that the inmate smelled of alcohol. The officer noted that the inmate took medication for high blood pressure and insulin. A nurse performed an intake triage assessment on 6/17/13 but did not time the note. The nurse noted that the patient had type 1 diabetes, hypertension, prior surgery for an industrial accident, and GERD. The patient described not taking antihypertensive medications for months due to not having money. The patient also said he took narco for years from the work injury. The nurse did not question the patient about specifics of his injury or current pain. The nurse documented that the patient took a sliding scale of insulin three times a day. The blood pressure was 138/83 with a pulse of 100. A capillary blood glucose test was not documented on the intake assessment sheet. All diabetics who are newly incarcerated should have a capillary blood glucose performed during intake screening and documented on the nurse intake evaluation. All inmates smelling of alcohol should also have capillary blood glucose as diabetic ketoacidosis can be confused with alcohol intoxication. Also blood pressure for diabetics should be controlled to less than 140/80. This patient's blood pressure of 138/83 was therefore slightly high for a diabetic. The nurse did not obtain an order for blood pressure medication.

On a doctor's order sheet, on 6/17/13, a nurse documented a 425 blood sugar but did not check for ketones. Nurse procedures for intake assessment should indicate where nurses are to document testing results. The order sheet is a pre-formatted insulin diabetic order sheet. This sheet used for all insulin requiring patients has standardized sliding scale coverage. Despite the high blood sugar and smell of alcohol on the patient's breath, the nurse did not check ketones. The patient said he had not consumed alcohol for years except just prior to arrest. The nurse noted that the patient had alcohol on his breath and assumed that it was alcohol and not ketones. Although the nurse checked a box that the patient denied drug use, the nurse placed the patient on an opiate withdrawal protocol. The reasoning of the nurse was not clear. There was nothing in the nursing note to justify placement on an opioid detoxification protocol other than the patient having previously taken narco. Other than performing vital signs and noting a scratch on the patient's face, the nurse performed no physical assessment. This was a poor nurse intake assessment. The patient had an elevated blood sugar and smelled of alcohol; ketones should have been checked. The nurse provided no documentation justifying placement in opioid detoxification. The nurse performed inadequate assessment.

With respect to the opiate withdrawal protocol, the nurse ordered by protocol, valium 10 mg three times a day for 3 days with vistaril, clonidine and multivitamins along with immodium and Maalox. Opiate, benzodiazepine, and alcohol withdrawal syndromes are entirely different clinical entities. Typically for alcohol withdrawal a long acting benzodiazepine is utilized along with thiamine. Most commonly chlordiazepoxide is used but valium is also acceptable. Alcohol withdrawal does not require vistaril, clonidine, immodium, or Maalox. Opiate withdrawal does not require benzodiazepine medication. Benzodiazepine withdrawal requires a longer period of long-acting benzodiazepines and none of the other medications. Each of these entities has a different duration of the withdrawal. Placing all individuals who are withdrawing into a single protocol will invariably result in inappropriate treatment for individual patients. It appears that

this patient was placed in detoxification for alcohol use. Nurses made a decision to treat based on undocumented judgment. This inadequate protocol was being managed entirely by a nurse without physician consultation and included prescription medication that was unnecessary. This placed the patient at risk.

A PA saw the patient on 6/19/13. The patient described having diabetes and hypertension. The patient described not taking medication because of lack of insurance. It would not be possible for the patient, if he were an insulin requiring type 1 diabetic, to survive without use of insulin. So, if the patient was not taking medication, he was probably a type 2 diabetic. The BMI should have been taken. He could have been placed on an oral medication instead of injecting insulin. The PA noted that the patient was placed on opiate detoxification because the narco was discontinued. The PA took no history of his diabetes except that the patient didn't take medication. The history of the chronic illness was poor. The patient weighted 190 pounds but his height was not taken and his BMI was not described. Minimal examination was performed. The PA ordered blood tests and continued sliding scale insulin but did not start an oral agent. The PA continued the narco and discontinued the opiate protocol. The rationale was not clear and a pain assessment wasn't performed. The blood pressure, pulse, or capillary blood glucose were not documented in the PA note. Vital signs should be performed at every provider visit. Capillary blood glucose testing (CBG) should be performed at every provider diabetic evaluation. The PA told me that vital signs are typically taken by nurses and recorded in a different section of the record. However, the PA should document those items in her note that are relevant to her care of the patient. The PA ordered a chart review in a week. Vital signs had been performed daily and were logged on the Treatment and Vital Sign Flow Sheet. The blood pressure was 138/83 on 6/17/13; 152/95 on 6/17/13; and 100/70 on 6/19/13. Also, blood tests had already been drawn and were reported on 6/19/13 but were not evaluated. They were signed as reviewed on 7/2/13. The PA ordered lantus insulin 20 units at night, lisinopril 20, aspirin, and simvastatin. It took 3 days for the patient to be treated for his high blood pressure and high blood lipids. This patient had high triglycerides probably due to poorly controlled diabetes. The PA should probably have started an oral diabetic agent.

Blood collected on 6/17/13 and reported 6/19/13 showed glucose of 407, bilirubin of 1.4 (0.2-1.2), triglycerides 375, HDL-C 39, LDL of 72, and a hemoglobin A1c of 12.2.

On 6/21/13 a PA saw the patient and described the patient being on 10 units of lantus in the morning despite having prescribed 20 units in the evening two days previous. The PA noted that capillary blood glucose levels were in the 300-400 range. No other history of diabetes was taken. The PA did not check laboratory tests. The PA wrote that she would continue the Lantus 10 units in the morning and add 20 units of lantus at night. The PA scheduled a July diabetes clinic. This was not a thorough evaluation but did include a scheduled follow up.

The PA saw the patient 6/26/13 and noted that the patient wasn't getting his medication. With the exception of Narco, it appeared that the patient was getting his medication but they were recorded on two different medication administration records.

On 7/2/13 a physician increased the lantus but did not document why. However, the laboratory results were noted on this date. The rationale for increasing medication should be documented. Moreover, changes of medications should be done in the context of a physician/patient interview so that the patient knows why medication is being adjusted.

On 7/9/13 the PA saw the patient for constipation but did not address the diabetes. On 7/19/13 the PA saw the patient for pain medication and noted that the blood sugar was not well controlled but did not document the blood sugars. The PA increased the lantus to 20 units in the morning and to 30 units in the evening. Providers should document the test data that result in change in therapy.

On 7/25/13 a PA saw the patient and noted that the blood sugars remained in the 200-300 range despite increasing doses of insulin. The blood pressure was 128/72. The PA started metformin at 1000 mg twice a day.

On 8/22/13, the physician spoke with an attorney for the patient who stated that he was not being treated for his arm pain. This prompted a physician visit the following day on 8/23/13. The physician only evaluated the patient for his arm pain. The diabetes, hypertension were not addressed. There were no further notes for this patient.

The patient had a poor nursing evaluation of substance use. A nurse used an inadequate nursing protocol to start an opiate detoxification protocol that included unnecessary medication placing the detainee at risk. The provider history of diabetes and hypertension was poor and did not include the type of diabetes, onset of disease or treatment course of his illness. The patient probably had type 2 diabetes but was treated only with insulin.

Patient #7

Patient #7 was incarcerated on 5/27/13. The officer noted that the patient had diabetes but noted that the patient was not taking medication. The patient was noted to have a drug or alcohol problem that could cause withdrawal. A nurse saw the patient the same day. The nurse took a history that the patient was on both metformin and insulin but hadn't taken medication for 3 days. The dose of these medications was not stated. Intake nursing assessments should include a history of all medications and their dosages. The temperature was documented as "afeb". The pulse was 138 and the blood pressure was 120/80. The patient was "extremely thirsty". The nurse documented speaking with the PA but did not document the contents of the conversation. The elevated pulse was not addressed in the assessment. There is no space for an assessment on this form. The CBG was documented on the doctor's order and was 392; this was not documented on the nurse intake assessment. Metformin at 1000 mg BID was ordered by verbal order and a check was placed next to sliding scale coverage presumably meaning that a standard sliding scale was ordered. This patient received medication timely. However, sliding scale shouldn't be ordered in a standardized format for all patients without first obtaining an adequate history. Brittle type 1 diabetics, for

example, may be harmed by this practice. The nurse and/or PA did not address the significantly abnormal pulse of 138.

A PA order was in the medical record dated 5/31/13 for lantus insulin 20 units, laboratory tests, electrocardiogram, lisinopril, simvastatin, and aspirin. There was no progress note associated with this order. If the PA ordered these medications without evaluation, it is not standard of care. The nurse intake evaluation did not include a history of high blood pressure so the medical record did not have documentation explaining why the patient was being treated with high blood pressure medication.

A PA saw the patient on 6/4/13 but did not address the patient's diabetes. The patient wanted to see a psychiatrist and the PA referred the patient to a psychiatrist. Between 5/29/13 and 6/4/13 the patient had refused insulin nine times, but the PA did not document this in her 6/4/13 note. The patient's blood sugar over that time period varied from 279 to 428. On 6/27/13 a PA noted that the patient refused clinic and had been refusing insulin. The PA documented that the patient would be re-scheduled. The patient refused clinic again on 7/16/13 and was rescheduled. There was no signed refusal for clinic in the chart that I could find. All refusals of medical care should be documented on a refusal form and include the patient's signature.

On 7/7/13 an untitled person documented in the chart that the patient refused sick call and laboratory tests and the person documented referring the chart to the PA. The PA did not write a note. The patient refused clinic again on 7/26/13. No refusal was in the record.

A nurse saw the patient on 10/6/13 for an infected ankle. The nurse noted 4 by 4 inch cellulitis of his ankle which is a large sized infection for a diabetic. The nurse did not perform vital signs so the temperature was not taken. The nurse described the patient as insulin dependent diabetes which is not likely. Type 1 diabetics require insulin and they can't survive long without it and usually develop diabetic ketoacidosis without insulin. Anyone who can do without treatment of their diabetes for any extended period of time is most likely a type 2 diabetic and is not insulin requiring. These individuals are best managed with oral medication because it is more convenient and more likely that they will take it. Nevertheless, the nurse spoke to a doctor and the nurse wrote that antibiotics were ordered but no order was in the medical record for this date. Diabetics with infections should be examined at the time of initiation of antibiotics.

On 10/8/13 a physician saw the patient. The doctor wrote that the patient had a healing wound on the ankle and healing abscess "areas" on the buttock. The doctor prescribed Bactrim for ten days. On 10/16/13 the inmate complained that the wound was not healing. A nurse evaluated the patient and noted a half dollar sized scab with erythema on the ankle. A doctor saw the patient the same day and noted that the infection was better but was still draining pus. The doctor prescribed Bactrim for another 7 day but did not culture the wound. The patient was not seen again. Foot wounds in diabetics that don't heal are classified as diabetic foot

wounds and require additional evaluation which did not occur for this patient. It was not clear from provider notes that the detainee was enrolled in a chronic clinic program.

Patient #8

Patient #8 was incarcerated 10/9/13. The officer performing the intake screen wrote something in the line about medication but it is illegible. The officer also noted that the inmate was under care of a physician for medical or mental health reasons. The patient was listed by the officer as having psychiatric issues and hepatitis C. A nurse saw the patient the same day and noted that the patient had "Benots Disease" and documented that he was on prednisone but did not specify the dose. The nurse documented no other history. This was not an adequate history. The nurse documented a normal current status assessment but under the plan documented a scheduled appointment on 10/9/13 for an abscess on his left leg. The physical assessment documented that the skin was warm and dry but no mention was made of an abscess. The nurse did not contact a physician for a medication order for the patient's prednisone. Prednisone is a significant medication typically used for serious disease. The patient should have had a prompt provider evaluation.

Instead, on 10/10/13 a PA ordered prednisone 20 mg a day without evaluation of the patient. The PA did not document an interview with the patient so it appears that the PA was guessing at the dose. This is not appropriate prescribing. Prednisone should not be used in such a cavalier manner. The PA should have consulted with a physician.

On 10/11/13 a PA saw the patient and documented that he had Bechet's disease and that the skin lesion was part of his Bechet's disease. Bechet's disease is a disease that can affect a wide variety of organs. Treatment and dosing with steroids is dependent on the organ(s) that are affected and the severity of disease. The patient told the PA that he took 60 mg of prednisone daily. This is a high dose indicating that the patient had a higher severity of illness. The PA noted that the patient was receiving 20 mg of prednisone consistent with the PA's prior prescription. The PA noted a 2 cm red ulceration on the lateral thigh with purulent drainage. The wound was painful. The PA took no history of the Bechet's with respect to which organs were involved. The PA did not perform a detailed history of the Bechet's disease. This was not standard of care. The PA should have referred the case to a physician. The PA diagnosed abscess and cultured the wound and continued the patient on the 20 mg of prednisone and started septrax. A culture was ordered. The culture was reported 10/17/11 and was methicillin resistant staphylococcus aureus. The patient has not been seen in follow up as of October 23, 2013. Care for this patient was not adequate. The PA should have consulted the patient's treating physician to understand why the patient was on high dose steroids. The patient was not enrolled in a chronic care program. The patient was not receiving the dose of medication his civilian physician prescribed, based on the PA note. This was not appropriate unless the PA understood what the patient's clinical status was.

Patient #9

Patient #9 was incarcerated on 5/27/13 at about 6:30 pm. The officer performing the intake screening noted that the patient took medication but did not write the name of the medication. The officer also noted that the patient had epilepsy. A nurse saw the patient the same day at 8 pm. The nurse documented that the patient was on lamotergine and levetiracetam which are used for epilepsy. Vital signs were taken. The only history was that the patient had epilepsy and his last seizure was a year ago. The nurse documented that the family brought his medication to the jail. The nurse wrote his medication on an order but there was no documentation that this medication was ordered by a licensed provider. The practice at the facility is that nurses are permitted to continue medications for patients when a patient comes into the jail with a properly labeled container. This is a reasonable practice. The nurse ordered a PA visit for 5/29/13 but the PA saw the patient 5/30/13. The PA did not document the seizure type but did note who his treating physician was and when his last seizure was. The history should contain the type of seizures the patient has with details of medication use and prior complications. The PA examined the patient, wrote to continue the medication and ordered a PRN follow up. Patients with chronic disease should not have a PRN follow up. They should be enrolled in a chronic illness program and scheduled for periodic visits. This did not happen for this patient.

A physician evaluated the patient on 6/21/13, took a reasonable history and performed a reasonable physical examination and rescheduled the patient for 90 days. The physician did not see the patient in 90 days. A PA saw the patient on 8/20/13 and ordered a 30 day follow up. The PA saw the patient on 10/14/13. The patient wanted to see a neurologist. The PA did not perform a physical examination. Except for asking whether the patient had a seizure, the PA took no history of his epilepsy and asked no questions about side effects of medication. The PA told the patient that it was unlikely that the neurologist would come to the jail. A PRN follow up was ordered. All patients with chronic illness should have scheduled appointments should have a history and physical examination for their chronic illness, and should have medication therapy reviewed with the patient. This did not occur based on the PA notes.

Patient #10

Patient #10 was incarcerated 9/24/13 and the officer documented that the patient took insulin for diabetes. A nurse saw the patient and noted that he had diabetes but obtained no further history of the diabetes. The nurse did document that the patient took insulin but did not document the dose. The blood sugar was 459. The nurse did not check urine for ketones. When the sugar is very high, nurses should check for ketones. The nurse completed a pre-formatted doctor's order sheet for diabetes and checked a clinic appointment for 9/25/13 and checked the item "sliding scale coverage". Nurses should obtain a history from patients with respect to the type of diabetes and the dosages of their medications including insulin. The dose of insulin should be determined with provider consultation. The practice of nurses managing the initial prescription of insulin without physician consultation is bad practice and may harm

the patient. This patient should also have had his ketones checked as the blood sugar was quite high.

On 9/24/13 the patient received 15 units of regular insulin based on the protocol. Two hours later the blood sugar was 452 but no action was taken. On 9/25/13 the sugar was 298 in the morning and the nurse gave the patient 5 units of insulin. At 3:30 pm a nurse obtained a blood sugar of 556. This was a dangerously high level of blood sugar. The nurse should have checked ketones. The nurse called a physician who ordered 20 units of lantus insulin but the nurse did not document a history of the patient's typical insulin regimen. At this point, neither the nurse nor the provider asked the patient how much insulin he used as a civilian. This is poor chronic care management.

The following day a PA saw the patient on 9/26/13 and wrote the following for the history related to the patient's diabetes.

He claims a three-year history of diabetes and on insulin for three years. He claims his usual medication includes lantus 25 units with a sliding scale of Humalog. The patient states that he has been off his insulin for the prior 2-3 days prior to incarceration. The patient denies a history of HTN or cardiovascular disease.

The patient's typical insulin regimen wasn't identified for 3 days. This reflects a poor intake screening medical program. Patient's medications should be identified at intake and there should be continuity of therapy after incarceration. This did not happen.

The PA diagnosed diabetes and started the patient on 30 units of lantus insulin and started a low dose of lisinopril 5 mg and simvastatin 10 mg a day without documenting abnormal blood pressure or elevated lipids. The patient's blood pressure was recorded as 108/76. This is not standard of care. In fact, the patient had low blood pressure and the lisinopril may have been harmful. Starting simvastatin and lisinopril without evidence of abnormal lipids or hypertension is not safe for the patient.

On 10/7/13 a physician documented a note in the record stating that he reviewed the chart and that the patient's blood glucose levels were in the 200-300 range despite 30 units of lantus. The doctor increased the lantus to 35 units in the pm and scheduled a one week follow up. The doctor did see the patient on 10/14/13 and noted the blood glucose log results but did not note that the patient was on lisinopril or simvastatin. When patients are evaluated their medication profile should be reviewed at the visit. The doctor noted that the patient weighed 193 pounds and had type 2 diabetes but did not start an oral agent or discuss options with the patient. Typically, the standard of care for type 2 diabetes is an oral agent not insulin. The doctor ordered a blood count, metabolic panel and a hemoglobin A1c and increased the lantus to 40 units a day. The laboratory results were reported on 10/16/13 and reviewed 10/18/13. The hemoglobin A1c was 11.3, which is very high. Lipids were not ordered. The creatinine was normal.

This patient did not receive his typical dose of medication when he arrived at the Jail for a period of 3 days. The PA started medication that was not indicated for the patient. Chronic care management was not good. The physician should have discussed with the patient the possibility of starting an oral agent. It isn't clear whether the patient was enrolled in a chronic care program.

Patient #11

Patient #11 was incarcerated on 6/15/13 at 4:51 pm and told the medical screening officer that he had diabetes, high blood pressure and took medication. The officer also documented that the patient was at risk of alcohol withdrawal and placed the patient in a detoxification cell. Officers make the decision to place inmates in detoxification cells. Medical staff should make this decision. Also, persons who appear intoxicated may have ketoacidosis, a complication of diabetes. Clinical staff should make the decision to place inmates in detoxification based on a medical assessment.

At 5 pm on 6/15/13 a nurse performed a sobering cell assessment. The nurse documented that the patient could not be assessed because he was argumentative. Even though vital signs may be difficult for someone in withdrawal, much of the CIWA detoxification assessment can be performed. At 8 pm the nurse documented that the inmate was asleep and could not be assessed.

A nurse performed an intake triage assessment on 6/16/13 at 1 am. The nurse noted that the patient had diabetes, hypertension, epilepsy, and alcohol use. The officer's history did not match the nurse history demonstrating the problem with officer screening. The nurse noted that the patient took metformin, glyburide, lotensin, and Dilantin. The blood pressure was 155/104. The patient had alcohol on his breath. In the assessment, the nurse did not document a blood sugar test result. The nurse noted that the patient was in a sobering cell. All diabetics with alcohol on their breath should be assessed for ketones. It is reasonable also to assess all intoxicated individuals with a blood sugar. The nurse did not obtain an order from a provider for the patient's medication.

On 6/16/13 at 1:40 am a nurse completed an Alcohol Withdrawal Protocol and circled level 1 but there was no indication how the nurse came to this conclusion. This protocol is an order for certain medication using a standardized protocol developed by the medical program. The patient received diazepam 10 mg four times a day with thiamine, folate, Tylenol, antacid, and promethazine for five days. There was no physical assessment documented at 1:40 am.

During an evaluation at 1 am, a nurse documented that the patient had a blood pressure of 155/104, pulse 82 and temperature of 97.2. The nurse described the patient as cooperative, with regular breathing, normal color, and with reactive pupils without any abnormalities noted. A nurse did complete an AWS Flow Sheet for this assessment.

At 1:45 am a nurse, by protocol, ordered blood sugars twice a day for three days and seizure precautions. The nurse did not contact a provider for orders for the patient's other medication.

At 7:52 am on 6/16/13 a nurse removed the patient from detoxification without specifying the clinical reason for doing so. The patient had a pulse of 108, had a temperature documented as "afebrile" and a blood pressure of 138/83. The nurse wrote, "pt w/steady gait. No N/V. OK to remove".

At 11 am on 6/16/13 a nurse ordered metformin and glyburide having received a phone order. The nurse did not obtain an order for the patient's blood pressure or epilepsy medication. These should have been ordered as well. The program was not continuing necessary medication of the patient. A nurse documented speaking with a doctor on 6/16/13 about a blood sugar but the nurse did not document the blood sugar value and the blood sugar log was not in the chart in its designated location.

On Friday 6/21/13 a nurse assessed the patient for a draining abscess of his hip. The patient had a temperature of 98.9. The blood sugar was not documented. The nurse obtained a phone order for sepra and Keflex with a follow up on "Monday" which would be 6/24/13. The patient wasn't seen until 7/4/13 more than a week later.

On 7/4/13, a PA saw the patient and noted that the patient was an insulin dependent diabetic who had been prescribed metformin and glyburide. This did not make sense as these medications are used for type 2 non-insulin dependent diabetics. The PA also noted that the patient took lotensin. The PA noted that the patient's diabetes was not controlled on metformin and glyburide. The PA did not document a blood pressure but started lisinopril 20 mg once a day. The patient wasn't treated for his hypertension for about 3 weeks after incarceration. It wasn't clear whether this dose of lisinopril was the patient's typical dose because the PA did not take a history of the patient's prior treatment for hypertension. Also, the PA did not take a history of epilepsy and did not start medication for this. The PA increased the metformin to 1000 mg twice a day and also ordered a number of laboratory tests. The PA took very little history of his diabetes. His weight and height were not documented.

A PA wrote a brief note on 7/9/13 documenting that the blood sugar was improving and that the patient could follow up PRN. Patients with chronic illness should be seen at regular intervals. PRN scheduling results in patients getting lost. This is further evidence that regularly scheduled visits are not part of chronic care management.

Laboratory tests were not drawn until 7/30/13. The creatinine was normal and the hemoglobin A1c was 9.5. The LDL cholesterol was 116. Non-HDL cholesterol was 145. HDL cholesterol was 52. These laboratory tests were signed as reviewed on 8/5/13. For persons with diabetes, the standard of care is to treat LDL cholesterol to < 100.

A doctor evaluated the patient on 8/23/13. The blood pressure was 119/71. The doctor did not document review of the laboratory results so the abnormal LDL cholesterol was not noted

but the doctor did start simvastatin. The doctor may have reviewed the blood test, but his review should be documented in the note. Blood sugars were reviewed and the patient had levels between 72 and 218. No pattern was noted. The patient was rescheduled for 4 months.

A doctor saw the patient again on 9/23/13 and assessed the weight, blood glucose values but did not examine the patient. The physician noted that the patient had glaucoma diagnosed recently. This was the last evaluation for this patient.

This patient had inaccurate officer medical intake screening, inappropriate nurse detoxification assessment, never received an assessment with respect to stated epilepsy, and received hypertension medication 3 weeks after incarceration. It was not clear if the patient was to be scheduled for chronic care follow up.

Patient #12

Patient #12 was incarcerated on 12/17/12 and the officer identified no medical problems.

On 1/15/13, a PA saw the patient, apparently for foot pain, but documented that the patient had hypertension. Apparently, the officer screening missed this medical condition. The blood pressure was not documented in this note. The PA should have checked the blood pressure. The PA ordered blood pressure checks for 5 days and a chart check on 1/21/13. It was not clear how the PA determined that the patient had hypertension. If the patient told that to the PA, the PA should have taken a history of the patient's condition including therapy. This was not done. The PA did not order a follow up to assess the patient. This was inappropriate for a patient with a stated chronic medical condition.

I could not locate evidence that blood pressures were checked as ordered.

On 2/3/13, almost 6 weeks after intake, the patient placed a health request stating that he had high blood pressure and would like to have his blood pressure checked. A nurse saw the patient on 2/4/13 and documented that the patient stated having diabetes and hypertension but never took medication for his diabetes. These conditions apparently were missed by the officer intake screening. The nurse ordered blood pressure and blood glucose checks for 5 days. The blood pressure was abnormal every day for 5 days with a high of 160/110. The patient was listed as 308 pounds.

On 2/11/13 a doctor reviewed the blood pressures and noted they were high and noted that blood sugars ranged from 78 to 118. The doctor started a diuretic without examining the patient or taking a history. The doctor ordered chronic clinic for 6 weeks but this didn't occur. Starting, stopping and changing medication should be done with the patient present so the patient understands the therapy ordered for him and why it is being done.

On 2/20/13 the patient wrote a request asking to be taken off low sodium diet. A nurse evaluated the patient on 2/25/13 and noted the patient's request. The nurse called a PA who

ordered lisinopril 20 mg Q day with 5 days of blood pressure checks. The nurse did not perform vital signs at this evaluation. Again, when providers initiate therapy, it should be done in the presence of the patient and based on a physical examination result. It is not clear why the PA ordered lisinopril. The patient had yet to see a provider for his hypertension; all interventions were by phone. Blood pressures were not performed as ordered. BP was taken 2/25/13; 3/3/13; 3/4/13; 3/11/13; 3/18/13 and 3/26/13. The blood pressures were mostly abnormal.

Chart reviews were performed on 3/4/13 and the blood pressure was noted to be decreasing but the doctor thought that the patient was on a diuretic and low sodium diet. The PA had stopped the low sodium diet and had started lisinopril. The doctor did not evaluate the patient.

On 3/11/13 the doctor noted in chart review that the patient was on lisinopril. The doctor checked the blood pressure log again on 3/26/13 but the patient was still not evaluated.

On 4/1/13 the patient placed a health request for chest pain, which should be considered urgent. On 4/2/13 a nurse evaluated the patient for chest pain. The nurse took no history of the chest pain except that it resolved earlier in the morning. The blood pressure was 140/96 and the pulse was 75. The nurse wrote "MD clinic, med renewal up" but scratched this out. The nurse did not document a disposition and the patient was apparently sent back to his cell. This was a very poor evaluation. The nurse should have consulted a physician for the chest pain. The nurse should have obtained cardiac risk factors and questioned the patient about symptoms associated with myocardial infarction. Typically, for a person with a history of chest pain, diabetes and hypertension, an electrocardiogram would be performed.

On 4/23/13 a nurse documented that the patient returned for medication renewal. The patient had still not seen a provider for an evaluation of his high blood pressure. The nurse documented a blood pressure of 160/90, which is high. The nurse called a physician who renewed the medication for 90 days. No appointment was scheduled. This demonstrates an absence of a chronic care program.

On 5/22/13, the patient wrote another health request stating that he had headaches and blurred vision and high blood pressure. A nurse evaluated the patient on 5/24/13. The history was extremely brief and poor. The blood pressure was 156/80 which is high. The nurse did not address the headache or vision problem but referred the patient to a dentist because the patient also complained of dental pain. The nurse did not note that a provider had never evaluated the patient for hypertension. Presumably, the nurse associated the headache and blurry vision with the dental problem, but that implied a decision which should have been made by a physician.

On 6/1/13 the patient placed a health request stating he had a "flu" and body aches. It doesn't appear that the patient was seen for this complaint.

On 6/2/13 the patient placed another health request complaining of "poor circulation in left leg" and also said that he had recent surgery on his leg a short while ago. This had not been

picked up on the officer intake screening. At this point the patient had not had an examination by a physician for almost 6 months. A nurse evaluated this complaint on 6/4/13. On 6/4/13 the patient placed another health request stating that he thought he had cellulitis. A nurse documented that he would be seen on 6/4/13.

Meanwhile a doctor documented seeing the patient on 6/3/13 noting that the patient had cellulitis. The doctor noted erythema, swelling, temperature of 97.8 and started Keflex and sepra. The doctor took no history of hypertension and did not note this as a problem. The issue of the circulatory problem was not addressed. The doctor saw the patient again in follow up on 6/5/13. The doctor noted increased redness and warmth and sent the patient to a local emergency room. No other vital signs were recorded. Typically vital signs are not recorded for visits.

The patient was hospitalized from 6/5/13 until 6/11/13. When he returned a nurse saw the patient. The blood pressure was 160/100. The nurse noted that the patient left the hospital with prescriptions for Keflex, doxycycline and lisinopril 40 mg a day. The lisinopril had been increased at the hospital. I could not locate hospital records in the medical record so it wasn't clear what evaluations or treatments occurred in the hospital.

A doctor saw the patient on 6/12/13 and noted that the patient had a resolving infection but did not note that the patient was now on an increased dose of lisinopril. Vital signs were not done. The doctor ordered a PRN follow up. The doctor did not document review of the hospital records, so it isn't clear what occurred in the hospital. This patient with a chronic illness should have had a scheduled visit not a PRN visit. His chronic medical conditions were not being addressed. This is a failure of the chronic care program.

On 6/13/13 the patient placed another health request stating that his leg was still infected. This complaint of an infected leg wasn't evaluated for 4 days. It should have been evaluated the same day. On 6/17/13 a nurse evaluated the patient for a complaint of cellulitis. The nurse documented 2+ edema of the leg that was warm to touch. The patient did not have fever. The nurse consulted with a doctor and ordered a physician follow up on 6/19/13.

On 6/19/13 a doctor evaluated the patient and noted that the leg was significantly improved and ordered a two day follow up.

The two day follow up did not occur. Instead the patient placed a health request on 6/21/13 stating that his leg was infected and that he was supposed to see a doctor that day but it didn't happen. A nurse documented on this request that the patient would be seen on 6/23/13 but that didn't happen either. Instead a nurse saw the patient on 6/24/13. The nurse noted swelling and warmth of the leg. Vital signs were not taken. The nurse documented referral to a physician.

A physician saw the patient on 6/25/13 and documented improvement. The doctor still did not document the hospital diagnosis or what work up had been performed at the hospital. The

doctor documented persistent leg pain and referred the patient to an orthopedic specialist. The hypertension was not acknowledged. The potential for circulatory disease of the leg was not investigated because the physicians did not question the patient regarding his surgery for poor circulation. Vital signs were not done.

On 7/1/13 the patient placed another health request stating that his leg was infected. The nurse documented 2+ leg swelling with a temperature of 98.4. The history was poor. The nurse noted that the patient already had an appointment. This was the last note in the medical record for this patient. The work up at the hospital wasn't noted. The patient probably needed a Doppler study as he had persistent edema of a single leg. It is likely that the patient had either arterial or venous disease of his leg.

This patient's care of his chronic illness was extremely poor. The officer intake screening did not identify his medical conditions. The patient did not receive his typically prescribed medication. The patient did not receive high blood pressure medication for almost 2 months despite having evidence of high blood pressure and having given nurses a history of taking medication for this condition. When providers started blood pressure medication, providers mostly managed the patient's hypertension remotely by phone prescriptions. The patient wasn't evaluated for 6 months and when evaluated the evaluation was not thorough. The patient never had a thorough history of his conditions. The patient initially told a nurse that he took Dilantin for epilepsy but there was never an evaluation for this. Nurses did not perform adequate assessments. The patient was hospitalized for 6 days but no one at the jail documented why the patient was hospitalized or what occurred at the hospital. The patient was discharged from custody 7/3/13 without having had a single thorough chronic care evaluation.

Patient #13

Patient #13 was incarcerated on 10/7/13. The officer performing medical screening identified that he had asthma and used an inhaler and Prilosec. A nurse performed intake triage the same day and noted that the patient wasn't under physician care and took no medication. The officer and nurse histories were not in agreement. The nurse did not perform any history other than that the patient took no medication and wasn't under physician care. The blood pressure was 136/93, which is abnormal. Normally, medical staff who assess persons with asthma listen to the lungs and perform a peak expiratory flow rate (PEFR) to measure their current status as a minimum. The nurse did not evaluate lung sounds and did not perform a PEFR. I noticed in charts reviewed that this standard testing was never done for a person complaining of asthma symptoms. In this case, the officer took a history of asthma but the nurse did not assess for asthma. The nurse did not refer the patient to a provider. This was an inappropriate chronic care intake nurse triage evaluation.

On 10/10/13 a PA saw the patient and took a history that the patient used Advair 250/50 and Prilosec. Advair is a combination drug including a steroid and long acting beta agonist medication in a combination inhaler. There are multiple types of medications for persons with

asthma. All persons with asthma should keep a beta agonist inhaler with them in the event of acute symptoms. In addition, depending on the frequency of symptoms, other medications may be used in order to keep the patient as symptom free as possible. The PA wrote that there were no other prescriptions registered although a nurse had documented that the patient also had a prescription for albuterol. The PA did not perform a PEFR but did auscultate the lungs which were clear. The PA assessed the patients as "complaining of asthma" and documented in the plan that she would verify the prescriptions with a pharmacy. The PA started the Prilosec. The PA did not perform a history of the patient's asthma and did not solicit symptoms or prior medication use related to symptoms. The PA did not question about prior hospitalizations or steroid use. The PA denied the patient access to needed medication.

Later on 10/10/13 a nurse verified that the patient had valid prescriptions for albuterol and Advair inhaler and took Prilosec. The PA then ordered Flovent on 10/10/13 for 30 days. It is not clear why the PA did not prescribe the patient's typical medication. Use of Flovent, a steroid inhaler, without use of a rescue beta agonist inhaler is not standard of care. Requiring verification of a prior prescription prior to providing medication is a good idea. However, if the inmate states medication use and has a reasonable history, the nurse should consult a provider as to whether medication should be started. Nurses should refer such patients to providers timely. The providers should take a history, perform a physical examination and based on their assessment a decision should be made on therapy. The practice at the jail is passive and indifferent. This is a cynical approach toward patients with asthma.

On 10/14/13 the PA saw the patient because the patient was requesting his Advair and Prilosec. The Prilosec was prescribed on 10/10/13. The PA noted that Flovent was substituted for the Advair without specifying a reason. The PA didn't perform a history or physical examination. The PA documented that she would follow up with nursing to confirm the current prescription. The PA did not meet previously with the patient to discuss the therapy change or the rationale. At the current visit, the PA did not document a discussion with the patient about the change in therapy. The PA scheduled a PRN follow up. All changes in therapy should include a discussion with the patient. Patients with asthma have a chronic illness and should be evaluated on a regular basis. PRN visits are not appropriate and result in episodic care.

This patient's care characterized asthma care at this facility. Patients do not have access to necessary medication. Asthma is not treated as a chronic illness and is not evaluated on a regular basis. Providers do not elicit symptoms and history sufficient to characterize the stage and status of the patient's asthma. PEFR testing is not evident in routine evaluations of persons with asthma.

Patient #14

Patient #14 was incarcerated on 10/20/13 at about 11 pm. The officer performing the medical intake screening noted that the patient appeared to be under the influence of alcohol. The officer noted that the patient said he took a medication called "moeproto!" and had high blood pressure and asthma. The officer placed the inmate in a sobering cell. A nurse evaluated the

patient shortly before midnight shortly after the officer performed the intake medical assessment. The nurse noted that the patient was unsteady, had slurred speech and was very intoxicated. A blood sugar was not performed. Vitals were normal.

At 4 am on 10/21/13 another nurse evaluated the patient. The nurse did not perform vital signs. The patient was asleep.

At about 8 am another nurse evaluated the patient. The pulse was 131 and temperature was 99.5. The patient was anxious and stated he binge drank and had a history of withdrawal. The nurse documented starting the AWS protocol but the AWS Flow Sheet was not used so it was not clear that the nurse was adhering to the protocol. The abnormal vital signs indicated that the patient might have been in early withdrawal.

At noon on 10/21/13 a nurse evaluated the patient who had pulse of 118 and a fever of 100.8. The nurse noted he was calm and cooperative and wanted to sleep. The AWS Flow Sheet was not used to document the status of the patient. The abnormal vital signs indicated that the patient might be in withdrawal. There was no evidence that the nurse was evaluating for this. The nurse did not consult a physician.

At about 4 pm another nurse evaluated the patient. The AWS Flow Sheet was not used. The pulse was 106 with a temperature of 97 with blood pressure of 141/87. The inmate asked for valium. The nurse responded that the next dose would be in about an hour. The prior nurse did not document giving a dose of valium. However, an alcohol withdrawal protocol order was in the record indicating a level 1 designation which was probably not accurate given his fever and pulse. However, this flow sheet was not used. There was no other order in the chart. No medication was documented as having been given to the patient. Based on documentation, it was not clear how the patient was being managed.

At 8 pm a nurse evaluated the patient. The pulse was 109 and blood pressure 115/93. Temperature was 97.6,

At about midnight on 10/21/13 a nurse evaluated the patient. His blood pressure was 148/92, pulse was 92, and temperature was 98. The nurse documented that the patient was OK to remove from detoxification.

On 10/22/13 at 9:55 am a nurse performed an evaluation. The blood pressure was 160/90; the pulse was 114 and temperature 98.4. This was documented on a progress note not on an AWS Flow Sheet. The nurse documented sick call PRN.

Based on documentation in the record, it was not clear how the patient was managed. Physical assessments were not clearly documented. If the nurse was engaged in use of a protocol, it could not be determined by examination of the record and the status of the patient was not clearly documented.

Patient #15

Patient #15 was incarcerated on 10/19/13 at 4:45 pm. An officer noted that he appeared to be intoxicated with alcohol. The officer also noted that the patient had seizures. The officer referred the patient to a nurse in intake.

A nurse documented a sobering cell note at 5:42 pm on 10/19/13. Pulse was 116, blood pressure was 140/69 and temperature was 98. The AWS Flow Sheet was not used.

At 8 pm on 10/19/13 a nurse evaluated the patient and the pulse was 103, temperature 98 and blood pressure 131/86. The nurse did not document signs of withdrawal but the AWS Flow Sheet was not used; the sobering cell form was used. It wasn't clear in the alcohol detoxification policy²⁷ when the sobering cell form is to be used as opposed to the AWS Flow Sheet even when persons undergoing alcohol detoxification are placed in a sobering cell.

At 1 am on 10/20/13 a nurse evaluated the patient. The blood pressure was 160/91, pulse 85, temperature 99.3. The patient was cooperative. The nurse described the patient as malodorous. The AWS Flow Sheet was not used. The sobering cell form was used. The nurse documented "meds given" but what meds and in what quantity were not documented. It wasn't clear if the patient was undergoing alcohol detoxification.

At 3:30 am on 10/20/13 a nurse attempted to evaluate the patient but he was asleep. This was documented on a sobering cell form.

At 6:30 am on 10/20/13 a nurse evaluated the patient on the sobering cell form. The blood pressure was 138/95, pulse 111, and temperature 98.1. The patient was cooperative. The AWS Flow Sheet was not used. The patient had mild tremors. The patient had symptoms of alcohol detoxification and should have had an assessment for that purpose.

A nurse did an intake triage evaluation on 10/20/13 at 5:36 pm, a day after incarceration, and noted that the patient had seizures from alcohol use. This was an important piece of information with respect to his care. This history should have been taken the previous day. The vitals were blood pressure of 142/92; pulse of 99 and temperature of 90. The temperature and pulse appear to have been reversed and written in the wrong space as a temperature of 90 is extremely hypothermic. The patient complained of ringing in his ears. The nurse noted that the patient was unstable, had unsteady gain, and drank heavy. The nurse documented placing the patient on an alcohol protocol. An alcohol protocol sheet was not used. The AWS Flow Sheet was not used. Given the existing policy, it isn't clear what the nurse meant by placing the patient on an alcohol protocol as this requires use of the Alcohol Withdrawal Scale Flow Sheet. The reason for this decision was not clearly documented and was not based on any protocol

²⁷ Alcohol Intoxification and Detoxification (Sobering Cells); Monterey County Adult Detention Facility Policy and Procedure Manual

format. This appears to be beyond the scope of nursing practice as the nurse was not adhering to the existing protocol.

At 8 pm on 10/20/13 a nurse re-evaluated the patient but vitals signs were not done. The nurse documented that the patient was taken to the day room for a shower. This was documented on a sobering cell form. There were no further nurse sobering cell notes

On 10/22/13 a nurse documented an assessment on a progress note. An AWS Flow Sheet was not used. The blood pressure was 118/78, pulse was 80 and temperature was 98.6. The nurse said that the patient had poor skin turgor, was dehydrated, had steady gait with mild tremor and had vomiting and diarrhea. The weight was 160 pounds. Orthostatic blood pressure was not taken. The plan was to continue AWS level 1 detoxification plan which calls for medication use. But medication administration was not documented. There were no other notes for this patient. The use of valium could not be ascertained because it was not documented as given.

Based on documentation, it was not clear whether the nurses were engaged in the standardized nurse protocol for alcohol detoxification because required forms were not used and there was no documentation on the medication administration record. Documentation did not indicate that nurses were following the protocol. It is not clear if nurses were using valium. If they were it did not appear to be in accordance with a nursing protocol which is inappropriate.

Patient #16

Patient #16 was incarcerated on 8/24/13. An officer performed medical intake screening and identified that the patient had an infection of her arm, heart disease, prior colon cancer and asthma and used an inhaler.

A nurse evaluated the patient the same day and also noted an infected stab wound, asthma, epilepsy, GERD, insomnia, bipolar disorder, PTSD, fecal incontinence, shingles, and prior history of myocardial infarction. The officer screening was not consistent with the nurse screening. The patient brought in a bag of medication but the nurse did not document on the intake assessment sheet what these medications were. The nurse wrote an order that she would start the home medications. The nurse did not perform a history or physical assessment of the patient. The medications that the nurse ordered included Keflex, nifedipine, propranolol, and acyclovir. The nurse wrote to verify that the patient was on Depakote so this was not ordered. The nurse allowed the patient to keep her own albuterol inhaler for asthma. The nurse wrote on the order sheet to obtain a discharge summary and chemotherapy orders and wrote to renew medications in 30 days. The nurse did not discuss this order with a physician.

A nurse also wrote a progress note which is not filed with the nurse intake triage note for this patient that was more thorough. The nurse wrote that the patient was on the following medications:

Keflex

Nifedipine
Cyclobenzaprine
Effexor
Lortab
Gabapentin
Acyclovir
Asacol EC
Folic acid
Atarax
Vistaril
Propranolol
Seroquel
Venlafaxine
Albuterol
Norco
Depakote
Benadryl

The nurse noted that the patient had an infected stab wound of her right upper arm. The colon cancer was diagnosed 9 months ago and the patient was receiving weekly taxol chemotherapy. The PICC line had just been removed and the patient was supposed to have colonoscopy and MRI before further chemotherapy. The patient had "faint" wheezing and had just used her albuterol. The patient had epilepsy with a last seizure 2 weeks previous and was on Depakote and gabapentin for her seizures. The nurse documented that the patient also had shingles on her legs and multiple mental health issues. The reason for the use of asacol was not identified; asacol is typically used in inflammatory bowel disease. Despite the note listing all of these medications, the nurse did not ensure that the patient received these medications. The nurse also did not communicate with a provider in order to obtain a prescription for the patient's necessary medication. This is a barrier to patient's obtaining necessary medication.

On 8/25/13 at 5:30 am a nurse wrote the following statement:

Due to lack of report regarding above named client's needs, I was unable to follow up with orders left from previous shift RN as they are written, the orders are unclear as to what needs to be done to effectively provide a continuation of care for this client. Will discuss with a day shift RN the continuation of care for this patient.

I agree with this comment. I could not determine what orders existed for this patient. The Director of Nurses intervened, called a physician who approved the order, which did not include all of the patient's medication. Two of the medications (acyclovir and nifedipine) were not available through the vendor pharmacy. It wasn't clear how this was to be addressed. The Director of Nursing also discussed the mental health medication with someone from the mental health program.

On 8/25/13 the patient placed a health request stating, "I have multiple medical and physc conditions and I need my meds immediatly please". On the corner of this request a nurse noted that the request was evaluated on 8/26/13.

A PA saw the patient and documented that the patient stated that she had an infection in her arm, shingles on her legs, colon cancer with a scheduled MRI, epilepsy with a seizure 2 weeks ago, Chron's disease, prior heart attacks (for which she took nifedipine), psychiatric history, and a history of alcohol use. The history did not include complete details of the various illnesses. For example, the PA did not assess the status of the Chron's disease, when the infection started, when the shingles started, what type of seizures the patient had, status of the asthma, etc. The PA noted that the patient exhibited "bizarre" behavior. The PA auscultated no wheezing. The arm infection was not evaluated. The shingles were not evaluated. The PA wrote that the skin was normal color temperature and moisture. It wasn't clear that the affected areas were evaluated. The PA continued the patient on alcohol detoxification, recommended follow up with the gastroenterologist after discharge, requested medical records, and documented that she would verify prescriptions. This was a very poor chronic clinic evaluation. None of the patient's medical chronic conditions was adequately characterized. The PA did not evaluate the patient's medication needs. The patient was denied access to her typical medications.

On 8/26/13 the patient placed a health request asking for diapers. The PA had failed to inquire the day before about the nurse history of incontinence.

On 8/27/13 nurses responded emergently to the patient for seizure activity. Apparently the patient was found on the floor of the bathroom. The blood pressure was 170/82 which is abnormal and pulse was 89. When nurses responded the patient was alert. Nurses did contact a provider and released the patient back to custody. The nurse did not document the discussion with the provider or who the provider was but the only order for this was to perform vital signs every shift for 24 hours and to schedule the patient with the PA on 8/28/13. The patient was on Depakote and Gabapentin both of which may be used for epilepsy. Even after the patient apparently had a seizure providers did not evaluate whether the patient required her medication which may have been for epilepsy. This was not good chronic care management and denied the patient access to necessary medication.

The patient was not seen on 8/28/13. On 8/31/13 the medication nurse wrote a progress note stating that the inmate complained of diarrhea secondary to her irritable bowel and requested asacol. The nurse wrote an order for asacol for 30 days that was not given as a verbal order. There was no further evaluation of the patient. This appears to be practicing out of the scope of nursing licensure. The patient had probable symptoms of her Chron's disease which had not been adequately assessed. The nurse should have referred this patient to a physician for an evaluation.

The patient was discharged from custody on 9/4/13 never having had an adequate evaluation of her problems and without having received her necessary medications. She never had a

thorough physician evaluation and did not have continuity of care for any of her chronic medical conditions demonstrating a defective chronic care program

Patient #17

Patient #17 was incarcerated on 10/17/13. The officer performing the intake screening identified only asthma as the patient's medical condition and noted that the patient was under a physician's care. A nurse evaluated the patient on the same day and noted only ventolin as a prescription medication. The nurse noted wheezing in all lung fields. The nurse took no history of the patient's asthma and did not obtain a PEFr. The pulse was 117 and the respiratory rate was 17. The nurse did not perform a detailed history of the patient's asthma. The nurse permitted the patient to retain the ventolin inhaler that she came in with. The nurse did not obtain provider approval for an order and did not order the ventolin. The nurse ordered sick call with the PA on 10/18/13. This visit did not occur.

On 10/18/13 a nurse documented that the patient requested a refill of her inhaler and would send a refill. There was no order for this medication. This medication was not tracked on a MAR and there were no physician orders for this medication. It appears that the patient received the ventolin based on nurse judgment. The patient did not have a provider evaluation. Based on protocol, patients with chronic illness are to be evaluated at the next scheduled PA or physician sick call. This did not occur. This is inappropriate management of the patient's chronic condition.

Patient #18

Patient #18 was incarcerated on 7/11/13 at about 7 pm. An officer performed health screening and identified asthma, heart disease, high blood pressure, emphysema and mental health problems. The officer noted that the patient was taking medication. A nurse evaluated the patient at about 8 pm and identified asthma/COPD, hypertension, heart disease, hepatitis, back pain and psychiatric problems. The patient didn't know the name of his blood pressure medication but identified albuterol as his medication for asthma/COPD. The blood pressure was 138/88 and the pulse was 100. The nurse did not evaluate lung sounds or check a PEFr. The patient told the nurse that he was worried about withdrawal from prescription opiates. The nurse placed the inmate on a detoxification protocol without specifying why and without consulting a physician. The nurse documented no alcohol use but said the patient used narco, a prescription opiate. The detoxification protocol included the following

Valium 10 tid for 3 days
Vistaril
Clonidine
Ibuprofen
Immodium

If the nurse was concerned about withdrawal from narcotic medication, the detoxification medication regimen was not appropriate. There is no indication for valium in narcotic withdrawal regimens and there is probably no indication for ibuprofen. Giving the patient unnecessary medications places the patient at risk of harm. The nurse also ordered albuterol without consulting a physician. This appears to be the practice of medicine and outside the scope of a nurse's license. The albuterol order as written by the nurse was:

Albuterol inh 2 puffs Q 20 min for 3 times then
Albuterol inh 2 puffs Q 4-6 hours prn shortness of breath for 24 hours

This appeared to be a single day of prescription albuterol. The nurse performed no assessment identifying abnormal lung function. Providing the patient her albuterol inhaler would have been appropriate. But a single day of medication was not appropriate medication therapy for this patient. In addition, the nurse did not call a physician to start blood pressure medication. The nurse did not consult with a physician but the nurse ordered mental health and medical evaluations for 7/15/13.

The patient was not seen on 7/15/13. On 7/16/13 a PA saw the patient. The history was poor. The entire history was the following:

"Patient states that he has a history of COPD. He states that he uses inhalers. He also takes Narco. He does not have any current prescriptions. He is not under the care of a physician. He is complaining of some mild shortness of breath."

The PA did not attempt to obtain any details of the patient's COPD or assess the status of the disease. The physical examination included a pulse oximeter reading of 96% but did not include vital signs or PEFr. The patient had wheezing. The blood pressure was not documented. Based on this brief assessment, the PA ordered solumedrol, a parenteral powerful steroid, which the patient refused. The documentation of the PA did not support the therapy. The patient had no objective findings warranting parenteral glucocorticoids. The reason for refusal was not clearly stated. The PA also ordered flovent, and an albuterol nebulizer treatment for 7 days with a PRN follow up. PRN follow up was inappropriate. A hand held beta agonist inhaler was not prescribed. Albuterol inhaler is typically used for COPD and asthma and the patient indicated that he used this medication. Yet the PA did not prescribe a hand held nebulizer but prescribed treatment by nebulization which is not typical for patients not on a hand held nebulizer. The PA did not address any of the other medical conditions. There was no order for a chronic illness follow up. There was no evidence that the albuterol nebulization occurred. This is not good chronic care management.

On 8/2/13 nurses evaluated the patient emergently for shortness of breath and left arm numbness. The blood pressure was 139/97 with a pulse of 68. The nurse did not perform a PEFr. The patient was taken to the booking area and given an albuterol and flovent inhaler. The nurse called the PA who ordered albuterol and flovent inhalers and aspirin. After about 3 weeks and only after an emergency evaluation, a provider ordered the patient's necessary

medication for COPD and asthma. The nurse did not perform an electrocardiogram. The PA also prescribed aspirin. The PA did not order a follow up. The patient should have had a more thorough evaluation and based on the history might have needed to see a physician. Even though the patient had high blood pressure and had given a history of high blood pressure at intake, no evaluation or treatment for this condition was given. This was neglectful of the patient's medical needs.

On 8/7/13 nurses evaluated the patient emergently for chest pain. The pulse was 135 and the SPO2 was 99%. Blood pressure was not obtained. The patient said he lost his inhalers. The nurse replaced the inhalers which the patient used resulting in the patient feeling better. The nurse did not consult a physician. The pulse of 135 was not addressed. An electrocardiogram was not done. The nurse should have consulted a physician or the patient should have been evaluated by a physician. This was an extremely poor nurse evaluation.

On 8/20/13 the PA saw the patient because he was requesting glasses. The PA did not address any of the patient's medical conditions. The PA told the patient to see an ophthalmologist when discharged from jail. A PRN follow up was documented. This was episodic care and neglected the patient's serious medical needs. .

On 9/3/13 the patient placed a health request because his inhaler ran out. A nurse wrote on the request that the patient would be seen in sick call on 9/4/13. This did not occur.

On 9/4/13 the patient placed another request stating that he gave an empty inhaler to a medical technician but hadn't received a replacement. There is no documentation that this request was addressed. A nurse documented having reviewed the request on 9/4/13 but the patient did not receive his medication.

On 9/6/13 the patient placed another request stating that he wanted another inhaler. A nurse triaged the request on 9/6/13 but there was no documentation that the patient received medication.

On 9/9/13 a PA evaluated the patient and took a history that the patient had night sweats and wanted a refill of his inhalers. The patient denied weight loss. The PA noted wheezing. PEFr and oxygen saturation were not obtained. The blood pressure was not taken. The assessment was "complaining of night sweats, history of COPD". The PA reordered the albuterol and flovent and ordered a TSH, CBC and metabolic panel. She did not order a chest x-ray and did not check his tuberculosis skin test. This was a poor evaluation of the patient's complaint.

The patient was not seen again as of October 24, 2013. The laboratory tests have not been done for almost 6 weeks.

This patient was denied necessary medication. The PA repeatedly failed to evaluate or treat the patient's high blood pressure or evaluate the patient for stated heart disease. This was neglect. The management of the patient's emphysema was not standard of care. The PA did

not thoroughly evaluate or appropriately treat any of the patient's serious medical conditions. This demonstrates a deficient chronic care program.

Patient #19

Patient #19 was incarcerated on 9/16/13 at about 2 am. An officer performed medical screening and identified that the patient had asthma and used an inhaler. A nurse saw the patient at about 5 am. The nurse history was that the patient had asthma but did not know the name of the inhaler. The blood pressure was 124/92. This is elevated blood pressure. PEFr was not performed in evaluation of the asthma. The nurse noted that the lungs were clear. The nurse scheduled a PRN sick call. This patient has not been seen as of October 24, 2013. This is inappropriate chronic care management. The chronic care policy stipulates that all patients with chronic illness are to be seen at the first PA or physician sick call after intake.

This patient had previously been incarcerated and on 9/6/13 the patient was seen emergently by a nurse stating she had asthma and was having trouble breathing. The nurse noted mild wheezing. The nurse documented that she would send an albuterol inhaler to the patient. The nurse wrote this as an order as part of a standard protocol. A physician was not consulted.

This is another example of failure to provide necessary medication to patients and another example of a deficient chronic care management.

Patient #20

Patient #20 was incarcerated on 6/20/13 at about 6 pm. An officer performed medical intake screening and documented that the patient had asthma and risk for alcohol and drug withdrawal and used albuterol inhaler. A nurse saw the patient at about 8 pm on 6/20/13 and documented asthma as well as drug and alcohol abuse. The nurse noted that the patient used albuterol. The lungs were clear on examination. PEFr testing was not done. The nurse ordered a PRN sick call follow up. This is not appropriate as asthma is a chronic illness and the chronic illness policy calls for every patient with chronic illness to be seen at the first PA or physician sick call. The nurse did not provide an albuterol inhaler to the patient and did not consult a physician. This demonstrates denial of necessary medication to the patient. The nurse documented that the Alcohol Withdrawal Protocol treatment was for Level 0 but an AWS form was not used to determine the level so it wasn't clear how this conclusion was drawn as the nurse had insufficient history on her note to draw this conclusion.

On 6/21/13 a nurse wrote a brief progress note stating that the patient was exhibiting signs of alcohol withdrawal and the AWS was 5 so the nurse started the AWS protocol at level 1. The nurse did not document vital signs and a completed AWS protocol was not in the progress note section of the chart and does not appear to have been done. It was not clear how the AWS score of 5 was obtained. This is extremely poor documentation.

The patient placed a health request but the request was undated. The patient stated he was having an asthma attack and wanted to see a physician. A nurse wrote that sick call would be scheduled for 6/25/13.

On 6/26/13 the patient placed a health request stating he had an open wound on his hand that wouldn't stop bleeding. He said that he hit someone in the mouth while playing basketball. The patient's request clearly stated that his injury was due to a human bite equivalent.

A PA saw the patient on 6/26/13. The PA took a history of a hand injury and added that the patient was requesting an inhaler. The patient had right hand swelling with a laceration to the PIP joint on the dorsum of the hand that was about a half centimeter in length. The PA described it as an avulsion. The PA documented that the patient hit a ball with a closed fist, which is not what the patient described on the health request. Human bite equivalent hand wounds are typically treated with an antibiotic (usually augmentin) and often require surgical debridement and evaluation by a hand or orthopedic surgeon. This did not occur. The history written by the patient on the health request apparently was not reviewed or believed.

The patient told the PA that he used flovent and albuterol inhalers. The PA identified no wheezing and did not assess the PEF. The PA did not take an appropriate history of the patient's asthma. In the assessment, the PA documented "history of asthma". The PA did not ask the patient questions about his asthma status or prior treatment history. The PA sent the patient for a hand x-ray and referred the patient to an orthopedic physician and placed the patient on a splint. This referral should have been emergently done because hand infections can spread quickly and cause damage to tendons. The PA ordered Flovent "prophylactically" but did not order albuterol. This is not standard of care for asthma. The x-ray was negative for a fracture. The PA did not order antibiotics and did not order a follow up. This was extremely poor care.

About a week later, on 7/3/13 the patient placed another health request wanting pain medication for hand pain. A PA saw the patient on 7/3/13 and noted increased swelling and redness with decreased range of motion. The PA ordered rocephin and sepra which are not optimal antibiotics for a human bite equivalent. The PA still did not assess this as a human bite. She placed a splint on the patient and ordered a sooner appointment with the orthopedic consultant.

The patient went to the orthopedic physician on 7/11/13, over 2 weeks from the injury. When the patient returned from the orthopedic visit a nurse at the jail documented that the patient might need surgical repair of the hand. Augmentin, an appropriate antibiotic for human bite was recommended for 21 days. On 7/16/13 the patient had surgical debridement of the wound. A physician at the jail saw the patient upon return after surgery and documented that the wound was a human bite wound. On 7/18/13 the patient refused to see the PA and requested to see the physician for follow up of his wound.

The patient has had multiple sick call visits to assess follow up of his hand injury but has not had any follow up or assessment of his asthma. The patient's human bite injury was mismanaged and the patient was denied access to medication for asthma. This PA needs supervision by a physician and should not be managing complex patients.

Patient #21

Patient #21 was incarcerated on 8/22/13 at about 11 pm. The officer performing the intake health screening noted that the patient was under the influence of alcohol, had asthma and took prednisone and advair inhaler. When prednisone is used for treatment of asthma, it indicates a severe stage of the disease. A nurse didn't see the patient until 8/23/13 at about 4 pm. The nurse took a history that the patient was in an emergency room 2 weeks previous for asthma and the doctor prescribed prednisone but the patient never got the prescription filled. The nurse documented that the patient also used an unknown inhaler. The officer did obtain information from the patient with respect to his specific inhaler used. PEFr testing was not done. The nurse noted wheezing bilaterally. The nurse diagnosed an AWS level 1 withdrawal but did not use the AWS form so it wasn't clear how the nurse came to the conclusion of a level 1 status. The nurse gave the patient an inhaler and wrote that she would verify the medical care at the hospital. The medication was provided by standard protocol and the nurse did not contact a physician. The nurse did not order a physician follow up.

On 8/26/13 a physician saw the patient and noted that the patient had been on prednisone recently but also noted that the patient was currently without symptoms. The doctor ordered a steroid inhaler for 60 days. The nurse had given an order by protocol for albuterol but this prescription did not have an expiration date and the doctor did not reorder medication. This does not ensure continuity of medication.

Patient #22

Patient #22 was incarcerated 6/18/13 at about 3:30 pm. The officer performing the intake health screening identified no medical problems. On 7/8/13 the patient requested a pregnancy test because she missed a period. The PA performed a pregnancy test in the office and it was negative.

On 7/17/13 the patient requested to be tested again and her test was positive. The PA estimated that the patient was 6 weeks pregnant and recommended an appointment at the Women's Health Center and a 30 day follow up. Iron supplement was ordered along with prenatal vitamins, a pregnancy diet, and a low bunk. The appointment with the obstetrician was scheduled for 9/5/13. All appropriate laboratory tests were ordered. The patient had obstetrical visits at the Women's Health Center.

Patient #23

Patient #23 was incarcerated 9/15/12. The officer noted that the patient had seizures and psychiatric problems. There was no nurse intake assessment in the record. The patient was a transfer from Atascadero State Hospital. He had traumatic brain injury in the late 90s and had severe residual brain injury. A physician at Atascadero described him as mumbling incoherently without ability to respond appropriately to questions. He was unable to state his name, didn't know where he was and was described as unable to comprehend and unable to express himself. He had seizures as a result of his head injury for which he was taking multiple seizure medications. The patient had a risk of falls. The patient was discharged from Atascadero on 3 anti-epilepsy drugs (levetiracetam, phenytoin, and valproate) and lorazepam, olanzapine, and simethicone. The patient also had ataxia (lack of coordination of muscle movements) from his injury necessitating use of a wheelchair.

After incarceration on 9/15/12 the first physician note was 9/17/12. Laboratory tests were evaluated. The physician examined the patient; noted his history continued his medication.

There was no nursing care plan for this patient evident in the medical record. Nurses see him in no pattern even though he is basically unable to provide care for himself. Based on the dates of nurse notes there are times when there are no nursing notes for several days. As example of the status of the patient, on 12/18/12 the patient defecated on the floor and was cleaning it up with his hands. The patient was cleaned and returned to the room. The patient would sometimes bang his hands on the door. Yet there was no documented care plan as would be evident in a skilled nursing unit to manage his inability to function on his own.

After the 9/17/12 note the next physician note was 2/12/13, almost 5 months later, when the patient appeared lethargic. Based on having epilepsy, the patient should have been seen at least every 3 months. This patient was seriously disabled and should have been seen more frequently. Nevertheless, he was not seen for 5 months. A physical examination was not performed except for vital signs and a brief assessment of his mental status. Laboratory values were checked.

On 3/25/13 a nurse documented that the patient was in possession of his medication, dropped it out of his shirt pocket and flushed it down the toilet indicating a potential problem with administration of his medication. This patient had serious brain damage and should not have been in possession of his medication.

On 4/8/13 a nurse documented that the patient appeared to have injured his right arm. An x-ray was ordered but a physician didn't evaluate the patient. The x-ray was normal. The patient had an injury and should have been evaluated by a physician. This was neglectful.

On 4/10/13 a nurse heard a loud noise and noted that the patient was on his right side holding his head. The nurse did not note any bleeding. Two deputies assisted the patient back into his bed. The nurse did not perform an evaluation. Later that day another nurse noted that the patient had a shoulder bruise and did a brief evaluation. She noted a shoulder contusion. A physician should have evaluated the patient for the injury.

On 4/11/13 at 5 am the patient fell and injured himself again. A nurse documented that the patient

“Was seen in room with dry blood on face, bruised right eye and surrounding area of eye. Dried blood seen on cell floor. Inmate with recent unsteady gait last few days. Neuro status hard to obtain with inmate current status. Cleansed wound with sterile water. Superficial quarter sized scratch on R eye brow line. Inmate lying in bed.”

The doctor was called and ordered a Dilantin level with other laboratory tests. Dilantin can cause ataxia which is a loss of muscular coordination. On 4/11/13 a doctor did a thorough evaluation of the patient and sent the patient to the emergency room for evaluation. The patient returned on 4/17/13 but it wasn't clear what transpired at the hospital as there was no hospital summary in the medical record. Hospital summaries should be available in the medical record. There was no provider evaluation upon return. All patients should be evaluated when they return from an offsite visit. On 4/30/13 a physician called the hospital and discovered that the patient was toxic from Dilantin which is what had caused his fall.

There was no follow up examination of the patient after this hospitalization. The patient had recurring episodes of soiling his room. One note documented that the officers took the inmate to the yard for exercise. On 5/21/13 the patient experienced a seizure. The pulse was 155 with a blood pressure of 95/50. The patient was referred to a hospital. The patient remained hospitalized until 5/28/13. A nurse noted that the patient had 25 staples from a surgical incision in his scalp but did not document why the patient had staples. There was no documentation as to what occurred at the hospital in the progress notes. For this hospitalization, there was a discharge summary from the hospital that documented that the patient had a craniotomy and evacuation of a subdural hematoma with removal of the epidural membrane. Apparently, the patient had fallen and sustained a serious potentially life-threatening brain bleed requiring neurosurgical intervention. There was no follow up at the jail by the physician with respect to this serious injury. This was neglectful.

On 7/6/13 a nurse documented that the patient was crying and when approached the nurse noticed blood dripping from a laceration on his scalp “across the internal shunt”. There had been no documentation that the patient had a shunt in the preceding notes. The nurse notified a PA and noted that the PA would see the patient on 7/6/13. This visit did not occur. This was neglectful.

A physician evaluated the patient more than 2 months later on 9/17/13 but did not mention why the patient had surgery in May. He addressed the patient's seizure disorder and noted recent therapeutic drug levels.

On 9/19/13 a physician saw the patient for unsteady gait noticed by the nurses. The doctor noted the most recent drug levels from early in September and re-ordered these levels. This blood level was 50 which is extremely toxic and dangerous. With a Dilantin level of 50, the

patient should have been admitted to a hospital. The doctor stopped the Dilantin, ordered another level and ordered restart of medication at 300 mg at night on the next day. This would be insufficient time off medication to lower the blood level of the drug. An electrocardiogram was not ordered but should have been immediately ordered because at this level, Dilantin can cause cardiac arrhythmias. The patient was not examined but should probably have been admitted to a hospital. This patient was not able to effectively communicate his symptoms and management therefore would rely on frequent blood testing of Dilantin levels, physical examination and assessment, and cardiac monitoring. At this time the patient was on 200 mg of Dilantin twice a day. The medication administration record shows that the patient received a 200 mg dose in the morning of 9/20/13. The medication administration record also documents that the patient received 300 mg on 9/21 as an evening dose. This was consistent with the physician order but given the half life of Dilantin, the level would not appreciably have changed.

On 9/24/13 at 4 pm the laboratory called and reported a Dilantin level of 43.6. This was also a dangerously high Dilantin level. The nurse called the physician who ordered the nurse to hold the Dilantin. The patient was not evaluated by a provider. The patient should have had an electrocardiogram and probably should have been sent to a hospital. On 9/27/13 the laboratory reported a Dilantin level of 32. The doctor gave a phone order to hold Dilantin for two more doses. Because the current regimen was a daily dose, this implied a re-start on 9/29/13. The doctor changed the dose to a liquid form. The patient was still not evaluated by a provider. Later the doctor ordered the Dilantin held.

On 9/28/13 a nurse documented that the patient was unstable on his feet. This implied ataxia, a side effect of an elevated Dilantin level. The patient should have been examined but this did not occur. On 9/30/13 a physician documented a therapeutic Dilantin level and the doctor ordered the Dilantin to be restarted. There was no examination of the patient.

The patient was not examined at all during the ensuing month as of October 24, 2013. The most recent Dilantin level was 23.1 which is a toxic level.

This patient with serious brain damage was not regularly examined while on the outpatient housing unit. He sustained 2 life threatening episodes of medication toxicity while on the unit. At one episode the patient sustained life-threatening brain bleeding requiring neurosurgical intervention. In the other episode the patient was not examined by a physician but managed remotely by phone orders. The patient's seizure disorder was not regularly evaluated in a chronic disease clinic setting. Physician evaluation of the patient was rare, even after significant injuries or after nurse documentation of significant clinical abnormalities. In this sense, from a clinical perspective, the patient was neglected. The medication levels were managed episodically based on significant events rather than on a routine basis. Based on a note describing the patient being in possession of his prescribed medication, the administration of medication did not appear consistently appropriate. This is a difficult patient but he did not appear to have appropriate care on this higher level of care unit.

Patient #24

Patient #24 was incarcerated 9/15/13 at noon. An officer suspected the patient of being under the influence of alcohol and placed the inmate in a sobering cell. A nurse did not perform an intake assessment at that time but performed an evaluation documented on a sobering cell form. The nurse noted that the patient was under the care of a Dr. Rosen and noted that the patient used a CVS pharmacy. The first nurse note was at noon on 9/15/13. The blood pressure was 156/94, pulse 118, and temperature 99.2. The blood pressure and pulse were abnormal. The nurse noted that the patient was cooperative but couldn't focus or give accurate information and that he was intoxicated. The nurses didn't check his blood sugar. The abnormal vital signs and alcohol intoxication should have prompted the nurse to perform an assessment for risk of withdrawal and communication with a physician but this did not occur.

The next nursing note was at 4:30 pm. The nurse documented that officers removed the patient from the sobering cell. The last vitals and physical presentation indicated that the patient might be in withdrawal, yet officers released the detainee from the monitoring. Admission and release from detoxification monitoring should be under medical management.

The nurse intake triage assessment took place a day later on 9/16/13 at 5 am. The nurse noted that the patient had bizarre behavior and didn't know the names of his medications. The nurse deferred vital signs because the patient was uncooperative and bizarre. The nurse also documented that the patient was unstable. The nurse documented that the patient refused to answer her questions. The nurse documented that the patient denied using alcohol but wrote in the comment section that the patient said, "I nib alcohol on my knees. Does that count as drinking daily". In the assessment the nurse wrote that the patient was uncooperative and repeated that his doctor knew his medications. The nurse scheduled a next sick call and the patient went to his housing unit. The patient was not placed in a protected unit. The patient wasn't seen the next day. This patient probably was in alcohol withdrawal or had a mental health disorder; he should have been immediately evaluated by a physician.

The patient placed an undated health request that was written in Spanish. A nurse triaged the health request on 9/19/13. On 9/19/13 the patient placed another health request. This one was written in English and documented pain in his knees.

On 9/20/13 a PA documented that the patient was scheduled for sick call but according to officers, he refused. There was no signed refusal in the record for this date.

On 10/1/13 family members brought the patient's medication to the jail. These included tamsulosin, furosemide, dicyclomine, benazepril, and simvastatin. This did not result in the patient obtaining a prescription for these medications. This was a systematic denial of providing the patient prescribed medication. This patient had previously been incarcerated. On 9/4/13 during a prior incarceration the last blood pressure taken was 168/100. A doctor performed a chart review on 10/3/13 and noted that the patient was at court so the patient was rescheduled. The doctor noted that the patient had been refusing vitals. This was documented on a blood pressure log but the patient did not sign a refusal.

A doctor saw the patient on 10/7/13 in follow up. The blood pressure was 142/93 which is abnormal. The doctor noted that the patient was "talkative" but no history was taken regarding his medical condition. The doctor did not examine the patient except for obtaining the vital signs. The doctor ordered blood pressure checks for 10 days despite the patient's prior refusal. The doctor did not take a medication history and the doctor did not prescribe the patient medication that the patient typically took as a civilian. This denied the patient access to necessary medication. There was no discussion with the patient regarding why the patient was refusing. On 10/2/13 the patient had been referred to a mental health provider for bizarre behavior but this was not noted.

On 10/10/13 the patient was found lying on the floor. His pulse was 103 and the blood pressure was 116/91. The nurse performed no examination except vitals and documentation that the skin was pink and warm to touch and that the patient was alert and oriented. The nurse did not question the patient about what might have caused him to fall. The nurse scheduled a PA sick call for 10/11/13. The PA sick call did not occur. This was neglectful.

On 10/14/13 a nurse emergently responded to the patient for a life-threateningly high blood pressure of 250/140. He was very "talkative". A doctor saw the patient and noted that as an outpatient the patient took amlodipine (a blood pressure medication), simvastatin and Flomax. The doctor ordered hctz, amlodipine, atenolol, Flomax, and simvastatin for the patient. The doctor also noted that the patient was rambling nonsensically about the Anton Scalia from the Supreme Court gave him approval to burn the flag as the flag was a symbol of his words. Clearly the patient was not normal. The doctor requested a psychiatry referral for dementia. If the doctor thought the patient had dementia, a CT scan would have been the standard of care.

The doctor saw the patient on 10/15/13 and the doctor noted that the patient didn't get up to get his medication in the morning. This might have been at 3 am. The doctor offered to change the medication to noon but the patient said he would get up. This was not a normal patient and the physician should have made the decision for the patient.

It appears that a psychiatrist wrote a note on 10/16/13 but it is illegible.

On 10/16/13 someone (I couldn't read the note and the author did not document their professional designation) wrote that the patient's blood pressure was still high. It was 190/98. This person documented referral back to the doctor. On 10/18/13 a doctor documented recent blood pressures without seeing the patient. The doctor increased the atenolol.

It isn't clear that a psychiatrist saw the patient. The altered mental status had not been appropriately evaluated. A CT scan was not done. Laboratory tests (metabolic panel) were not done. This patient had a significant delay in receiving necessary medication resulting in a life threatening high blood pressure. The patient also had a mental health or physical abnormality resulting in bizarre behavior that did not appear to be appropriately evaluated. The physician

evaluations were inadequate in that they did not have appropriate history or physical evaluation.

Patient #25

Patient #25 was incarcerated 8/28/12. On 9/13/12 a nurse documented that a tuberculin skin test was placed on his left arm was negative. It was recorded as 0 millimeters. On 10/15/13 an annual physical examination tuberculin skin test was positive. In the TB log the result was recorded as 20 millimeters. This is a significant test. Because the 2012 skin test was negative, a positive test means that the patient was exposed and infected with tuberculosis during the prior year while at the jail. A nurse ordered a PA follow up but as of 10/24/13 the patient has not been seen, no symptom history of tuberculosis has taken place and the patient hasn't had a chest x-ray. This is very poor infectious disease care. The tuberculosis exposure indicates that someone in the jail had undetected active tuberculosis or the nurse performing the tuberculin skin test in 2012 performed the test inaccurately. In either case, tuberculosis screening was not good.

Patient #26

Patient #26 was incarcerated 8/21/13. On 8/31/13 a nurse performed a TB assessment form. The patient described night sweats, cough, sputum production, and described a previous negative skin test. A skin test was performed and read as 30 millimeters positive on 9/2/13. On 9/19/13 a chest x-ray was ordered. As of 10/24/13 the x-ray has not been performed and the patient has not seen a provider. Because the patient had positive symptoms of tuberculosis (night sweats, cough and sputum production) the patient should have been immediately isolated and evaluated for active tuberculosis. This was not done. The patient has not been fully evaluated for tuberculosis for almost 2 months. It should not take almost 2 months to obtain an x-ray after a positive tuberculin skin test. When the tuberculin skin test was positive given his symptoms, the patient should have been immediately isolated and had an x-ray to test for active tuberculosis. These failures demonstrate an ineffective tuberculosis screening program.

Patient #27

Patient #27 was incarcerated on 8/2/13. Almost a month later, on 8/30/13 a tuberculin skin test was completed and was 30 millimeters positive. The patient had no symptoms of TB. The nurse ordered a chest x-ray on 9/3/13. The chest x-ray was completed 9/5/13 and was negative for acute disease. There was no follow up of the positive skin test with a history of potential exposure and prophylaxis. Screening for tuberculosis for this man was accomplished in a little over a month. This should be done as soon as possible upon admission. The procedure at the facility is that this should occur within 2 weeks, which did not happen.

Patient #28

Patient #28 was incarcerated 9/12/13. He had a tuberculin skin test read as 30 + millimeters read on 10/2/13. The patient had a prior negative skin test in 2012. He was asymptomatic. A chest x-ray was ordered 10/3/13 and was negative on 10/8/13. There was no documentation that the patient was informed and the patient was not seen in follow up. Tuberculosis screening occurred later than recommended by the facility policy and there was no follow up with a provider with respect to the patient's abnormal test result.

Patient #29

Patient #29 was incarcerated 10/1/13. On 10/14/13 a nurse documented a 30 millimeter tuberculin skin test. On the TB assessment form a nurse documented a prior negative test in 2007. However, an old TB assessment form from 10/25/08 recorded a 10 millimeter positive TB skin test. On 10/15/13 a nurse ordered a chest x-ray. The inmate was discharged before an x-ray could be done. The nurses performing tuberculosis screening failed to notice a prior positive tuberculosis skin test which is not effective tuberculosis management.