

First Monitoring Report

US Department of Justice v. Erie County

This report reviews the status of medical program conditions at the time of the first monitoring visit, which took place November 1-3, 2011.

The format for this report will follow the provisions of the Agreement within the medical care section of the Agreement. Each area will be described in terms of compliance status, findings and recommendations. Because this is the first monitoring report and therefore the County will have had no experience in appreciating the methodology utilized, this Monitor views this report as a baseline description of the status. What will become important is the extent to which each subsequent monitoring visit is able to demonstrate improvements in the areas identified as needing improvement. Compliance status will be assessed as: substantial compliance, meaning the program has achieved the intent of the agreement; partial compliance, which means the program has accomplished one or more aspects of the intent but not the full intent, non-compliance, meaning that we have not been able to observe any progress in the delineated area or non-ratable meaning insufficient data was available to assess compliance. We would expect that the recommendations would assist the jurisdiction in identifying major areas of focus. We would also expect that over time the number of areas being noncompliant will become substantially reduced and the number of areas becoming substantially compliant will be significantly increased. We remain available for consultative input during this entire process and would encourage the jurisdiction, where indicated, to avail themselves of this resource. We are also allowing the jurisdiction to submit any additional policies, procedures or other relevant documents to the Monitor before the end of January 2012. This data will be used to craft the final version of this first monitoring report, to be submitted to the court by the end of February 2012.

B. Medical Care

1. Policies and Procedures

Compliance Status: Partial compliance.

Findings

I have reviewed over 40 policies and procedures along with associated forms and although there are modifications that are needed, it is very clear that the County has invested a substantial amount of work into developing an organized and coherent policy and procedure set to guide their staff.

Recommendation

1. Continue to work on the policies and procedures and use my letter as a basis for many of the changes.

2. Medical Autonomy

Compliance Status: Substantial compliance.

Findings

We came across no situations in which there was custody or administrative intervention overriding a clinical decision. In our discussion with the Erie County stakeholders, it seemed clear that the County was committed to the philosophy of medical autonomy. We have reviewed policy 01.01.00 and it is consistent with the intent of paragraph 2.

Recommendation: None.

3. Privacy

Compliance Status: Noncompliance.

Findings

Not only were we unable to observe all the clinical areas where assessments were performed, but also there is no discreet policy that addresses privacy issues, especially in clinical areas. Although there is an effort to insure confidentiality is afforded during clinical assessments, we were not able to thoroughly review the matter of patient refusals of medication. In fact, during the observed medication rounds, if people on medications did not show up for their medications it was treated as a refusal without any verbal or written confirmation.

B. We were not able during this visit to observe the variety of areas where clinical assessments occur. Thus, we could not confirm that the County was compliant in insuring confidentiality during assessments.

C. We also were not able to observe that appropriate documented training on how to maintain patient confidentiality is provided for all those non-healthcare staff who facilitate healthcare through performing the interpreter role.

D. We did observe that healthcare records are maintained separate from correctional records and are transported in a secure fashion.

Recommendations

1. Modify the medication administration procedure so that patients are forced to either refuse or accept medication. Not being present is an unacceptable alternative.
2. Be prepared to demonstrate training regarding confidentiality given to custody staff or others who perform the interpreter role.
3. Develop a policy that addresses privacy, in particular for all of the clinical areas.

4. Training of Custody Staff

Compliance Status: Substantial compliance.

Findings

The County was able to demonstrate documentation of training provided to custody on responding to medical urgencies and emergencies as well as supervision of inmates with serious medical needs.

Recommendation

1. Continue to maintain records of appropriate training provided to officers with regard to these healthcare areas.

5. Management of Health Records

Compliance Status: Partial compliance.

Findings

Although the County is attempting to insure that all healthcare data are kept in a single file, the current file lacks both medication lists as well as updated problem lists, thus inhibiting the efficient use of these files. We are aware that the County plans to transition to an electronic record and this may ultimately resolve many of these issues.

A. We reviewed policies 03.00.00 through 03.03.00. These policies are consistent with the intent of the Agreement.

B. We did identify records in which documentation was missing greater than 72 hours after its creation. This suggests that there is a problem with timeliness of filing and thus ultimately completeness of medical records.

C. We were not able to verify that health record documentation is sent offsite timely and that upon return necessary information is available in a timely manner. On the other hand, we did identify that in most instances records were transported from ECHC to ECCF and vice versa in a timely manner.

D. We were unable to verify that the lead physician is being notified of transfers from the County's custody staff to another facility and therefore that critical health information is prepared and sent with the prisoner at the time of transfer.

E. We were informed that there currently is not a procedure to provide prisoners with written instructions including a fax number where future medical providers can request a summary which includes the prisoner's major health problems and current medications and dosages.

Recommendations

1. Implement a procedure to insure that both an updated problem list and a medication list is available in each record which includes both medical, mental health and dental documentation.
2. Implement a timely process for medical record filing, preferably faster than 72 hours, so that critical information is virtually always available at the time that services need to be provided.
3. Implement a procedure that insures that as soon as the patient returns from the offsite service, efforts are made to retrieve the documentation of the service, have that documentation reviewed by a clinician and acted upon, including follow up with the primary care clinician.
4. Insure that custody notifies medical leadership timely so that appropriate documents can be prepared for transfer when patients are sent or transferred to offsite facilities.
5. Implement a policy and procedure to provide prisoners with written instructions including a fax number where future medical providers can request a summary of the prisoner's medical treatment.

6. Medication Administration

Compliance Status: Partial compliance.

Findings

We have reviewed policies 0.6.03.00 through 0.6.04.00. We did review the medication administration process on Echo Northeast and Southwest as well as letter B linear. From our observation, medical staff who administer medications were all nurses, either licensed practical nurses or registered nurses, who were working within the scope of their license. We were unable to verify that greater than 90% of medications were received by the patient within 48 hours of the order. Due to the underestimation of time required to complete the monitoring review, we were not able to perform a study which would have allowed us to reach a conclusion regarding the timeliness of receipt of medications. This was true both for patients who had been in the

facility as well as new arrivals. We did observe that medical staff who administer the medications document on the medication administration record the date and time medication is administered. However, there were two major problems with the medication administration process. First, patients who did not show up were treated as refusals, which may not always be the case. There must be a more concerted effort to identify the reasons for patients not receiving their medications. In addition, although there was good coordination with custody staff during the medication administration process, in general there was no mouth check after the medication was ingested.

We were unable to review the process to provide medications during transit nor were we able to review the process for providing access to medications upon release for those in house 30 days.

Recommendations

1. Perform a study looking at the timeliness between medication order and patient receipt of medication.
2. Perform a study looking at timeliness of receipt of medications identified as necessary during the intake process.
3. Implement a procedure so that medication refusals are in fact documented on the basis of patient description as opposed to patients not showing up.
4. Implement a procedure so that ingestion of the medication is witnessed after mouth inspection by the correctional officer.
5. Perform a study of patients being transferred to other facilities and look at whether medications are transferred with them.
6. Perform a study looking at patients who have been in the facility 30 days and are released and whether or not they receive a seven-day supply of medications. Both of these studies will require excellent cooperation with custody.

7. Access to Care

Compliance Status: Partial compliance.

Findings

We reviewed policies 0.8.00.00 through 0.8.09.00. We do know that the process includes slips being available seven days per week and picked up daily by medical staff. We are also aware that the process is to include an immediate screening by an RN or advanced level practitioner within 24 hours of collection. Patients with symptoms are to be seen in no more than 48 hours or sooner when indicated. In a brief review of the sick call process we found some instances of patients being seen timely but others in which we could not locate a documented note within the medical record.

Recommendations

1. Conduct a study in which the timeliness of both initial triage and face-to-face visit are tracked by housing area to insure that each housing area is in compliance with this agreement.
2. Conduct a study reviewing the nursing professional performance with regard to nursing assessments for sick call symptoms. This study should be part of an ongoing process of professional performance enhancement such that nursing skills are continually refurbished.

8. Emergency Care

Compliance Status: Partial compliance.

Findings

We reviewed policy 11.01.00. We had several recommendations which are included in the attached letter. In the letter is a restatement of the need to create both an emergency medical care policy and an urgent care policy. We are strongly recommending that each be developed. Emergency care most commonly refers to man down situations and may result in offsite referrals. We did review several records in which emergency care services were provided. That documentation is consistent with at least a partial compliance status.

Recommendations

1. A logbook should be maintained which has the date, the time of the emergency, the patient name, the presenting complaint and the disposition.
2. Similarly for urgent matters such as a patient telling an officer they have developed a severe abdominal pain, a similar log book maintained in the nursing station should track urgent complaints, most of which will not result in an offsite referral but must result in a nursing assessment. The same fields should, however, be tracked. On a regular basis, at least once per month, a study should be done looking at selected emergency send offs as well as urgent symptoms treated onsite. In both studies, appropriateness and timeliness of response is critical as well as follow up after the fact.

9. Follow Up Care

Compliance Status: Partial compliance.

Findings

We reviewed policy 07.01.00, which addresses offsite diagnostic and treatment services, including their follow up, after our site visit. Without the policy and procedures at the time of the

visit, we did not look carefully at patients who underwent offsite referrals. However, what is important is that the sendoff is performed timely and the follow up on return begins with an assessment when the patient returns to the facility and is completed when the necessary paperwork is available and the patient is seen in follow up by the primary care clinician who documents a discussion with the patient regarding findings and plan. This is true for emergency department visits offsite, hospitalizations offsite, outpatient specialty procedures as well as consultations. The same elements must be in place for all of these services to be adequately followed up.

Recommendation

1. Implement a policy and procedure conjointly with custody that insures that when patients return from offsite services there is a medical person who reviews the material and if critical information is unavailable makes sure that the offsite documents are available and where indicated, acted upon. In addition, a follow up visit with the primary care clinician must take place.

10. Chronic Disease

Compliance Status: Partial compliance.

Findings

We have reviewed the chronic disease policy 08.03.00. We know that patients are being followed regularly for certain chronic diseases, but we did not have an opportunity to review a significant sample of records. We strongly encourage the Medical Director to selectively review records of those patients who are the most poorly controlled or the sickest. This review should occur on a regular, monthly basis so that feedback can be provided to the primary care clinicians that may help improve their responses.

Recommendations

1. Add a general medicine clinic for less common chronic diseases so that diseases such as hypothyroidism and rheumatoid arthritis may be followed in such a clinic.
2. Begin reviewing a sample of records, if possible, of patients who are least well controlled. If there is any question on how to do this we would be happy to help.
3. The program must insure that all patients with chronic diseases have these diseases listed on the problem list in the medical record.

11. Dental Care

Compliance Status: Partial compliance.

Findings

We have reviewed policy 08.06.00 on dental care. For purposes of this Agreement, our concerns focus on the following areas:

1. Treatment decisions are based on clinical factors only and not overarching policies.
2. There is a system in place to insure that patients are able to receive timely temporary relief from pain through accessing a nurse who uses a protocol before being assessed by the dentist.
3. The dental program must have a viable infection control component, including sterilization, monitoring of biologicals, etc.

Recommendation

1. Begin also monitoring the ratio of restorations to extractions as part of your quality improvement program.

12. Care for Pregnant Prisoners

Compliance Status: Partial compliance.

Findings

We have reviewed policy 08.04.00. We do know that a County obstetric service is made available. Our expectation is that practice is consistent with the American College of Obstetrics and Gynecology guidelines, including prenatal monitoring, testing, etc. Offsite documented encounters must be available in the ECHC medical record.

Recommendation

1. Insure that documented offsite obstetric encounters are part of the Erie County medical program's medical record.

13. Dietary Allowances and Food Service

Compliance Status: Partial compliance.

Findings

We have reviewed policy 06.09.00 and this policy is generally acceptable. We did not have a chance to review this area in any detail. However, we believe the medical care section is only responsible for insuring medical diets' appropriateness and availability. Religious diets are best reviewed by another area.

Recommendations

1. Perform a study of the timeliness of the availability of medical diets, from the time of the medical order to the time the patient receives the diet.

14. Health Screening of Food Service Workers

Compliance Status: Partial compliance.

Findings

We have reviewed policy 02.11.00 and find it to be acceptable. All food service experts now believe that the best way to prevent food borne illnesses is a daily screening by the food service supervisor looking for open lesions on hands and arms and a history of any recent diarrhea. This screening should be done by dietary supervisors and not by healthcare staff. Healthcare staff may in fact clear people to work in the area in the sense that they are physically and mentally capable. Beyond that the responsibility rests with food service supervisors.

Recommendation: None.

15. Treatment and Management of Communicable Diseases

Compliance Status: Partial compliance.

Findings

This is a County program managed by the Department of Health. We have reviewed policies 08.08.00 through policy 08.09.00. These policies are comprehensive. Implementation should be monitored as an aspect of your quality improvement program.

Recommendation

1. Begin monitoring appropriate elements of the communicable disease program as part of your quality improvement program.

16. Sexual Abuse

Compliance Status: Partial compliance.

Findings

The County is obligated to report and protect individuals who are at risk for sexual abuse. We have reviewed policy 02.02.00 and it appears to address MOA issues.

Recommendation

1. Develop a log so that allegations of sexual abuse are trackable and records can be reviewed on the basis of log data.

2. Send any studies, meeting minutes or other documentation that is consistent with a systematic effort to identify problems and mitigate them.

17. Quality Management

Compliance Status: Partial compliance.

Findings

We have reviewed policies 12.00.00 through 12.02.00. These policies, in general, contain the elements one would expect to see in a correctional quality improvement program. If the County chooses, this Monitor would be happy to do a training program for the staff with regard to a corrections quality management committee program. Because this is a baseline visit, we certainly have not anticipated that this area would have gone beyond noncompliance.

Recommendation

1. Begin implementation of your quality improvement program.

18. Review of Clinical Care by Responsible Physician

Compliance Status: Partial compliance.

Findings

We have reviewed the policy on peer review, 12.02.00. It provides for a systematic review of clinical work by the supervising physician. We are unaware of a systematic review by the responsible physician. We will work closely with the responsible physician so that he will develop an efficient methodology to sample records in order to help improve the care.

Recommendation

1. Develop a systematic process for review of clinical care, focusing on care of those whose disease process is least well controlled.

Summary

In many areas, we have now reviewed policies which have been drafted and approved. In an accompanying letter we are going to suggest some changes. However, we wish to commend the staff of the Erie County Department of Health for developing this substantial number of policies and procedures. We look forward to monitoring the implementation of many of these policies and procedures. We would like to see a schedule for training and implementation of as many of these policies as possible. We look forward to being able to monitor and find successful implementation in many of these areas at the time of our June visit.

Respectfully submitted,

R. Shansky, MD

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APPENDIX (compliance indicators)

5. Management of Health Records

Compliance indicators:

- a. Amount of loose filing available at the time of visit as a reflection of timeliness of filing of documents.
- b. A form provided to inmates, including a fax number where future medication providers can request a summary.

6. Medication Administration

Compliance indicators:

- a. Documentation of training for officers which includes inspection of mouths after ingestion.
- b. Documentation of a procedure which instructs nurses to only document refusals when the patient is present to refuse.

7. Access to Care

Compliance indicators:

- a. Use of a log that tracks receipt by health care staff of request slips documenting patient's name and number as well as date of receipt, nature of complaint and timeframe for patient to be seen by a nurse.
- b. Using this log, studies that document timeliness of both initial triage and face-to-face visits.

8. Emergency Care

Compliance indicators:

- a. Presence of a logbook for emergency services as well as one for urgent services that allows studies of both timeliness and appropriateness to be performed.

9. Follow Up Care

Compliance indicators:

- a. Policies and procedures which insure that when patients return from either scheduled or unscheduled offsite services, they are brought to the medical area for review of offsite documentation including efforts to obtain such if not available.
- b. The scheduling of follow up visits with an advanced level clinician so that the findings and plan can be discussed with the patient. Studies of timeliness of access, both for urgent and routine care, are documented.

11. Dental Care

Compliance indicators:

- a. Studies from the sick call log of nursing responses to toothaches for both timeliness and appropriateness.
- b. Documentation of the ratio of extractions to restorations are maintained on a monthly basis.

15. Treatment and Management of Communicable Diseases

Compliance indicators:

- a. The presence of an infection control nurse.
- b. The tracking of the incidence of MRSA infections, TB infections as well as active disease and the tracking and incidence of sexually transmitted diseases.

16. Sexual Abuse

Compliance indicators:

- a. A logbook that documents names and identifiers for patients who have made these allegations.

17. Quality Management

Compliance indicators:

- a. Policies and procedures.
- b. Minutes of quality improvement committee meetings.
- c. Quality improvement studies looking at particular areas in systematic ways with an eye towards identifying problems and mitigating them.

Second Monitoring Report

US Department of Justice v. Erie County New York

This report reviews the status of medical program conditions at the time of the second monitoring visit, which took place June 4-8, 2012.

B. Medical Care

1. Policies and Procedures

Compliance Status: Substantial compliance-drafting of policies; Partial compliance-implementation of policies.

Findings

With the addition of the policy on privacy, the set of over 40 policies and procedures and forms that I have reviewed addresses all of the areas concerned and in most of them, implementation has begun. In many of them, as would be anticipated with early implementation of policies and procedures, conformance to the policy and procedure requirements warrants improvement. However, what has been accomplished since our last visit, in the eyes of the Monitor, is quite impressive.

Recommendation

1. When it occurs that in the judgment of the leadership team a policy needs to be significantly modified, please send the draft modification for my review before approval and implementation.

2. Medical Autonomy

Compliance Status: Substantial compliance.

Findings

We had a very constructive discussion with the Medical Director and the custody leadership of the jail regarding the use of controlled substances. We were impressed with the desire of both health care leadership and custody leadership to accommodate each others' needs and concerns in a way that allowed for the availability of necessary medications but under very controlled requirements.

Recommendation: None.

3. Privacy

Compliance Status: Partial compliance.

Findings

The main privacy problem identified was that in order to screen unarraigned patients the screening takes place in an open area where other individuals may overhear the querying and responses. Since mid-May, however, the unarraigned males are no longer coming to Erie County Holding Center and thus a comprehensive screening for unarraigned males will no longer be needed. This will allow for the screening of the arraigned males which is currently done in a much more confidential area, to be the mechanism used not only for the arraigned males but also, we are told, for unarraigned and arraigned females. We are hoping that this change in procedure can occur as rapidly as possible but certainly before our next visit. We also identified concerns about the placement of the nurse, the patient and the officer in the exam room where the arraigned are receiving their screen. It is our perception that if the room is reconfigured slightly and the position of the three individuals is modified it will be much easier to insure auditory confidentiality. We also discussed the need for staff to be trained in how to conduct a very quiet interview in a way that gives the patient confidence that a nearby officer is unable to hear the details of the interchange. We did observe documentation which demonstrates that officers have received the required training regarding confidentiality as have medical staff. All of the interactions with the use of the exam space in the new building pods could be conducted confidentially; however, these rooms are not commonly used. The same is also true for the exam spaces in the old building. The clinic area can afford confidentiality; however, there is a concern that one clinical exam space is used by health care staff as a thruway between two different areas. Although these are health care staff it would be advantageous if the use of the space as a thruway could be diminished. Finally, the maintenance of the health records continues to be separate from the custody records and, from our observation, are transported securely. If the changes described above occur in the booking area, it is entirely possible that this area could move to substantial compliance at our next visit.

Recommendations

1. Health care leadership should train their clinical staff in how to conduct muted, confidential interviews with patients so that a nearby correctional officer would be unable to discern the details.
2. Implement the new procedure in the booking area so that the only screening rooms used by health care staff are afforded reasonable confidentiality.
3. Reconfigure the locations of the patient, the nurse and the custody officer in a manner that allows confidentiality while assuring safety.

4. Training of Custody Staff

Compliance Status: Substantial compliance.

Findings

We reviewed the database which includes all of the required training listed in this Agreement, with the training supervisor for custody. We were able to identify that well over 90% of the officers have received the required training regarding responding to medical urgencies and emergencies, supervision of inmates with serious medical needs, identifying the signs and symptoms of drug and alcohol withdrawal, suicide prevention, sexual abuse, confidentiality as well as CPR and First Aid. The system used by the custody staff is a model for both insuring that training occurs timely as well as tracking when annual training is due.

Recommendation None.

5. Management of Health Records

Compliance Status: Partial compliance.

Findings

Although the medical program has, in a general sense, described a desire to convert to an electronic record, there really has been no progress in this area since our last visit. This Agreement does not require an electronic record although having one would eliminate many of the existing problems that remain to be resolved for compliance with this Agreement. The one thing we emphasized with medical and mental health leadership, whether the final decision is for a paper record or an electronic record, is that the Agreement anticipates a unified record and in order to achieve substantial compliance the record must be unified.

With regard to our review of the records, we learned that on weekends there is no access to old inactive records. If this were also true for active records the assessment could be noncompliance, but since it is only true for inactive records the assessment is partial compliance. This problem must be resolved as soon as possible, certainly well before the implementation of an electronic record. We also learned that there is what we perceive as a counterproductive turf problem between medical and mental health staff, in that medical clerks do not pull records for mental health clinicians. All of the staff are County employees and the turf problems can only lead to avoidable delays in the availability of a record. This should be resolved prior to our return. We learned that although loose filing is tracked for the active records it has not been addressed as conscientiously for the archived records. Thus, one could retrieve an archived record and not realize that there was loose filing that was not in the record. We did observe that in the last few weeks a problem list has been utilized in the medical records; however, in most of the records we reviewed, of course, there was no problem list. The implementation of a problem list requires very specific training for clinicians with regard to who can enter problems and what problems should be entered on the problem list. There should be a list of rules for problem list use. In one of the problem lists we observed that a patient who had been in and out had his chronic problem, hypertension, listed twice even though the purpose of a problem list containing chronic problems is to avoid the repetition since these medical problems tend to occur usually for life. We also did not see a

medication list or profile in any of the records; although this is available electronically, it would have to be printed out for use by the clinician. At a minimum, this should be available for chronic care encounters. We were impressed with the studies done addressing the timeliness of availability of records at ECCF when patients are transferred there from ECHC. The rate of availability in less than one day was well over 80-85%. We strongly encourage studying the outliers in order to improve the timeliness of availability. We also suggest studying the much less frequent transfers from ECCF to ECHC to insure that much more infrequent process is accomplished timely.

Recommendations

1. Insure that there is an updated problem list in each medical record.
2. Track loose filing, both for active and archived records.
3. Correct the access problems for archived records on the weekends.
4. Implement a strategy to insure that there is a medical list or profile available at a minimum for chronic disease visits.
5. Department of Health and Department of Mental Health should jointly pursue a strategy to insure a unified medical record, including the possibility of an electronic record.
6. Perform studies looking at the outlier records which are not available at ECCF within 24 hours of transfer.
7. Perform a study looking at the timeliness of availability at ECHC of records of patients transferred from ECCF to ECHC.

6. Medication Administration

Compliance Status: Partial compliance.

Findings

There has been significant improvement in that it is much less common that patients who may be in the housing unit but do not show up to the nurse cart are documented as refusals without any effort to contact them. We observed both a morning and an evening medication pass; in each timeframe we observed medications administered in both the old facility and the new facility. In general, there was improvement in contacting patients and in performing mouth checks. Documentation by the nurses was observed to occur timely. About 10% of those who received medications did not undergo a mouth check. We might add parenthetically the inmates appeared to be quite cooperative when requested to undergo a mouth check. We did observe on one medication pass that although the officer did call in a loud voice that the nurse was present and then at the end of the med pass the officer called for a last call, an inmate who had been somewhere in the housing unit showed up just as the nurse was ready to leave the unit. We discussed with nursing leadership the importance of the medication nurses having a procedure that allowed them to know which of the patients for whom medications should have been administered did not show up in the medication line. This would allow the nurse to request the officer

to specifically contact this patient and, if there was a refusal, obtain that refusal between the patient and the nurse.

We also observed medication records in which there were at least three doses in a row with a documented refusal but no referral to the prescribing clinician. We found other records in which there were multiple blank spaces. We have explained to nursing leadership how to calculate a medication error rate comparing the number of blank spaces to the number of doses that should have been offered in a given period of time, usually a month. We encouraged reviewing this by analyzing a sample of MARs of patients who are on more than two medications, each month for each nurse that performs a medication administration service.

We also reviewed timeliness studies that were presented to the medical review committee from time of order to time of receipt. Those studies demonstrated that for new orders for patients entering booking, time to receipt at the holding center was 26 hours whereas time to receive at the correctional facility was 18 hours. For medication continuity, the average time at the holding center was 19 hours on reorders and 27 hours at the correctional facility. All of these times are satisfactory with regard to the performance of the medication administration program.

We learned that patients in Erie County who are released by the court do not return to a correctional facility automatically, even to retrieve their property. In our experience this is unusual. This poses a greater challenge for the program to insure reentry medications are available. We looked at a log of patients who had been released and the log documented whether or not they had called the facility regarding their release medications. The rate of calls was extremely low. Thus, medication continuity on reentry is extremely low. There is national data that demonstrates a link between absence of reentry healthcare continuity and an increased rate of recidivism. Thus, not only is the patient affected, but also ultimately the County is affected by this problem. We would strongly encourage you to be creative in designing strategies that would facilitate reentry health care continuity.

Finally, we did discuss the desire in any correctional facility for clinicians to minimize the use of medications that have to be administered more than twice per day and also the desire to minimize the number of medications ordered on an as needed basis.

Recommendations

1. Perform medication error studies each month, calculating the error rate using the methodology previously described and attempt to achieve an error rate of less than 1%.
2. Perform studies on compliance with the policy regarding repetitive refusals. This phenomenon is much increased for patients on psychotropic medications.
3. Repeat the timeliness studies, particularly with regard to patients who enter the holding center and whose medications are verified.

4. Implement your plan for a poster to be available outside the property window which has information describing how patients can access medications on reentry.

7. Access to Care

Compliance Status: Partial compliance, near substantial compliance.

Findings

The Erie County Holding Center and Correctional Facility have implemented procedures that utilize a paper health service request form filled out by the inmate at the time there is a request for a non-urgent symptom to be addressed. These are collected daily and initially paper triaged by an RN. The paper triage is to determine whether the slip describes symptoms that are either urgent or emergent that should be addressed immediately. The slips are then at the Holding Center, given to a nurse practitioner who schedules visits for most of them with a nurse practitioner within the next two days or, for some that appear to be less complex, for a registered nurse. At the Correctional Facility, all patients are scheduled to be seen the next day and when they arrive the head nurse triages them to either a nurse practitioner or a registered nurse. Studies at both facilities demonstrate that well over 80% do have a face-to-face encounter within the required two days. In general, the notes documenting the nursing assessment were appropriate. One of the requirements for the sick call process is that the registered nurse or nurse practitioner insure that the symptom described on their request is addressed. It is not uncommon for both the patient and the clinician to become distracted if some new symptom has developed and the end result is, although the new symptom may be adequately addressed, there is no documentation of any discussion regarding the symptom described on the request form. For the sick call process to achieve substantial compliance, it must be timely, which it appears to be, although it would be extremely useful to review the outliers to determine what is the timeframe in which they get seen and what are the causes for the delays. In addition, the professional performance has to be regularly assessed. The Medical Director is looking at professional performance and we discussed how this can be most effectively done, including reviewing to make sure that the symptom on the request slip has in fact been addressed.

Recommendations

1. Analyze timeliness outliers both to determine how long the delays are and also to implement procedure changes to mitigate the number of outliers.
2. In performing the professional performance review, insure that the clinicians are addressing the symptom described on the request.

8. Emergency Care

Compliance Status: Partial compliance.

Findings

The County has both an emergency care and an urgent care policy. During this visit, the emergency care approach at the time of the emergency and including transport to the offsite service is clinically appropriate and timely. We did find that on return to the facility, there were instances where there was no documentation of the patient's return through nursing in the booking area and also there was no timely clinician follow up visit to insure that the patient's health status was appropriate and that the patient understood the findings and plan.

With regard to the urgent care policy, there is a telephone log that has been implemented to document and track the urgent care responses. However, the implementation of this log has created some confusion in that it is not only used for officer calls subsequent to patient expression of urgent symptoms but also used as a vehicle for mental health staff to refer to medical clinicians. If it is necessary to use this for both purposes, it is important that the documentation as well as staff understanding make it clear what the differences are between the two uses of the log. In addition, we identified a few circumstances in which a nurse did not perform a face-to-face assessment as a result of the officer phone call. The policy requires that upon receiving the expression of an urgent symptom from a detainee, the officer is required to contact the medical staff. Similarly, the medical staff is required to perform a face-to-face assessment. When a nurse tells an officer to tell the patient to sign up for sick call instead of complying with the policy and assessing the patient directly, this can be construed by the officer as an appropriate response for him the next time an urgent symptom request is conveyed to him and thus conclude there is no need to call. Serious negative outcomes may ensue. There must be a certain degree of rigidity, both for officers and for nursing staff, in order for this procedure to minimize risk to the patient and reduce liability for the County. We must add that most nurses responded timely with an appropriate assessment. However, in this particular area, most is not good enough.

Recommendations

1. Monitor for nursing notes documenting both send out and return for emergency related trips.
2. Monitor follow up visits by advanced level providers after emergency send outs with documentation of current health status as well as the offsite services, findings and plan having been discussed with the patient.
3. Clarify the utilization of the telephone log with all staff.
4. Monitor adherence to the telephone log documentation rules.
5. Monitor the urgent symptom phone calls for a timely assessment by a nurse in all instances.

9. Follow Up Care

Compliance Status: Partial compliance.

Findings

This item requires the facilities to implement procedures that insure a process is in place that guarantees timely assessment and follow up, both for unscheduled as well as scheduled offsite services. At both facilities, we reviewed a small sample of unscheduled offsite services provided as well as a mixture of both procedures and consultations within the scheduled offsite service category. We found that implementation of the policies in this area is not yet fully compliant with policy requirements. With regard to the unscheduled offsite services, there should be a nursing note for the send out as well as the return, although in some instances an advanced level clinician note at the time of send out may substitute for the registered nurse note. At the time of return, the nursing note should include whether or not the required documentation of the offsite service is available as well as the patient's current health status and a description of any new orders that may be recommended. Where there are new orders the nurse is required to contact an advanced level clinician to receive those orders verbally and then to schedule a follow up visit with a clinician and the patient. At the follow up visit by the advanced level clinician, there must be documentation of a discussion with the patient regarding his health status and any offsite findings and recommendations.

With regard to the scheduled offsite services, we again found that there was frequently an absence of nursing notes on return as well as an absence of timely follow up visits with the advanced level provider. The nursing note on return should document what specific service was received and the fact that the patient is being scheduled for a follow up visit and the offsite service report is being retrieved. The clinician visit for follow up to a scheduled offsite service must include a description of the patient's status, the findings of the offsite service and any future plans. It was quite infrequent that we found records where all of the required assessments and documentation were present. However, we did find in differing records that each of the required assessments were documented. This should explain the assessment as partial compliance.

Recommendations

1. For unscheduled offsite services, monitor for presence and appropriateness of registered nurse notes both at the time of send out and upon return.
2. Monitor for the presence of offsite service records which have been initialed.
3. Monitor for the timeliness and appropriateness of follow up visits with the advanced level clinician.
4. With regard to scheduled offsite services, monitor for the presence of nursing notes on return that contain the information described above.
5. Monitor for the appropriateness and timeliness of advanced level clinician follow up visits containing the required elements listed above.

10. Chronic Disease

Compliance Status: Partial compliance.

Findings

A chronic disease program has been implemented at both facilities. There is a chronic disease registry that lists the names of patients with each chronic disease. However, the current method of creating the chronic disease registry requires a clinician to fill out an encounter form listing the diagnosis, which is then forwarded to a clerk who enters it into a jerry-rigged space in the scheduling software. The data entry by the clerical staff is greatly backlogged so that the list does not contain names of patients recently added to the program and may not be up to date with those who have been released. This is of course an area where an electronic record should solve this problem. We looked at a small sample of records of patients with chronic diseases at each facility and identified opportunities for improvement which were reviewed with the Medical Director. The performance by the advanced level clinicians was consistent with what one would expect to find in a newly implemented program where the staff are becoming used to the guideline requirements. If the Medical Director is able to continue to review records and provide feedback to each clinician, we are confident performance will improve.

Recommendations

1. Work on improving the completeness of the chronic disease registry.
2. During the individual clinical performance reviews, identify patterns of deficiencies which could be used in group training.
3. Consider a procedure that requires the advanced level clinicians to refer any patient whose disease is poorly controlled and does not improve at the follow up visit to the Medical Director. This should enable the Medical Director to be involved with the sickest patients.

11. Dental Care

Compliance Status: Partial compliance.

Findings

In reviewing the dental program, our focus is on timeliness of access, particularly with regard to pain, as well as based on the quality of the dentition and the utilization of other procedures than exclusively extractions. We learned at this visit that at the Holding Center, the dentist is onsite two days per week and on one of those days there is no dental assistant available. We also learned that at the Holding Center restorations are not performed. There have been instances where patients are sent offsite to obtain restorations. It is unlikely that the number of restorations performed, if appropriate assistance and equipment were available onsite, would not exceed the number of restorations sent offsite. The standard in the community requires a dental assistant hour for each dentist hour and the use of restorations as an alternative to extractions when the dentition is well maintained. That is the standard that we look for. We also learned that when nurses are addressing dental pain they contact the dentist for orders. We do think that it is important to review the timeliness and appropriateness of the nursing response to dental pain.

Recommendation

1. Provide a dental assistant hour for each onsite hour of dentist.
2. Implement the requested equipment in order to facilitate onsite restorations.
3. Monitor the timeliness and appropriateness of nursing response to dental pain.
4. Report to the quality improvement committee on a quarterly basis the monthly ratio of restorations to extractions.
5. Monitor and report to the QI committee the rate of post extraction infections.

12. Care for Pregnant Prisoners

Compliance Status: Partial compliance.

Findings

Although in the few records we reviewed pregnant women were receiving prenatal vitamins and special diets, we could not review the care because the Women's and Children's Hospital was not sending copies of their encounter forms. Rather, they sent a one line note indicating the condition was fine. This is not adequate, either for the Monitor nor for the Medical Director to know the details of what was found at specific prenatal visits. Since the Women and Children's Hospital utilizes a program which has been certified by the American College of Obstetrics and Gynecology, I am of the belief that the documentation to be received will be fully compliant with those guidelines. However, that documentation must be available within the Erie County medical records. This should explain the basis for the assessment as partial compliance.

Recommendation

1. Insure copies of prenatal visit encounters are present in a timely manner in the Erie County Correctional Institution records.

13. Dietary Allowances and Food Service

Compliance Status: Substantial compliance.

Findings

The dietary program at both ECHC and ECCF do provide for special medical diets. In fact, a study was done by the quality improvement program which showed that at both facilities, the timeliness of diet implementation from the time of order was generally within 48 hours. Both facilities have reasonable programs to insure a minimalization of food borne illnesses. With regard to food service workers, the Erie County policy requires that a history and physical be performed within 30 days prior to an inmate being assigned to dietary service. At ECHC inmates are not involved in food preparation, whereas they are involved in food preparation at ECCF. The method for screening, therefore, is to insure that inmates have been cleared by the medical program. This clearance is primarily to insure that the inmate is physically and mentally capable of working in the assigned area. Once assigned to the ECCF

food service assignment, the inmates are observed and queried at the beginning of the shift by the food service supervisors. This is the appropriate strategy to minimize the likelihood of food borne illness being spread from workers. At ECHC, on the other hand, the escort officer queries the inmates and observes them at the time he collects them in the housing units. This allows him to substitute people if he finds open lesions or if there is a history of gastrointestinal or other disease. Although the methodology at the correctional facility is preferred, given the fact that the inmates at the holding center only work in serving lines, the alternative strategy is satisfactory.

In both areas there has been training on the preparation of special diets. When we reviewed the diet lists there was a large number of what appeared to be dietary preferences, that is, "I cannot eat beans," or "I cannot eat tomatoes." These are not special diets. The person who requests such should be counseled to avoid those foods when they are on the menu. There are diets for diabetes and hypertension and low fat, all of which could be eliminated if the master menu was heart healthy. We would encourage investigating the possibility of utilizing a heart healthy diet. We would also encourage the Medical Director working conjointly with custody leadership to implement a plan to educate the inmates on what type of diets are appropriate to be requested and for the Medical Director to instruct the clinicians also as to what type of diets are medically indicated.

With regard to food allergies, the highest degree of sensitivity has been found with peanuts and shellfish and a few other less common items; patients with allergies should avoid those they are allergic to. On the other hand, food sensitivities indicate that a food should be avoided but food with that item on a plate doesn't result in an allergic reaction. Pregnant women do receive the appropriate vitamin supplements and additional food. Although there could be significant improvement in the education of inmates regarding medical diets and in the education of advanced level clinicians regarding ordering them, the process is timely and is meeting the needs of the patients and that it why there is a finding of substantial compliance.

Recommendations

1. Consider investigating the possibility of a heart healthy master menu.
2. Provide education for inmates and advanced level clinicians regarding the indications for a medical diet.

14. Health Screening of Food Service Workers

Compliance Status: Substantial compliance.

Findings

As described in the findings under number 13, all inmates are in essence required to be medically cleared by the health care program no more than 30 days prior to assignment. In addition, at the beginning of each shift that workers work, they are queried regarding any acute illnesses, including

gastrointestinal, and their arms and hands are observed for open skin lesions. This is consistent with recommended strategies to reduce the probability of spread of food borne illnesses.

Recommendation: None.

15. Treatment and Management of Communicable Diseases

Compliance Status: Partial compliance.

Findings

Although the Erie County program has specific procedures with regard to TB prevention as well as the treatment of skin infections and the handling of blood borne illnesses, I have not had a chance to meet with the communicable disease or infection control nurse. This program is a crucial one given the proportion of high risk patients entering your facilities and the focus of the program should be TB control, tracking, monitoring and preventing skin infections, identifying and treating sexually transmitted diseases, monitoring dental sterilization process and post-operative infections and insuring that any reportable diseases are appropriately reported.

Recommendations

1. Draft a position description for the communicable disease/infection control nurse and send it to me for my review.
2. Although the infection control nurse should collect data monthly, she should summarize it on a quarterly basis for the quality improvement committee. Particular areas to be reported on include TB control and prevention, the tracking of skin infections including both presumptive and culture confirmed MRSA, the incidence of sexually transmitted diseases and the occurrence of reportable diseases along with a sterilization report.

16. Sexual Abuse

Compliance Status: Partial compliance.

Findings

The County has developed a policy including training regarding the issues of sexual abuse. Quite recently, guidelines have been published by the federal government pursuant to the Prison Rape Elimination Act that describe what should be done in a facility to accomplish the goals of the Act. The training developed by the Department of Corrections and the policy appear to comply with these goals. In addition, we have reviewed the training records and better than 90% of officers have received this training. On the other hand, since medical staff have not yet been trained and they may play a key role in identifying and responding to cases, the assessment is partial compliance.

Recommendation

1. Provide the training to all medical staff with regard to the sexual abuse policy that we have reviewed.
2. Maintain a log so that when cases arise, their handling can be tracked for compliance with the substance abuse policy requirements.

17. Quality Management

Compliance Status: Partial compliance.

Findings

Remarkably, despite the absence of a Director of Nursing and a Director of Correctional Health Services, there has been a substantial amount accomplished between our visit six months ago and the current visit. A medical review committee has been created along with a structure of other committees, which were developed in order to achieve compliance with the description in the Agreement. However, in order to simplify the institutional quality management structure, we would suggest that at the top of the structure, as currently exists, there is a correctional oversight committee. Underneath that should be the quality improvement committee which should have a person reporting to it from both DOH and DMH whose responsibility is to track compliance and progress with compliance with the Settlement Agreement. In addition, the quality improvement committee should receive reports containing minutes from the mental health subcommittee as well as the pharmacy and therapeutics subcommittees and training subcommittee. Although the mental health subcommittee should probably report monthly, the other two subcommittees and the infection control nurse should also report quarterly. The mental health subcommittee will be reviewing both the quality of the mental health program from booking to chronic disease treatment as well as compliance with the requirements of the suicide prevention program. Both the Director of Nursing and the Director of Mental Health and the Medical Director should report professional performance enhancement activities on a regular but less frequent basis. Professional performance enhancement review is review of the clinical performance of one clinician by a peer. We are using the language "professional performance enhancement review" as opposed to the phrase "peer review" only because in hospitals the term peer review has been unfortunately associated with possible discipline and its use has been emphasized in relationship to investigations surrounding negative outcomes. Our use of the professional performance enhancement review program is to facilitate professional skill development and thus mitigate the possibility of requiring any type of professional sanction. For all disciplines, professional performance enhancement review should occur more frequently with each clinician at the outset until such time as their performance is deemed to be at appropriate thresholds and after that regular review should occur on a less frequent basis. The Medical Director has begun to review advanced level clinician professional performance and provide feedback. During this visit we discussed documentation requirements for a variety of patient encounters, including offsite service follow-ups as well as chronic disease follow up visits. After training has been provided to the staff, they should expect to be reviewed against the criteria. Among the quality improvement studies already performed, include timeliness of receipt of transfer records,

completeness of nursing assessments with regard to withdrawal protocol requirements, completeness of placing and reading the TB skin tests on intake, timeliness of visits for sick call, appropriateness of unscheduled send out visits, ratio of extractions to restorations, compliance with chronic care assessments, timeliness of filing loose documents in the medical records and peer review or professional enhancement review by the Medical Director. The program is to be commended for all of its efforts in this area. It is off to an excellent start. With the addition of a Director of Nursing and a Director of Correctional Health Care Services, we are very optimistic about the expansion of this program.

Recommendations

1. Consider restructuring the program so that underneath the correctional oversight committee is the quality improvement committee which reviews data from both medical and mental health. Underneath the quality improvement committee will be subcommittees including mental health, pharmacy and therapeutics, training as well as reporting from dental, infection control and detoxification. This structure would reduce some of the frequency of meetings.
2. Consider initiating patient satisfaction surveys which are targeted to very specific issues, such as sick call program or chronic disease services for either medical or mental health.
3. Begin analyzing and reporting on grievance data, both timeliness and appropriateness of response along with frequency with which the grievant is interviewed by a health care staff member.
4. Include in the quality improvement program mortality reviews as well as sentinel event reviews.
5. During specific areas of this report we have suggested specific items to be studied regarding several of the services. It is expected that those reviews will be part of the data presented at the quality improvement committee meeting.

18. Review of Clinical Care by Responsible Physician

Compliance Status: Partial compliance.

Findings

The Medical Director has begun reviewing the work of the advanced level clinicians. When they begin employment he has them work alongside him and he ultimately certifies their privileges. Similar oversight of nursing clinical activities has not yet begun. We would hope that both programs begin to be more completely implemented before our next visit.

Recommendation

1. After the Director of Nursing begins employment the nursing professional performance review program should be initiated.

2. This program should include review and feedback for all nursing clinical activities including intake screening, sick call, urgent care and medication administration.
3. The Medical Director reviews should include intake health assessments, chronic disease visits, sick call assessments, urgent care assessments and returns from scheduled and unscheduled offsite services.

Respectfully submitted,

R. Shansky, MD
Medical Monitor

RS/kh

Third Monitoring Report

US Department of Justice v. Erie County New York

This report reviews the status of medical program conditions at the time of the Third Monitoring visit, which took place November 26-November 30, 2012.

B. Medical Care

1. Policies and Procedures

Compliance Status: Substantial compliance-drafting of policies; Partial compliance-implementation of policies.

Findings

As indicated previously, the program has a fairly comprehensive set of policies and procedures which have been reviewed and approved by the Monitor. With regard to implementation, especially the reconstruction of the nursing staff but also changeover in the primary care clinician staff has resulted in significant inconsistencies in compliance with the policies and procedures. In our review of records, we identified problems in the areas of access to care, chronic disease, emergency services and follow up on scheduled and unscheduled offsite services. These inconsistencies with policy and procedure are not surprising given the turnover in staff, due partly to an effort to develop a committed in-house staffing complement. With the addition of the new Director of Nursing who begins in the month of December, we anticipate substantial improvements in implementation of policies at the time of our next visit.

Recommendation

1. Staff should receive training on the policies and procedures, area by area and then the QI program should monitor compliance.

2. Medical Autonomy

Compliance Status: Substantial compliance.

Findings

This area remains in substantial compliance as a result of the excellent working relationship between the Medical Director and custody leadership of the jail. As issues develop, the leaders of their respective teams work collegially to address each of their concerns and ultimately, satisfactory resolution does occur.

Recommendation: None.

3. Privacy

Compliance Status: Substantial compliance.

Findings

With the change in the intake processing and the absence of receipt of pre-arraignment males, the current procedure in the booking area is that the medical screen begins in a private area which is appropriate for a confidential service to be provided. There are two available rooms, both of which may be used during high volume periods and each affords appropriate privacy. We observed the intake process and confirmed that privacy is protected. Additionally, we again looked at the medical assessment rooms on the pods in the newer part of the jail. These rooms also are appropriately designed and equipped, and do afford reasonable privacy. They are currently not utilized by nursing staff but are utilized by clinician staff. With regard to the old section of the jail, there are interview rooms which do afford privacy but are not equipped for a clinician or a nurse to perform a health care assessment. These rooms may be utilized for a nursing face-to-face triage as part of the sick call process. If these rooms can be appropriately equipped they could be utilized for health care assessments.

Recommendation

1. Determine whether the interview rooms in the older section of the jail can be equipped so that they can accommodate health care assessments or whether, if this is not possible, they can be utilized for a nursing face-to-face triage.

4. Training of Custody Staff

Compliance Status: Substantial compliance.

Findings

We again reviewed the database utilized to track the required training with regard to medical issues, mental health issues including suicide prevention, sexual abuse training, supervision of inmates with serious medical needs, identifying signs and symptoms of drug and alcohol withdrawal, confidentiality as well as CPR and first aid. The sexual abuse training had been performed approximately 12 months earlier and was in the process of being completed in this annual cycle. All other training had been completed. Clearly well over 90% of the officers have received all of the required training.

Recommendation None.

5. Management of Health Records

Compliance Status: Partial compliance.

Findings

There has been significant progress with regard to the management of health records. The problem of lack of access to inactive files, especially on weekends, has been resolved, with staff now available to retrieve records seven days a week. In addition, there has been an effort to improve the timeliness of filing both for active and inactive records. We did not have the opportunity to go through the active and inactive files to determine the effectiveness of this effort. In addition, we are told that clerical staff are now servicing clinicians independent of their particular health care field. We also observed that a majority of the records we reviewed contained both a problem list and on the same document a listing of medications. This is a significant advance and reflects both training and effort on the part of the staff. However, the problem lists contained only medical problems; thus, the mental health program was not participating in the utilization of the problem list and the medication list. Although the problem list form does include a place for mental health diagnoses and psychiatric history, in the records we reviewed of patients with mental illnesses, these sections were not utilized. This is not consistent with the goal of the program or of this Agreement that there be a unified medical record. Thus, the status despite progress remains in partial compliance. There has been some activity working toward the implementation of an electronic record and several of these problems clearly could be resolved with the implementation of an electronic record.

Since October 15 the Medical Director has instructed the clinicians to utilize a specific documentation mnemonic to insure that each encounter includes the required information. This mnemonic is O for outcomes of visit, F for follow up, I for any infection referrals, R for any registrations and M for medical management. This has improved the quality of the documentation. We also discussed setting up processes that enable clinicians to better utilize available information; that is, when chronic care encounters occur there should be available a copy of the active medication administration record, both for medical and mental health, as well as copies of monitoring data, such as fingersticks or blood pressures, that would enable the clinician to use that data to better assess the health status of the patient.

Recommendations

1. Work on implementing the problem list and medication list in the mental health section so that the record becomes more unified.
2. Continue efforts to pursue an electronic medical record that should help resolve several of the outstanding issues.
3. Make available for medical and mental health chronic care visits a copy of the active MAR and any monitoring data.

6. Medication Administration

Compliance Status: Partial compliance.

Findings

We observed both a morning and evening medication administration process at the holding center. In each medication pass, both morning and evening, we reviewed the administration as it occurred in both the old jail housing units and the newer jail housing units. Although it is our perception that improvement has occurred, we still identified some problems and discussed these with a member of the nursing leadership team. Most importantly, when the nurses perform the medication administration service there are a sequence of steps that they must perform for each patient. What we observed was that intermittently they might skip one or more of these required steps, including the documentation of the administration. We suggested development of a card for each nurse performing medication administration services that would list the sequence of steps so that they would ultimately develop a rhythm that insured that they perform all steps for each patient. We also observed, in some housing units, that rather than the nurse determining at the end of the medication administration service that there were some medication administration records which had not yet been utilized and the patient had not come forward to the nurse, officers in the housing unit would instead announce "last call" like you might hear in a tavern. Right now only the nurse should know if there are any medication administration records that have yet to be addressed. We discussed with custody that in many facilities the pharmacy each day provides for each housing unit for both the nurse and custody a list of patients in that housing unit on medications. This would allow both the nurse and the officer to know who had presented themselves and who had not, because as they presented themselves the name would be checked off the list. In any event, it is the responsibility of the nurse to know who has not presented themselves and to request of the officer that the patient be contacted so that they are able to either receive the ordered medication or refuse it. In the pod housing units, we observed that at the end of the medication administration there were still several medication administration records that had not been utilized. We learned that this was due to the fact that several of the patients who should have received medications were out to recreation. We discussed with custody the need to coordinate the timing of the medication administration so that there is no conflict with recreation. Currently, when there is such a conflict, the nurse has to return to the housing unit after the recreation has been completed in order to complete the medication administration. This is clearly very inefficient.

We learned that for patients leaving the jail, instead of posting a flyer outside the window where they receive their property, a handout had been developed which not only has information about where to obtain the discharge medications but also information regarding patients who were receiving detoxification treatment, as well as information regarding medical record requests and tuberculosis testing. Unfortunately, when we first came to the window and requested the information record we were told that it did not exist. This was corrected ultimately and is based on an inexplicable decision by staff working at the window. Presumably this will be intermittently monitored.

Another problem we identified was that nurses are not referring patients to clinicians when they refuse medications consistently. The policy requires that when three medications are refused sequentially, or a significant number in a week, the patient is to be given an appointment with the clinician. We

observed a patient who was receiving medication for his diabetes, but had been refusing his evening dose. He indicated that because the order to perform finger sticks had been discontinued he was anxious that without a finger stick his sugar might be too low for him to be taking the medication, which would only drive the sugar lower. He had refused consistently over the month and there was no referral. He also indicated that he had requested on two occasions through a paper request to see the clinician, but nothing had happened. This is a very good example of why it is important for patients who are refusing medications consistently to be referred to the clinician automatically.

We reviewed the data with regard to medication errors and observed that most recently the error rate was about 3.5%. We indicated that the initial target should be a rate of less than 1%. This error rate is mostly a reflection of failure to document either administration or refusal for given doses for given patients. This is a reflection of the fact that nurses are probably forgetting the documentation step when they are administering the medications.

Recommendations

1. Develop a list of the steps that the nurse must perform for each patient medication administration and make this available so that the sequence can be observed by nursing supervisors.
2. The nurse must determine at the end of each medication administration which patients have not stepped forward and need to be contacted by the officer.
3. The timing of the medication administration for each housing unit should be coordinated with custody so that all of the patients, with the exception of those out to court for whom a separate arrangement is made, are available for the medication administration.
4. Intermittently monitor the availability of the discharge medical information sheet to be given to patients upon release.
5. Continue to monitor medication errors by reviewing MARs of patients on multiple medications.
6. Also monitor for whether consistent refusal results in a referral to the clinician to discuss the treatment plan.
7. Perform studies on the timeliness of receipt of medications from time of order at intake.
8. Perform studies of the timeliness from order of medications not at intake to receipt by the patient.

7. Access to Care

Compliance Status: Partial compliance.

Findings

Both at the Erie County Holding Center and Erie County Correctional Facility studies have been performed which document that about 80% of requests are seen within two days of receipt. At the

holding center the triaging nurse refers patients usually to the clinician, but where the case seems to be non-complicated they may go directly to a registered nurse. At the correctional facility, each morning the clinician and the nurse discuss which patients should be seen by which discipline, either an advanced level provider or a registered nurse. Sick call slips are collected daily at both facilities and paper triage also by an RN at each facility. One of the problems we identified which results in a compliance status of partial compliance is that both clinicians and nurses sometimes fail to address the complaints documented on the paper request. This is not unusual. Clinicians if taking an urgent care center approach, may say something like, "What is your problem today?" The patient therefore may respond by whatever symptom has been most recent. All encounters by both clinicians and nurses must begin with the assessor questioning the symptoms documented on the health service request. Once those are addressed, any other issues may be also addressed. It is unacceptable to begin the encounter in a completely open-ended fashion when in fact in the record there is a description of one or more specific symptoms. To use the open-ended approach merely manufactures liability for both the patient and the County. We also did identify that of the roughly 20% of patients who were not seen within two days, there may be problems in that some of them do not appear to be seen at all. It would be important to review the timelines for the outliers, insuring that the studies document whether the patients are remaining in the facilities. We of course found variability in the quality also of the professional performance with regard to the assessments. This should ultimately be addressed by the Medical Director, reviewing and providing feedback to the clinicians and the new Nursing Director reviewing and providing feedback to the registered nurses.

Recommendations

1. Review the timeliness and circumstances surrounding the 20% of requests that are not addressed within two days.
2. Insure that the professional performance review monitors whether all symptoms described on the paper request have in fact been addressed during the encounter.

8. Emergency Care

Compliance Status: Partial compliance.

Findings

The emergency response (man down) tends to be handled quite well. Assessments seem to be both timely and appropriate and where indicated patients are sent out timely. The policy with regard to urgent care services requires a log be maintained at each facility that documents the patient name, date and time and presenting complaint and ultimately the disposition. This log ceased to be maintained a few months ago at the holding center. This is a requirement of the policy and it is critically useful for supervisory staff to review selected records and provide feedback to clinicians. Additionally, for all unscheduled send outs, there should be a nursing note that briefly describes the clinical circumstances and the discussion with the authorizing clinician who ordered the send out. In our record review this

did not always occur. Additionally, patients are to be seen by a nurse at the time of return and in that encounter the nurse also determines whether the required paperwork from the offsite service is available. If it is not available it is the obligation of that nurse to take steps to retrieve it. The patient is then supposed to be seen by the primary care clinician within 24 hours. That latter step is usually occurring, although not always. The nursing note on return is occurring even less frequently. This is an area that clearly requires addressing. Both training for the nurses and then monitoring by the quality improvement program will facilitate compliance with these items.

Recommendations

1. Insure that an urgent care log is in fact conscientiously maintained at each facility.
2. This urgent care log should be reviewed on a regular basis by both the Medical Director and Director of Nursing in order to provide feedback to clinicians and nurses with regard to professional performance.
3. Training should be provided to the nursing staff with regard to their obligations regarding documentation both on send out of unscheduled services and on return.
4. The QI program should also monitor the nursing performance with regard to these services.
5. The QI program must also monitor the clinician performance with regard to initial assessments and follow up visits after unscheduled services are provided.

9. Follow Up Care

Compliance Status: Partial compliance.

Findings

This item refers to follow up visits for both unscheduled and scheduled offsite services. However, we discussed follow up on unscheduled services with regard to number eight. So on this item we will focus on scheduled offsite services. With regard to this process, when patients are sent offsite for either consultations or procedures any documentation should be returned to nursing staff. It is important that nursing staff are aware of what offsite services have been provided and whether when the patient is returned the patient is accompanied by a report of the services. Ultimately, either a nurse or the scheduler must insure that the reports are available and insure that there is a follow up visit with the primary care clinician within a week of the retrieval of the report. It was common in the records we reviewed for these follow up visits not to be located. The process has to insure that not only are the visits scheduled timely but also that the paperwork is then retrieved timely and there is a timely follow up encounter with a primary care clinician in which there is documentation of a discussion of both the findings and plan. A program that consistently accomplishes this substantially reduces liability, both to the patient and to the County.

Recommendations

1. Institute a process that insures that scheduled offsite service reports are retrieved and reviewed by the clinician timely.
2. Institute a process whereby the patient is seen within two weeks of the offsite service and the findings and plan are documented as having been discussed.
3. Monitor this process through your QI program.

10. Chronic Disease

Compliance Status: Partial compliance.

Findings

Although there is a chronic disease program at both facilities, performance by the clinicians is not consistent with either local policy or national guidelines. One problem we identified was despite a policy requirement that any patient on chronic medications must have a history and physical within three to five days of entry, this was commonly not occurring. Secondly, patients who entered with a chronic disease were not having their initial baseline chronic disease visit scheduled within the first 30 days. Instead, some patients were scheduled to have their first chronic disease visit more than 90 days after entry. Thirdly, follow up visits were not consistently scheduled based on how well controlled the patient's diseases were. The standard requires that follow up visits of patients in poor control occur more rapidly than patients in good control. In addition, clinicians were not insuring that baseline lab data was available for the initial chronic disease visit. This is also a policy requirement which enables the clinician to appropriately assess the degree of control. The current process of creating the database for tracking patients with chronic diseases is backlogged by at least three to four days, thus precluding an up-to-date registry of all the patients who have chronic diseases. We did identify a patient who, despite entering the system in June and despite having been seen on several occasions as a result of sick call requests, had still not had a baseline visit addressing her hypertension or diabetes as of November. Clearly, this system can and will be tightened up substantially. Part of the problem we ascribed to the turnover of clinician staff and some of the clinicians are quite new to the program. This clearly is a challenge for the Medical Director. We also found treatment regimens which utilized medications that resulted in multiple times per day dosing, which creates extra resource demands in a correctional setting. Simplifying regimens, particularly with hypertension where there are so many options, should be part of the treatment planning. We would expect, assuming that the clinician staff is stable, substantial progress will be made in this area by the time of our next visit.

Recommendations

1. Work on improving the completeness of the chronic disease registry.
2. During the individual clinical performance reviews, identify patterns of deficiencies which could be used in group training.

3. Consider a procedure that requires the advanced level clinicians to refer any patient whose disease is poorly controlled and does not improve at the follow up visit to the Medical Director. This should enable the Medical Director to be involved with the sickest patients.
4. Insure that the first database visit occurs no later than Day 30 after intake for patients who are well controlled and significantly earlier for patients who are less well controlled.

11. Dental Care

Compliance Status: Partial compliance.

Findings

The dental program has been handicapped by the fact that since the dentists have been scheduled to be at the holding center and at the correctional facility on Tuesdays and Thursdays, the one dental assistant is only able to assist one dentist at a time. We are told that there are plans to change the dental schedule so that at each site there will be three days of dentist, two of which will include a dental assistant. Our understanding is on Mondays the holding center will have a dentist and dental assistant. On Tuesdays, the correctional facility will have a dentist plus a dental assistant and the holding center will just have a dentist. On Wednesdays there will a dentist and dental assistant at the correctional facility and on Thursdays there will be a dentist and dental assistant at the holding center but just a dentist at the correctional facility. Finally, every other Friday there will be a dentist with an assistant at the holding center and every other Saturday there will be a dentist with an assistant at the correctional facility. We are pleased to report that the dentists have recently begun to perform restorations. We have indicated that the ratio of restorations to extractions should be monitored on a monthly basis. The standard of practice in the community is that when the dentition is in relatively good shape, a restoration is the appropriate plan rather than an extraction. Historically, the Erie County dental program almost exclusively provided extractions independent of the maintenance of the dentition. Fortunately this is changing. We are encouraging the monitoring of these ratios on a regular basis.

Recommendations

1. Monitor the timeliness and appropriateness of nursing response to dental pain with the new schedule, nursing may be less involved in responding to dental pain as dentists will be onsite more frequently.
2. Continue to monitor the ratio of restorations to extractions.
3. The QI committee should monitor the rate of post-extraction infections.
4. The dental program should report to the infection control coordinator on a quarterly basis sterilization monitoring data.

12. Care for Pregnant Prisoners

Compliance Status: Substantial compliance.

Findings

Most of the pregnant females are housed at the correctional facility. We reviewed records there and found that patients are being seen regularly by OB/GYN programs and are being monitored in a manner consistent with American College of Obstetrics and Gynecology guidelines. The full record of each encounter is now present in the Erie County record and any recommendations from the OB/GYN program are carried out timely. The County is to be commended for improving this area.

Recommendation None.

13. Dietary Allowances and Food Service

Compliance Status: Partial compliance.

Findings

This area has slipped back to partial compliance because we were unaware of the lack of availability of a dietary consultant to advise the chief cook at each facility. The issue came up when we came across a type 1 diabetic and although there were some behavioral issues with this patient, nonetheless this is the type of fragile patient for whom such consultation needs to be available so that appropriate substitutions can be made. It is our understanding that current efforts are underway to acquire a dietitian consultant who could serve both facilities. Once this is in place this area could return to substantial compliance. We also learned that although there has been a reduction in what we characterize as food preference diets, some of these are still being ordered. This is being monitored by the Medical Director and hopefully these will be eliminated before our next visit. We continue to recommend the consideration of a heart healthy diet which we feel would greatly reduce the requirement for special diets. We understand that the dietitian consultant could be of immense help in providing guidance for specifications on such a diet.

Recommendations

1. Acquire the services of a dietitian consultant.
2. Consider adopting a heart healthy master menu.

14. Health Screening of Food Service Workers

Compliance Status: Substantial compliance.

Findings

As indicated previously, food services workers at the holding center are not involved in food preparation. They are only involved in serving and cleaning. At the correctional facility, food service workers are involved in food preparation. In both facilities, there is a daily effort to screen out individuals who could potentially spread food borne illnesses. This effort consists of insuring that workers are not suffering from any gastrointestinal disease and have no open lesions on their arms or

hands. In both facilities there is a prior medical clearance that is performed to insure that eligible workers are physically and mentally capable of working in the assigned area. The current methods for screening are satisfactory.

Recommendation None.

15. Treatment and Management of Communicable Diseases

Compliance Status: Partial compliance.

Findings

Although there is monitoring of TB control and especially the rate at which eligible and available new entries to the jail are screened, the communicable disease program needs to be much broader. We are encouraged that the new Director of Nursing has superb credentials with regard to infection control and in fact has run such programs at hospitals during her career. Any correctional communicable disease program, as indicated earlier, must focus not only on TB control but also tracking, monitoring and preventing skin infections, identifying and treating sexually transmitted diseases, monitoring dental sterilization processes and post-operative infections and insuring that any reportable diseases are appropriately reported. Additionally, alertness for outbreaks such as food borne illnesses or other communicable diseases must be addressed. Working through the health department is a huge advantage for this program.

Recommendations

1. Draft a position description for the communicable disease/infection control nurse and send it to me for my review.
2. Although the infection control nurse should collect data monthly, she should summarize it on a quarterly basis for the quality improvement committee. Particular areas to be reported on include TB control and prevention, the tracking of skin infections including both presumptive and culture confirmed MRSA, the incidence of sexually transmitted diseases and the occurrence of reportable diseases along with a sterilization report.

16. Sexual Abuse

Compliance Status: Substantial compliance except for the training of medical staff.

Findings

We have reviewed investigative reports regarding allegations of sexual abuse since our last visit and one of these in fact was initially reported to a member of the health care staff. In each instance the required procedures were followed and the program appears to have handled the issue well. All of the correctional staff are in the process of being retrained and the mental health staff have also been trained. Because of the turnover in the medical staff, the sexual abuse training has not been completed

for a significant number of staff and on that basis there cannot be full substantial compliance until health care staff have been trained.

Recommendation

1. Provide the training to all medical staff with regard to the sexual abuse policy that we have reviewed.

17. Quality Management

Compliance Status: Partial compliance.

Findings

Despite the turnover of staff and the absence of a Quality Improvement Coordinator, there has been as reviewed by the Monitor a substantial amount of data collected regarding the performance of the program. This data includes timeliness to be seen in sick call after receipt of health service requests, both at the holding center and at Alden, data on the occurrence of booking, a study of the timeliness of filing within the medical record, a study of completion of detoxification monitoring and studies done on timeliness of initial physical exam as well as TB skin testing. The program is to be commended for these efforts in the face of competing demands as the program is reconstructed. It is our understanding that there is a proposal by the Director of Correctional Health Services for a Quality Improvement Coordinator position. This Monitor is comfortable stating that without that resource the probability of achieving substantial compliance on all items and most especially items 17 and 18 is greatly reduced. This is a critical resource that will help provide the final piece of the infrastructure that has yet to be put in place. As you have read this report, in many of the sections the recommendations entail quality improvement monitoring in order to identify opportunities for improvement. Let me be clear: monitoring alone without data analysis including understanding the underlying contributing factors to performance that is not adequate and then from that understanding targeting improvement strategies to address those factors is what the quality management program anticipates and requires. This takes energy not just from the leadership team but also from as many line staff as is possible. In this report we have identified several areas where there are opportunities for improvement either with regard to professional performance or with regard to process improvement. Those improvements will not occur without a viable and robust quality management program. It is apparent to this Monitor that the County is assembling a very talented leadership team that is quite capable of achieving the goals of this Agreement. However, unless the quality management program is actualized, achieving substantial compliance is not very likely. Throughout this report the recommendations include activities to be performed through the quality management program. I will not relist those items but they should form the basis for some initial activities to be performed through the quality management program.

Recommendations

1. Bring on board a quality management coordinator to facilitate the development of this critical program.

18. Review of Clinical Care by Responsible Physician

Compliance Status: Partial compliance.

Findings

We have reviewed the reviews performed by the Medical Director of each of the clinician staff. He is reviewing five records per provider per quarter randomly selected. We discussed the advisability of rather than randomly selecting records, an effort should be made to identify records of higher risk patients. This can be done through chronic disease lists, particularly patients with multiple chronic diseases, including patients who are elderly as well as patients sent offsite for either scheduled or unscheduled services. The more complex the patient is the more material for review with the staff and more opportunities for educating the staff. Clearly there is so much for the Medical Director to do with his staff, including the chronic care program, sick call performance, urgent care performance, follow up of offsite services and responses to emergencies. Particularly given the staff turnover, this is going to take some time. We also understand that the Medical Director himself has clinical obligations which in part are impacted by the availability of a full staffing compliment and we do understand that clinical mandates supersede mentoring mandates. On the other hand, we have seen the Medical Director interact with his staff and we have found his approach to be extremely constructive and collegial, even in the face of chagrin at the observed level of performance. With the required positions filled we are confident that this can become a high performing group.

Recommendations

1. Make an effort to select cases for review with each clinician that are by design more complex or high risk.

III. Protection from Harm

E. Training of Officers with Regard to Sexual Abuse and Policy on Handling Sexual Abuse

Compliance Status: Substantial compliance.

Findings

Both the policy and the training are consistent with an assessment of substantial compliance.

Recommendation None.

I. Training of Medical and Mental Health Staff

Compliance Status: Partial compliance.

Findings

Although the mental health staff have completed their training, the medical staff due to turnover have not yet completed their training.

Recommendation

1. Complete the training with regard to sexual abuse policy for all medical staff.

J. Suicide Prevention Program

e. Privacy

Compliance Status: Substantial compliance.

Findings

See number 3 under Medical Care section.

Recommendation None.

f. Assessment of Inmates in Detoxification

Compliance Status: Partial compliance.

Findings

When CIWA screens are started in the booking area, compliance tends to be quite good. However, when the detox screening is not started in the booking area nurses have not been initiating detoxification screening the leadership of nursing is aware of this and this will be addressed, thus the partial compliance.

D. Training of Officer Staff with Regard to Suicide Prevention Training

Compliance Status: Substantial compliance.

Findings

See number 4 under Medical Care section.

3. Detoxification Training Program

Compliance Status: Partial compliance.

Findings

A significant number of the medical staff due to turnover have not had this training.

Recommendation

1. Where they are in partial compliance in each instance provide the training.

Respectfully submitted,

R. Shansky, MD
Medical Monitor

RS/kh

Fourth Monitoring Report

US Department of Justice v. Erie County New York

This report reviews the status of medical program conditions at the time of the Fourth Monitoring visit, which took place June 9-14, 2013.

B. Medical Care

1. Policies and Procedures

Compliance Status: Substantial compliance drafting of policies; partial compliance, implementation of policies.

Findings

The department of Health leadership at the Erie County Detention Facility medical programs continues to annually review and update policies. Most recently, we had the opportunity to briefly review the new TB control policy. The Department of Health is fortunate in that the Medical Director of their jail medical program is also the Department's chief tuberculosis control officer. Centers for Disease Control recommendations with regard to TB services in correctional facilities recommends that the local jail health program comply with local health department recommendations. Having the same person responsible for both areas guarantees that this will always be the case.

With regard to implementation, however, this is still a work in progress. In reviewing records at both the correctional facility and the holding center, we identified problems with implementation with regard to the sick call process, the chronic care program, the unscheduled offsite service program and the scheduled offsite service program. This is understandable in that there are many newly trained staff, especially at the holding center. In fact, with the new leadership team focusing primarily at the holding center, our review demonstrated that compliance with policies in these areas was better at the holding center than at the correctional facility. Prior to our review, the Health Service Administrator had already decided to station himself a majority of the time at the correctional facility. Clearly, through the program's own self-monitoring, they were aware that process performance at the correctional facility was problematic. We have been quite impressed with the excellence of the new leadership team. We have long admired the work of the Medical Director; however, we believe that both the new Health Service Administrator and the new Director of Nursing have greatly contributed to the creation of a strong leadership team. With their ability to work closely with what is also perceived as a strong custody leadership team, we anticipate relatively rapid progress which will be measureable at the time of our next visit.

Recommendation

1. Continue to train staff at both facilities with regard to these operational policies and procedures and continue to monitor performance with regard to these processes through your quality improvement program.

2. Medical Autonomy

Compliance Status: Substantial compliance.

Findings

This area remains in substantial compliance because of the excellent working relationship between health care leadership and custody leadership at both facilities. All respond professionally to conflicts and resolutions of the conflicts are achieved relatively quickly.

Recommendation: None.

3. Privacy

Compliance Status: Substantial compliance.

Findings

We reviewed the new space for the intake process and find it well designed to provide both privacy and efficiency. We also revisited the rooms that are used for assessments in the pods and although the privacy was quite adequate, we did find the use of examination tables without the use of examination table paper on the tables and also without the use of any sanitizing fluid between patients. This of course is not a privacy matter but it clearly is a sanitation and hygiene matter and the leadership agreed that this had to be corrected immediately. The analogous rooms in the old jail are not yet equipped for assessments but they do afford some privacy for patient interviews. Only if these rooms are appropriately equipped should they be utilized for nursing or clinician assessments.

Recommendation

1. When the program begins to utilize the new intake space, observe the processes for adequacy of the protection of privacy; sometimes even if the space is adequate, staff needs to be trained with regard to how they provide services so that it is done in a manner that protects privacy.

4. Training of Custody Staff

Compliance Status: Substantial compliance.

Findings

The training coordinator of the custody staff continues to maintain meticulous records documenting the receipt of training in the required topics. As we understand it, training regarding recognition of medical problems is only done for new officers. On the other hand, training with regard to alcohol and substance abuse and withdrawal symptoms along with suicide issues and CPR are redone annually. All officers completed the training in 2012 and this will be repeated later this fall. We did identify that an important topic for which they have not received training deals with the problem of MRSA. The Medical Director and Director of Nursing indicated that they would provide training to the officers so that they have a realistic understanding of how to respond to patients with MRSA.

Recommendation

1. Provide the training to officers with regard to MRSA.

5. Management of Health Records

Compliance Status: Partial compliance.

Findings

Although there has been some improvement with regard to the organization of the health records, problems persist with regard to timely filing of important documents as well as maintenance of the problem lists. There is timely accessibility to old records and we visited a converted room that has well-organized, easily accessible filing cabinets as is found in a typical free world health care program. We were told that next week the use of the filing area outside of the jail would no longer be needed as within a five-day period records will be moved from that site to the new space described above. This is a substantial step forward and continues to demonstrate the County's good faith in meeting the obligations of the settlement agreement. With the old records onsite within the medical program space, access should never again present a problem. Additionally, plans for a new electronic record system are in the works and we look forward to when that process begins implementation. At this point there is a request for a proposal for which proposals will be submitted and a vendor selected. We look forward to working with the leadership team on implementation.

Medical staff continue to utilize the O for outcomes, F for follow up, I for infection control issues, R for any registrations and M for medical management methodology, insuring that content for each area is addressed when appropriate. In addition, the Medical Director has created some disease specific order sheets for cardiovascular diseases, viral diseases, hypertension, hyperlipidemia, asthma and neurologic problems. These are helpful in prompting the clinicians to write orders based on specific chronic disease guidelines.

Recommendations

1. Work on implementing the problem list and medication list in the mental health section so that the record becomes more unified.
2. Continue efforts to pursue an electronic medical record that should help resolve several of the outstanding issues.
3. Make available for medical and mental health chronic care visits a copy of the active MAR and any monitoring data.

6. Medication Administration

Compliance Status: Substantial compliance.

Findings

We observed both a morning and evening medication administration process at the holding center. For both the morning and evening passes, we observed the pass performed in both the old and the new jail housing units. There was a substantial improvement with regard to the four nurses whose work we reviewed. They were well organized, they accomplished the sequence of steps required in the medication administration process so that the correct patient receives the correct medication in the correct dose and is observed ingesting it and that this is documented timely. The nurses utilized a process with the loose leaf binder such that at the beginning of the medication administration process the medication administration records were on the left side of the binder; as the meds were administered they were moved to the center of the binder and this enabled the nurses to determine whether all the patients who should have presented themselves for the medication administration were in fact presenting themselves. In some of the housing units the nurse was able to request that the officer contact a patient who had not shown up so that they could either receive the medication or refuse face-to-face with a nurse. This was a well-run medication administration process. The nurses also were conscientious in inspecting the mouths of patients post-ingestion.

We also checked at the window outside where patients receive their property and the appropriate form was available. This form provided a phone number to a pharmacy which would enable the patients to access a prescription in the community. This form also contains information regarding detoxification treatment as well as medical record requests and tuberculosis testing. At this visit, we did not review records in which we observed three refusals in a row. We will clearly review this the next time. It is also important that the quality improvement program monitor compliance with this requirement.

Recommendations

1. The nursing QI program should continue to intermittently monitor the performance of nursing during the medication administration process.
2. Continue to monitor referral of patients after their three consecutive refusals. This is particularly important in the mental health housing units. These referrals must go to the

prescribing clinician, who must see the patient and determine whether the dosage schedule should be changed, the medication discontinued or some other strategy be implemented.

3. Continue to monitor medication errors by reviewing MARs of patients on multiple medications.
4. Continue to monitor the timeliness of availability of medications, both prescribed during the intake process and at other times during an inmate's stay.

7. Access to Care

Compliance Status: Partial compliance.

Findings

Quality improvement data continues to support the view that 80% of requests are seen within two days of receipt. In the record reviews we performed, the most common breakdown, which was worse at the correctional facility than at the holding center, was with regard to the referral to clinicians. We found several instances, again more commonly at the correctional facility than at the holding center, where a documented referral was not followed by a documented encounter in the records we reviewed. The reasons for this must be investigated. When the QI program performs a study and finds records where this is what was observed, it behooves them to, at that time, attempt to identify the causes. It is only by identifying the causes that your QI program can develop a targeted improvement strategy that will mitigate the cause and improve the outcome. It is also important for the professional performance part of the QI program and in this instance discipline-specific leadership, that is Medical Director for review of clinician performance and Nursing Director for review of nursing performance, to insure that the encounter addressed the issues raised on the Health Service Request form in a manner that results in adequate subjective data, adequate objective data and appropriate assessment/diagnosis and an appropriate plan. This must be done on an ongoing basis until such time as the professional performance has reached a satisfactory level. After that, these reviews should be intermittent, such as quarterly. Given the turnover of both advanced level provider staff as well as nursing staff, these types of professional performance issues are not at all surprising. As the nurses consistently receive feedback with regard to their performance, I am quite optimistic that they will achieve the threshold that the program expects.

Recommendations

1. Review the timeliness and circumstances surrounding the 20% of requests that are not addressed within two days.
2. Insure that the professional performance review monitors whether all symptoms described on the paper request have in fact been addressed during the encounter.

8. Emergency Care

Compliance Status: Partial compliance.**Findings**

The emergency response (man down) continues to be handled well. However, there are sometimes process issues with regard to insuring that a nursing note accompanies each send out offsite. There is now an urgent care log maintained at each facility that documents patient name, date and time. It needs to continue to document the presenting complaint but in addition it must include the ultimate disposition for the patient. These dispositions could be “returned to housing unit,” or “send out to emergency room” or sometimes “maintain in clinic for observation.” It is also important that patients are seen by a nurse at the time of return, where that nurse documents the presence of required paperwork from the offsite service or, if that paperwork is not available, takes steps to retrieve it. More often than not, the patient was seen by a primary care clinician timely. However, we did not find this 100% of the time. As you continue to monitor both the process and professional performance through your quality improvement program, we anticipate compliance with the policies.

Recommendations

1. Insure that the urgent care log at both facilities contains a field for presenting complaint and a field for disposition. You may want to add other fields that you would find helpful.
2. The urgent care log should be reviewed on a regular basis by both the Medical Director and Director of Nursing in order to provide feedback to clinicians and nurses with regard to professional performance.
3. Nursing staff should be retrained with regard to their obligations regarding documentation, both at the time of send out of unscheduled services and at the time of return.
4. The QI program should monitor nursing performance with regard to the services.
5. The QI program should also monitor clinician performance with regard to both initial assessments and follow up visits after unscheduled services are provided.

9. Follow Up Care**Compliance Status: Partial compliance.****Findings**

We will continue for this item to refer to the follow-up care after scheduled offsite services. This includes both specialty consults as well as procedures. Our review of records included samples from both the correctional facility as well as the holding center. Critical to this service is an adequate justification by the clinician for the need for this service. Recently, the Medical Director implemented a prior review and approval before such services are scheduled. What is critical for the Medical Director is if his assessment reveals that the recommended service is not best for the patient, he should recommend an alternative plan of care. He should not view this as

purely approving or denying, since denying does not address the patient's ongoing problem. Once the service is approved or there is an alternative plan of care, the patient must be notified and then the service scheduled or the alternative plan implemented in a timely manner. When the offsite service is approved, the return of the patient should require that custody bring the patient to a nurse. This was happening at the holding center; however, it was not always happening at the correctional facility. When the patient is seen by the receiving nurse, the nurse should determine if the appropriate paperwork has accompanied the patient and if not, arrange for the report to be retrieved. For consultations, almost invariably the paperwork accompanies the patient. For procedures which require a dictation and a transcription after the service is reviewed, it is possible there may be a two-to-four day delay. Either the nurse or more commonly the scheduler should be aware of the expected timeframe for return of the report and contact the service when that timeframe has elapsed. Once the report is available, the patient should be scheduled for a follow-up visit with the primary care clinician, who should document a discussion with the patient regarding the findings and plan and the patient's understanding thereof. There were problems at both facilities with this service in the records we reviewed; however, the frequency of the problems was greater at the correctional facility.

Recommendations

1. Insure that, especially at the correctional facility, patients returning from all offsite services that are scheduled or unscheduled return through a nurse.
2. The Medical Director should insure that where a recommended service is not approved, there is a recommended alternative plan of care which gets implemented.
3. Both facilities must have a process in place to insure that after reports have returned, there is a follow-up visit with the primary care clinician in which they document a discussion with the patient regarding the findings and plan and the patient's understanding.

10. Chronic Disease

Compliance Status: Partial compliance.

Findings

There has been some progress with the chronic disease program, including the implementation of some disease specific order sheets along with the introduction of a disease specific follow-up visit form that can be used for patients with multiple chronic diseases. The form is modeled after the National Commission on Correctional Health Care follow-up form and does contain the content that is required in that form. Currently, there is no form used for the initial visits and, as a result, several of the initial visit encounters we reviewed lacked some of the required disease specific history that should be collected on patients with those specific diseases. The Medical Director indicated that he would be implementing a variation of the NCCHC initial visit form which I have reviewed. He is also training his clinicians to utilize the framework of disease

control as the basis for the program, with the philosophy that it is the clinician's responsibility to work with the patient to bring the disease or diseases into good control as expeditiously as is clinically appropriate. Many of these changes are very recent and we look forward to reviewing records on the next visit when we should see improved performance. Although the chronic disease list was generally appropriate, we did find at least one inconsistency with the list that we received.

Recommendations

1. Continue to work on validating the completeness of the chronic disease registry.
2. Continue to review the professional performance, particularly with the utilization of the chronic disease order forms and the chronic disease initial visit and follow-up visit encounter forms. If, despite the aid of these forms, performance does not improve, which is unlikely, it suggests that continuation working for the jail health service may not be appropriate.
3. Consider a procedure that requires the advanced level clinicians to refer any patient whose disease is poorly controlled and does not improve at the follow-up visit to the Medical Director. This should enable the Medical Director to be involved with the sickest patients.
4. Insure that the first database visit occurs no later than Day 30 after intake for patients who are well controlled and significantly earlier for patients who are less well controlled.

11. Dental Care

Compliance Status: Substantial compliance.

Findings

The dental program which has been handicapped by the availability of resources is now more appropriately staffed. In our review of the dental program at the holding center, it did appear that restorations as well as extractions and assessments are being provided and generally they are being provided timely. There is still one day a week when there is no dental assistant, but that day is utilized to conduct assessments. It appears that there are now adequate resources to insure timely services.

Recommendations

1. Given the new dental schedule, continue to monitor the timeliness of access to analgesia for patients who request assistance with dental pain.
2. Continue to monitor the ratio of restorations to extractions.
3. The QI committee, including its infection control nurse, should monitor the rate of post-extraction infections.
4. The dental program should continue to report to the infection control coordinator sterilization monitoring data on a quarterly basis.

12. Care for Pregnant Prisoners

Compliance Status: Substantial compliance.

Findings

Since the care provided by the Erie County Medical Center OB/GYN program is consistent with American College of Obstetrics and Gynecology Guidelines and since the records of these encounters are now available in the Erie County records, this program is now in substantial compliance.

Recommendation None.

13. Dietary Allowances and Food Service

Compliance Status: Partial compliance.

Findings

There is still no access to a dietitian or nutritionist services. It is unclear to me why in Erie County with a population of several hundred thousand it is impossible to develop a small part-time contract with an available dietitian. Problems do arise with patients with special needs and those problems should have the input from a dietitian. Neither of the food service managers is credentialed in the nutritionist field and therefore they cannot be expected to know how to respond to such demands. I am aware that the department is again looking into the possibility of moving to a heart-healthy diet and I would strongly encourage that because it dramatically reduces the work required to maintain a substantial number of special diets that are disease based. We are aware that the Medical Director has continued to reduce the number of previously ordered preference diets.

Recommendations

1. Acquire the services of a part-time dietician consultant.
2. Consider adopting a heart-healthy master menu.

14. Health Screening of Food Service Workers

Compliance Status: Substantial compliance.

Findings

As indicated previously, food service workers at the holding center are not involved in food preparation. They are only involved in serving and cleaning. At the correctional facility, food service workers are involved in food preparation. In both facilities, there is a daily effort to screen out individuals who could potentially spread foodborne illness. This effort consists of insuring that workers are not suffering from any gastrointestinal disease and have no open lesions on their arms or hands. In both facilities, there is a prior clearance that is performed that

insures that all eligible workers are physically and mentally capable of working in the assigned area. The current methods for screening are satisfactory.

Recommendation None.

15. Treatment and Management of Communicable Diseases

Compliance Status: Partial compliance.

Findings

There is a new Infection Control Coordinator and she is well experienced, having had the same responsibilities in hospitals. However, at the time of this visit, she has not yet organized the program to be able to present data to the quality improvement committee or to me. Due to the absence of data with regard to TB control, MRSA, reportable diseases, sexually transmitted diseases and any outbreaks, this area remains in partial compliance. I would expect that this finding should change at the time of our next visit.

Recommendations

1. Although the infection control nurse should collect data monthly, she should summarize it on a quarterly basis for the quality improvement committee. Particular areas to be reported on include TB control and prevention, the tracking and trending of skin infections including both presumptive and culture confirmed MRSA, the incidence of sexually transmitted diseases, the occurrence of reportable diseases along with dental post-op infections and a dental sterilization monitoring report.

16. Sexual Abuse

Compliance Status: Substantial compliance.

Findings

The program has insured that both medical and custody staff are trained in this area and in addition, in the one record we reviewed, the patient was sent offsite for an assessment by a credentialed sexual abuse nurse examiner. There was no documentation that the patient was afforded a rape crisis counselor. This service should also be offered. It is now required that all sexual abuse in correctional facilities must be officially reported. It is important that inmates be aware of this requirement; they can be made aware through a notice in the inmate handbook as well as signage in the institution, most especially in the medical clinic area. We also encouraged the Health Service Administrator to meet with the Erie County Medical Center leadership team in order to make them aware of the requirements under law with regard to not only an examination by a sexual abuse nurse examiner or forensic examiner but also the provision of a sexual abuse crisis counselor.

Recommendation

1. The Health Service Administrator should meet with the ECMC leadership to inform that of the requirements under federal legislation with regard to services required through the Prison Rape Elimination Act.

17. Quality Management

Compliance Status: Partial compliance.

Findings

There continues to be significant amount of work in this area. In fact, the program is now providing two quality improvement meetings per month; the first meeting is one in which data collected is reviewed and commented on and the second meeting is supposed to include a review of infection control data and any analysis of the prior data reviewed and any proposed changes to policy or procedure. The activities that formed much of the work by the quality improvement committee in the last six months included a review of professional performance with regard to the approach to diabetes, a review of the sick call process emphasizing timeliness and this included an analysis of outliers, a review of the medication administration process, looking especially at professional performance and in fact, this in all likelihood contributed to the improvement as documented in my assessment, going from partial to substantial compliance. There continue to be a review of the timeliness of receipt of medications compared to the time of order. There was also a review of the completeness of the intake process as well as the timeliness of the intake process and there continues to be a review and analysis of medication errors. As I have indicated previously, in this report there are several areas that I have recommended quality improvement monitoring, including sick call or access to care, emergency care, follow-up care, chronic care and the medical record program as well as the dental program. This review, analysis and implementation of changes should facilitate the development of substantial compliance in all areas.

Recommendations

1. Review the earlier sections of this report and insure that some activities are implemented as part of the QI program between now and the next report.

18. Review of Clinical Care by Responsible Physician

Compliance Status: Substantial compliance.

Findings

I have reviewed not only the forms but also the specific content of reviews with counseling by the Medical Director of his clinicians and am impressed with his efforts to use the process in a constructive manner. I am also impressed with the fact that when the performance is below threshold, he repeats the review more frequently so as to facilitate more timely improvement. This puts this section into substantial compliance. He is also assuring me that he is, when

reviewing performance, selecting records that tend to be of patients who are more complex or high risk or more poorly controlled.

Recommendations None.

III. Protection from Harm

E. Training of Officers with Regard to Sexual Abuse and Policy on Handling Sexual Abuse

Compliance Status: Substantial compliance.

Findings

Both the policy and the training are consistent with an assessment of substantial compliance.

Recommendation None.

I. Training of Medical and Mental Health Staff

Compliance Status: Substantial compliance.

Findings

Both the medical and mental health staff have completed their training with regard to the handling of sexual abuse.

Recommendation None.

J. Suicide Prevention Program

e. Privacy

Compliance Status: Substantial compliance.

Findings

See number 3 under Medical Care section.

Recommendation None.

f. Assessment of Inmates in Detoxification

Compliance Status: Substantial compliance.

Findings

The problem of initiating CIWA screens in the detox area seems to have been resolved. With the move into the new housing unit this, of course, will facilitate improved compliance.

Recommendation

1. Monitor the detoxification program by the quality improvement program.

D. Training of Officer Staff with Regard to Suicide Prevention Training

Compliance Status: Substantial compliance.

Findings

See number 4 under Medical Care section.

3. Detoxification Training Program

Compliance Status: Substantial compliance.

Findings

All of the required medical staff have had this training.

Recommendation None.

Respectfully submitted,

R. Shansky, MD
Medical Monitor

RS/kh

Fifth Monitoring Report

US Department of Justice v. Erie County New York

This report reviews the status of medical program conditions at the time of the Fifth Monitoring visit, which took place from November 18 through November 22, 2013.

B. Medical Care

1. Policies and Procedures

Compliance Status: Substantial compliance drafting of policies; substantial compliance implementation of policies.

Findings

Although the implementation of some policies requires improvement, in general the implementation is far enough along such that it is important to recognize these advances. With the departure of the Medical Director who has been with the program since the beginning of this litigation, we are concerned that the progress thus far achieved be sustained. There is a very strong leadership team remaining in the medical program, including the Director of Health Services as well as the Director of Nursing Services. What they are unable to provide, however, is the clinical oversight of the remaining clinicians. We are aware that the County has contracted with a vendor to be able to present candidates to be hired for the Medical Director position. We hope that this is accomplished expeditiously.

The main areas for improvement in implementation will be detailed later in this report. However, they include the chronic care program and the scheduled offsite service program predominantly.

Recommendation

1. Continue to provide feedback to the clinicians with respect to their performance in both the chronic disease area and the scheduled offsite service area.

2. Medical Autonomy

Compliance Status: Substantial compliance.

Findings

This area remains in substantial compliance, because for the period reviewed we were well aware that custody and health care leadership worked well together. This does not mean that there were not differences, but it does mean that the differences were resolved in a professional and timely manner. Again, we are concerned that the new Medical Director will have to establish a working relationship with custody leadership. This of course will take time. We have been

impressed with the professionalism of the custody leadership and expect that this will be accomplished in a reasonable period of time.

Recommendation: None.

3. Privacy

Compliance Status: Substantial compliance.

Findings

The new space for the intake process is now fully utilized. It is well designed for both privacy and efficiency of processing. We reviewed the additional exam room to be created at the Erie County Correctional Facility and although it is not yet furnished and does not yet have privacy curtains, we appreciate the potential and the plans to create a professional setting which affords patient privacy. We did not, on this visit, review the exam rooms in the holding center; however, we do expect to visit them in our next visit and hope we will observe appropriate professional sanitation procedures.

Recommendation

1. Insure privacy is afforded patients when the new exam room is utilized within the Erie County Correctional Facility.

4. Training of Custody Staff

This area has been in compliance for 18 months.

5. Management of Health Records

Compliance Status: Partial Compliance.

Findings

There continues to be improvement in this area in several ways. First of all, the backlog for filing for the active records was within the target timeline of no more than 48 hours. In general, when we reviewed records, we found that not only were the necessary documents available but also they were generally filed in the appropriate sequence and in the appropriate section. On the other hand, we did find that the inactive files were not up to date. In fact, documents in the “to be filed” area went back almost to the beginning of October. We were informed that a new position will be filled and the person’s duties will include filing documents in the inactive records. We would expect that when we return in May this problem of a filing backlog for documents to be filed in inactive records will have been resolved. Finally, we must commend the County for its creation of a large, professionally designed storage area for the inactive records. There is a modern set of rolling files which enable the clerical staff accessing records to access the space between the numbers to be selected from the shelving in an efficient manner. Ultimately, the

plans for an electronic record will greatly facilitate the accessibility of both active and inactive records. We understand that the RFP process has progressed to such an extent that there are now two companies which are finalists for providing the electronic record software. We also understand that there will be site visits to each of these potential vendors within the next month and then a selection shortly thereafter. We remain ready to assist in the implementation in any way possible.

The medical staff continue to utilize the O for outcomes, F for follow-up, I for infection control issues, R for registrations and M for medical management methodology. This approach is designed to facilitate continuity of care. We would also note that a progress note form has been designed that can also serve as a chronic care follow-up form. We have never seen this done in any other facility and hope it works out well. We have reviewed the chronic disease initial visit form and in reviewing records can report that although the forms are utilized, our review of the professional performance demonstrated that there remain opportunities for improvement.

Recommendations

1. Fill the clerical position, which should facilitate eliminating the backlog in filing documents for inactive records.
2. Sustain the progress with regard to selecting, contracting, training of staff and implementing an electronic record.
3. Continue to make available for medical and mental health chronic care visits a copy of the active medication administration record and any monitoring (blood pressure, fingerstick) data.

6. Medication Administration

Compliance Status: Substantial compliance.

Findings

In both the morning and evening medication administration that we observed, we attended medications passed in both linear units and in podular units. We continued to find that the nurses consistently performed both professionally and efficiently. Their interaction with the inmates was also appropriate. They continued to utilize a process with the loose-leaf binders such that at the beginning of the medication administration process, the medical administration records were on the left side of the binder and as the meds were administered they were moved to the center of the binder, and this enabled the nurses to determine whether all the patients who should have presented themselves for the medication administration were in fact presenting themselves. We did identify two concerns. One was with regard to the consistency of the nurse referring patients to the ordering clinician when patients refused three days in a row. We found a few cases where we could not, in reviewing the records, identify a progress note through which counseling by the clinician was documented. Additionally, we identified a concern with regard to the manner in

which nurses were documenting patient refusals. Most of the nurses documented refusals by initialing the appropriate space and circling their initials. One nurse wrote in, "REF." It is our understanding that the latter nurse is incorrect and not performing in a manner consistent with nursing requirements. There was also some confusion with regard to whether a nurse is required to record a refusal when patients ask not to receive an as needed medication. This area also needs to be clarified.

Finally, we also checked at the window outside where patients receive their property and found that the appropriate form was available. This form provides a phone number to a pharmacy, which would enable the patients to access a prescription in the community. This form also contains information regarding detoxification treatment as well as medical record requests and tuberculosis testing.

Recommendations

1. The nursing QI program should continue to monitor the performance of nurses during the medication process, specifically looking at patients who refuse their medications three days in a row and whether or not a referral and counseling has taken place as documented in the medical record.
2. Nursing should clarify the correct manner of documenting refusals on the medication administration records.
3. Nursing program should clarify what is the appropriate method of documenting an as needed medicine not being needed as described by the patient.
4. The method of MAR selection for these reviews should include patients on multiple medications, and when selecting records to identify refusals, it is most useful to select medication administration records of patients on psychotropic medications.

7. Access to Care

Compliance Status: Partial compliance.

Findings

We were chagrined to find that a system used to insure that every sick call box is opened daily had been abandoned at the holding center. Our understanding is that the person who performed that task left the program but no one else continued to do it. This is not a personal duty; it is a process duty in order to insure that every location has daily access to sick call. I was informed that there will be a replacement procedure implemented shortly. It is our view that if staff understood why this was being done it would not have been discontinued unless an alternative procedure that accomplished the same result was implemented in its place. We also learned that patients' slips that address so called administrative issues as opposed to symptom requests are all handled together. It is our view that since the policy requires a face-to-face assessment with regard to symptom requests exclusively, it would be valuable to separate these two types of

requests in order to determine that the timeliness targets for symptoms assessments by nurses are in fact being achieved. The data to be monitored is the percent of symptom kites that are seen by a nurse for a face-to-face assessment in an appropriate space within 48 hours of having received the symptom request. The goal is at least 80% of those requests are seen within 48 hours. For those that are not seen within 48 hours, the QI program should study the causes for the delay. The goal is to improve potentially to 90% seen within two days. The other goal is to make sure that those not seen within 48 hours are seen within one day after 48 hours. This is the challenge. In addition, we reviewed nursing professional performance at both sites and there continue to be opportunities for improvement. This is common in most facilities. We know that the more review and feedback directly with the nurses occurs, the more the performance improves.

Recommendations

1. Separate the symptom kites from the administrative kites and monitor the timeliness of face-to-face assessment from the time of receipt of the symptom kites.
2. For those symptom kites not seen within 48 hours, determine the contributing factors in order to target improvement strategies that could mitigate these factors.
3. If possible, designate a nurse as a nurse educator and have her review the performance of nurses, both during sick call and urgent care, and provide feedback to the nurses in a constructive manner. This should be done at both facilities. All these recommendations are directed to the quality improvement program.

8. Emergency Care

Compliance Status: Substantial compliance.

Findings

We reviewed a series of records at both institutions in order to determine whether the immediate response was appropriate, whether the assessment and disposition were appropriate and whether, where continuity of care was required, that was appropriate. In fact, we found that consistently at both facilities, the assessment was appropriate; where indicated, patients were sent out timely and when patients returned, the necessary paperwork was available; and patients were seen by their primary care clinician, usually within the next day. The clinician adequately addressed the reason for the send out and facilitated follow-up care where indicated. This is the basis for the move to substantial compliance. Our only concern was that there was not always assiduousness demonstrated to us when we reviewed the urgent care log. In discussing the urgent care system, we also learned that there was not yet a way for the medical program to insure that when a call was made to the medical area by custody staff, a consistent nurse was responding over the phone. We were informed that, especially at the holding center, nurses sometimes get pulled away from the phone that custody accesses. Our suggestion is a wireless system that enables a nurse to move about but retain the phone number provided to custody. That person should always also

maintain the log so that she can document the name of the patient and presenting complaint right after the call has been made.

Recommendations

1. Instruct the nursing staff on the importance of assiduously maintaining the urgent care log, which must include patient identifiers, date and time of call, presenting complaint and disposition.
2. Develop a system that insures that on each shift custody needs to access only a single number and will always reach the appropriate nurse who will also have the responsibility of maintaining the urgent care log.
3. The QI program should once a quarter monitor both the process aspects of urgent care services as well as the professional performance aspects, which includes both nursing and clinician performance.

9. Follow-Up Care

Compliance Status: Partial compliance.

Findings

We continue, for this item, to refer to follow-up care after scheduled offsite services. This includes both specialty consults as well as procedures. Our reviews at both facilities demonstrated that specialty services were consistently accessible timely. For routine services, this means within 30 days. However, especially at the correctional facility, we found a tendency for nursing to refer to the advanced level clinicians for a record review of patients who had returned to the facility. At the ECCF holding center, in none of the cases we reviewed did this result in a face-to-face encounter when this happened. Less frequently at the holding center this also occurred. When a clinician reviews a record post-encounter the record review may edify the clinician; it is generally of minimal benefit to the patient. The patient gets to understand what was found and what the plan is only when the clinician meets with the patient and discusses these items. This needs to happen consistently without exception. In general, we did find that patients at the correctional facility as well as at the holding center did return through a nurse. It was only the clinician follow-up that was problematic. Thus, there has been some progress.

Recommendations

1. For consultations and procedures, the exceptions being physical therapy or some other ongoing treatment, follow up by a clinician with a face-to-face encounter must be documented.
2. That encounter must indicate that the findings and the plan were discussed with the patient. This process should be reviewed by the QI program at least twice before our next visit.

10. Chronic Disease

Compliance Status: Partial compliance.

Findings

There has been some progress since our last review. There is now an initial chronic disease encounter form which was implemented within the last few months. Although the use of this form is a step forward, we have identified some performance issues with regard to the utilization of the form. Specifically, we identified records with only a partial history taken. We also identified records where despite the patient having multiple problems, only some of those problems were addressed. We also found that assessment of degree of control was not always consistent with the defined definitions taught by Erie County to its clinicians. And finally, we found some cases where the frequency of the follow up was not consistent with what the degree of control would have indicated. We are not surprised that immediately post implementation of new forms there are some problems in performance. However, if there is consistent constructive feedback to the clinicians, we have every reason to believe that the performance will improve. However, we reiterate our concern about the loss of the Medical Director and the ability to provide this type of feedback. We understand there is an interim plan that is being put in place but we have no sense as to whether the physician service contracted will effectively review and provide feedback to the clinicians. The problem of delayed initial chronic care visit has been somewhat mitigated by the strategy to utilize the initial chronic care visit form in lieu of the history and physical form. This insures that an initial chronic care visit occurs at least two weeks prior to the former 30-day initial visit.

Recommendations

1. Fill the Medical Director position as quickly as possible.
2. Find a clinician with the appropriate skills to provide constructive feedback to the clinicians with regard to their performance.
3. Find a clinician in the interim to whom more complex chronic disease patients, particularly those in repeated poor control, can be referred.

11. Dental Care

Compliance Status: Substantial compliance.

Findings

The dental program, whose resources were increased prior to our last visit, continues to provide timely access to services. Patients are generally seen within a few days of submitting their request for services. However, we have concerns with regard to clinician performance. Two of the three dentists demonstrated performance where the ratios of restorations to extractions were almost 1:1. For both of them they were slightly under that. However, for one of the dentists, the ratio of restorations to extractions was 1:8. This is difficult to reconcile. We believe the

administrator should discuss with his dentists the fact that these ratios are being monitored and that the expectation is that adequate dentition requires an effort at restoration rather than immediate extraction.

Recommendations

1. Continue to monitor and report to the QI committee the ratio of restorations to extractions.
2. The QI committee, including its infection control nurse, should monitor the rate of post-extraction infections, thus requiring clinicians to report to the infection control nurse all post-extraction infections.
3. The dental program should continue to report to the infection control coordinator sterilization monitoring data on a quarterly basis.

12. Care for Pregnant Prisoners

Compliance Status: conditional substantial compliance.*

Findings

There were only four records for us to review, but in one of the four records, the patient arrived the first week of October and the first prenatal visit was unacceptably delayed. Since then, Erie County has adopted a policy that requires the initial history and physical on pregnant females to be performed within the first seven days of arrival. The policy also requires the first prenatal visit to occur within the first 14 days. In addition, we found that with the switch to a new obstetric service, namely Women and Children's Hospital, the success achieved in receiving the necessary prenatal encounter progress notes from ECMC has not been sustained. However, since the monitoring visit, the leadership of the health care program reached an agreement with Women and Children's Hospital, which will provide critical prenatal data to the jail program for each prenatal visit. What is required are the necessary prenatal progress notes which provide such important data as blood pressure, weight, fetal heart tones, abdominal circumference measurements, urinalysis data as well as complete blood count data. Since this area was in substantial compliance previously and there appears to be a good faith commitment to rectifying these problems, we have created the conditional compliance status as described earlier.

Recommendation

1. Insure that for all pregnant females the history and physical occurs no later than by day 7 and the initial obstetric prenatal exam occurs no later than day 14.
2. The QI program should track and report on the timeliness of both the services for pregnant females.

* If during the Sixth monitoring visit the commitments to initial prenatal visits within the first few weeks, as well as prenatal visit data are verified, the assessment stands as is. If either commitment is not verified, the compliance status for both the Fifth and Sixth visits will be partial compliance.

3. The QI program should also track the availability of progress notes from the prenatal obstetrician.

13. Dietary Allowances and Food Service

Compliance Status: Partial compliance.

Findings

We are encouraged that a dietician is about to be hired on a part-time basis on contract. We understand her responsibilities include analyzing the nutritional content of the current master menu as well as proposing a heart healthy master menu along with a cost analysis. As we understand, these tasks are to be accomplished by April so that they should be available by the time of our next visit.

Recommendations

1. Proceed with the dietician contract and make available to us by the time of our next visit the work product.

14. Health Screening of Food Service Workers

This area has been in compliance for 18 months.

15. Treatment and Management of Communicable Diseases

Compliance Status: Partial compliance.

We discussed with the infection control nurse the duties of that role. As part of that discussion, we indicated the need to implement a procedure where all clinicians who identified and treated a case of presumptive MRSA are required to immediately notify the infection control nurse. But culture proven and presumptively treated MRSA cases must be tracked monthly.

Recommendations

1. Establish a procedure to facilitate tracking these categories of MRSA monthly.

16. Sexual Abuse

Compliance Status: Substantial compliance.

Findings

It is our impression that this County was making every effort to have its leadership well educated on this issue. We were able to review three records of individuals who had alleged sexual abuse since our last review. In all three instances, the patients were handled appropriately. In one of the three, although paperwork was returned by the medical center to the jail, it did not include all of the required elements, most specifically the documentation of the physical exam assessment by

the clinician. The leadership of the health care program must meet with the leadership of ECMC to make it clear what data and what documents are required to be returned to the jail.

Recommendation

1. This item should be monitored by the QI program for all alleged sexual abuse incidents.

17. Quality Management

Compliance Status: Partial compliance.

Findings

We identified that the minutes were created by a clerical staff person not well versed in quality improvement. Therefore, the minutes contained anecdotal summary statements as opposed to data. We were able to explain some of the basic requirements of QI minutes and most importantly that QI minutes be designed in a way that educated staff who are unable to attend the QI meeting on both what was learned and why any changes in processes or procedures are being designed. The design is to mitigate causes of subthreshold performance. We did appreciate that the QI program was looking at multiple major service areas, such as medication administration, sick call, urgent/emergent care, consultations, chronic care, dietary and infection control. However, as a person who did not attend the meeting, I did not learn much from these minutes. It is clearly important that the quality improvement program be utilized to facilitate the achievement of substantial compliance in the remaining areas. This would suggest some key areas be reviewed at least twice before our next visit.

Recommendations

1. The QI program should focus activities on chronic disease, scheduled offsite services and sick call, with each area reviewed at least twice prior to our next visit.
2. Other areas in this report in which we recommend quality improvement activities should also be addressed at least once prior to our next visit.
3. The person assigned to create the minutes must be knowledgeable in quality improvement philosophy and methodology and therefore be capable of creating minutes which will be educational for the line staff who are not able to attend the QI meetings.

18. Review of Clinical Care by Responsible Physician

Compliance Status: Substantial compliance.

Findings

Again, I have been provided with the actual quality of care review forms for each of the clinicians and have been impressed with the accuracy and candor of the Medical Director in identifying and providing instruction for the clinicians with regard to their deficiencies. However, I am concerned that with the departure of the Medical Director this process will be

continued. I am especially concerned that the interim strategy, which includes at most a day and a half per week onsite by two clinicians who share the day and a half, will be adequate to provide this review, particularly with regard to one clinician whose performance has been identified as more problematic and whose work will have to be reviewed at least monthly if not more frequently.

Recommendations

1. The transitional Medical Director contracted services should include at least quarterly reviews of the clinical performance of clinicians so as to facilitate performance improvement.

III. Protection from Harm

E. Training of Officers with Regard to Sexual Abuse and Policy on Handling Sexual Abuse

Compliance Status: Substantial compliance.

Findings

Both the policy and the training are consistent with an assessment of substantial compliance.

Recommendation None.

I. Training of Medical and Mental Health Staff

Compliance Status: Substantial compliance.

Findings

Both the medical and mental health staff have completed their training with regard to the handling of sexual abuse. The percent trained is well above 90%.

Recommendation None.

J. Suicide Prevention Program

e. Privacy

Compliance Status: Substantial compliance.

Findings

See number 3 under Medical Care section.

Recommendation None.

f. Assessment of Inmates in Detoxification

Compliance Status: Substantial compliance.

Findings

The detoxification unit is now in a brand new, well-designed infirmary housing and the ability of the nursing staff to perform their assessment screens has been enhanced.

Recommendation

1. The QI program should continue to monitor the compliance of the nursing staff in performing the CIWA assessments.

D. Training of Officer Staff with Regard to Suicide Prevention Training

Compliance Status: Substantial compliance.

Findings

This area remains in substantial compliance. All who require training have received it.

3. Detoxification Training Program

Compliance Status: Substantial compliance.

Findings

All of the required medical staff have had this training.

Recommendation None.

Respectfully submitted,

R. Shansky, MD
Medical Monitor

RS/kh

Sixth Monitoring Report

US Department of Justice v. Erie County New York

This report reviews the status of medical program conditions at the time of the Sixth Monitoring visit, which took place from May 13-17, 2014.

B. Medical Care

1. Policies and Procedures

Compliance Status: Substantial compliance drafting of policies; substantial compliance implementation of policies.

Findings

Under the leadership of the Director of Health Care Services and the Director of Nursing, policies remain in compliance and in most areas, implementation improved. There is no question that the absence of a Medical Director has had a negative impact on the program. This is particularly true with regard to professional performance improvement of the advanced level clinicians. We were encouraged to hear that a successor Medical Director has been identified and is able to begin employment in that role in early September 2014. We also learned that this candidate is interested in working on a fee-for-service basis before then by involving himself in the professional performance improvement program with the advanced level clinicians.

Recommendations

1. Please forward the curriculum vitae of the newly selected Medical Director to the medical monitor.
2. Develop a format for systematic and consistent review of professional performance of the advanced level clinicians by the Medical Director. The medical monitor would be happy to assist in the development of this performance review.

2. Medical Autonomy

Compliance Status: Substantial compliance.

Findings

Although there has been a vacuum in the clinical leadership of the medical program, the medical monitor has developed a degree of confidence in the professionalism of the custody leadership such that it is my belief that custody leadership will not exploit this vacuum by intervening in necessary medical decisions. It will be up to the new Medical Director to again establish credibility with custody leadership and it is our belief that this certainly is achievable.

Recommendation: None.

3. Privacy

Compliance Status: Substantial compliance.

Findings

Besides the improved privacy provided by the new intake space, we learned that at the Alden Erie County Correctional Facility the room in the hallway will not be utilized. Rather, an additional exam room has been created in the clinic area. We are also aware that in the pod housing units there is an appropriately equipped examination room which affords the required privacy. Although there is no such room in the linear designed housing units, we are aware that patients are brought instead to the main clinic area where such privacy can be afforded.

Recommendation

1. Continue to provide appropriate privacy for any and all clinical assessments. This precludes any assessments being conducted cell-side.

4. Training of Custody Staff

This area has been in compliance for 18 months.

5. Management of Health Records

Compliance Status: Partial Compliance.

Findings

Although the backlog in inactive records has been eliminated, the effort to integrate all medical and mental health documents into the same record has resulted in increased filing needed to be performed for the active records. At the time of this visit, the loose filing area contained between seven and eight inches of unfiled documents that extended as far back as mid-April. These documents were mostly mental health initiated documents. It is expected that the electronic health record will go live as early as September of this year and certainly before our next visit in November. This should eliminate any of the active record filing as well as inactive record filing within six months of the implementation of the electronic record. The medical monitor is familiar with the particular software chosen and has experience with it, finding it quite user friendly. Another positive aspect of this software is that it is easily customizable with regard to the data entry screens which can be customized by local staff or a consultant to the program. We look forward to this section coming into substantial compliance.

Recommendation

1. Work closely with the IT integration vendor in order to design encounter forms that allow tracking and reporting on important data fields and also to insure that the transition from paper to an electronic record goes as smoothly as possible.

6. Medication Administration

Compliance Status: Substantial compliance.

Findings

Once again, we observed both morning and evening medication administration in both the linear housing units and in the pods. We were pleased to find that the nurses continue to perform both appropriately and professionally. We found that there was helpful participation by the correctional officers. We also found that there had been retraining of nurses such that there was consistency with regard to how they documented inmate refusals of specific medications. We also learned that there has been retraining with regard to the manner of documentation when as needed medications are felt by the patient not to be needed. Finally, we were particularly pleased with the nursing staff compliance with the policy requirement that when a patient refuses a medication for three consecutive medication passes they are referred to the ordering clinician. We observed several medication administration records where there were consecutive refusals and the patients had been referred to the clinicians. This was especially common with regard to the forensic clinicians. We were quite disappointed, however, with the response of the forensic clinicians who neither documented counseling nor made any effort to modify or revise the existing regimen. The purpose of the referral is for any clinician to explain the risks and/or benefits and to work out with the patient a regimen that is much less likely to be refused. There was no documentation that we saw that achieved these goals. We also believe that blank spaces that occur on medication administration records where the medicine is ordered at least daily should be treated as medication errors.

Recommendation

1. The quality improvement program should select MARs that reflect the work of a variety of nurses, especially for patients who are on multiple medications, multiple times per day. In reviewing these medication administration records, a calculation should be performed of the error rate, meaning the rate of blank spaces versus the total number of expected doses administered. This error rate should not only be used to improve performance, but it also should be reported in the quality improvement minutes at least quarterly.

7. Access to Care

Compliance Status: Partial compliance.

Findings

We were pleased to observe that the logging of medical sick call requests is occurring and these requests have been separated into symptom describing requests and other so-called administrative or informational requests. However, the manner in which they were recorded does not easily allow for a simple observation of the timeframe between request received and face-to-face assessment having occurred. We believe it will be more useful to have a logbook that lists patient identifiers, date received, nature of the complaint, date of assessment and disposition. This would allow to visually determine the average timeframe in which these assessments occur simply by glancing at the two columns, date received and date of assessment,. Finally, with regard to the disposition, we attempted to do a study looking at the records of patients in which the disposition described referral to an advanced level provider. The first five such records we pulled contained zero notes by an advanced level clinician. We learned that a policy had been implemented in which, when the nurses refer the patients to the advanced level clinicians, these advanced level clinicians had a choice of reviewing the record alone or also seeing the patient. In none of the records we reviewed was the patient seen face-to-face for an assessment by an advanced level clinician. Therefore, we are strongly recommending that the policy with regard to referral be changed. The discretion by an advanced level clinician of only reviewing the record should be eliminated. We have never heard of an instance where a patient learned anything when their record had been reviewed by any clinician. The choices the nurses should have is to either discuss the case with the clinician at the time the patient is there or refer the patient to the clinician for a mandatory face-to-face assessment by the clinician. We also discussed with the Director of Health Services that it is very important that no clinicians are allowed to conserve personal energy by manipulating the list of patients they are to see in such a way that their workload is reduced.

Recommendations

1. Set up a logbook that allows visual tracking of symptom complaints for time of receipt, presenting complaint, time of nurse assessment as well as disposition.
2. The QI program should present data from these logbooks with regard to average timeframe between receipt and nurse assessment.
3. Eliminate the advanced level provider review and make all referrals to an advanced level provider mandatory, face-to-face assessments where they can help understand the patient's problems and educate their patient.
4. The QI program should monitor the average timeframe for advanced level clinician face-to-face assessment after nurse referral, with a threshold of no more than five business days.

8. Emergency Care

Compliance Status: Substantial compliance.

Findings

We reviewed seven records of patients who were sent offsite on an emergency basis. In general, these patients were assessed timely prior to send out, an advanced level clinician was notified and recommended the patient be sent out, and when the patient returned the appropriate offsite documents were available and the patients were seen by a nurse upon return and by an advanced level clinician within a few days after return. In most of those follow-up visits, the findings and plan were discussed. However, we did find an occasional record where there was no documentation of contact with an advanced level provider as well as an occasional record where the offsite service document was missing. We also found an occasional record where the nurse note on return was absent and an occasional record where the follow-up visit with the advanced level clinician either did not occur or did not include documentation of a discussion with the patient regarding the findings and plan. Because we did not identify a pattern to any of these individual errors, we still assessed this area as substantial compliance.

Recommendations

1. The QI program should be monitoring a set of emergency offsite visits and insuring that there is documentation of a discussion with an advanced level clinician prior to send out and that there is a nurse note upon return, as well as both the available documents from the offsite service and a timely follow up by an advanced level clinician at which there is documentation of a discussion regarding the findings and plan.

9. Follow-Up Care

Compliance Status: Partial compliance.

Findings

We looked at scheduled offsite services, that is consultations and procedures, both at Alden and at the holding center. In both facilities, we identified multiple records where there was a breakdown in either availability of offsite service documents or in a timely follow up by the clinician in which there was documentation of a discussion with the patient regarding findings and plan. There were records at both sites in which all of the required elements were present. However, between the two sites the rate of records where all of the elements in the offsite service process were successfully completed was less than 50%. Therefore, the assessment of partial compliance.

Recommendation

1. The QI program should monitor at each site a sample of patients sent offsite for scheduled offsite services. The monitoring should include the timeliness of the appointment, the presence of the offsite service report upon return and the follow-up visit with an advanced level clinician in which they document the findings and plan having been discussed with the patient. When there is breakdown in any of these steps, the QI

program should assess the contributing factors and develop improvement strategies to mitigate the occurrence of these factors.

10. Chronic Disease

Compliance Status: Partial compliance.

Findings

In our last report we voiced concerns regarding the loss of the Medical Director and the ability of the program to therefore improve clinical performance. At this visit, with regard to chronic diseases, our concerns were realized. During this visit, we looked particularly at diabetes care and HIV care in order to determine whether problems we had identified in our prior visit had in fact been mitigated. In general, with some exceptions, we found that many of the prior stated performance issues have not been mitigated. The following is a list of those concerns.

We found patients for whom for the first visit, the initial baseline form was not utilized and as a result there was insufficient disease specific history. We also found records where only one of the chronic diseases was addressed and therefore the other chronic diseases appeared to have been ignored. We also found records where there was no assessment of degree of control, which ultimately determines the management approach. In the case of HIV disease, we found patients seen where at the initial visit there was no order for the viral load, although there was an order for the CD 4 count. The viral load is critical in order to determine viral activity. The CD 4 count may be within normal range, but if the viral load is significantly elevated, this may mean either that if the patient is on medications, resistance is possibly developing or in a patient not on medications, it is likely to indicate the need for initiating medications. With the absence of the viral load at the time the patient is sent to the HIV specialist, this may delay the ability of the HIV specialist to determine when treatment needs to be initiated. These types of problems hopefully will be easily addressed by the new Medical Director. If the program is able to develop a contract with the proposed Medical Director in the interim before he is to start as Medical Director, this could allow improvement in ALP performance over the next few months.

Recommendations

1. Send to the medical monitor the curriculum vitae of the proposed Medical Director,
2. Proceed with the administrative steps necessary to bring the proposed Medical Director on board in the interim to perform professional performance enhancement reviews.
3. The Director of Correctional Health Services should contact the medical monitor about designing a form to be utilized by the proposed Medical Director in performing the professional performance reviews.

11. Dental Care

Compliance Status: Substantial compliance.

Findings

We were not able to interview the dentist during this visit and therefore we were not able to review the program as thoroughly as during our prior visits. However, when we reviewed the data on performance of restorations versus extractions, we observed that the prior problem of one dentist overwhelmingly performing extractions has been eliminated. We were informed that that dentist has been terminated. We believe that it is important for the quality improvement program to track date of receipt of symptomatic requests that reflect tooth pain and date of face-to-face encounter either with a nurse or with dental staff during which analgesia is provided. We also believe that tracking of dental pain in relationship to assessment by a dentist should also be tracked.

Recommendations

1. The QI program should track symptomatic requests that discuss tooth pain and date of initiation of analgesia.
2. The QI program should also track date of request received describing dental pain along with date of assessment by the dentist. These studies should be reported monthly and reviewed at the QI meeting quarterly.

12. Care for Pregnant Prisoners

Compliance Status: Partial compliance.

Findings

During our last monitoring visit, we assessed the compliance status as conditionally substantial compliance. We have downgraded the assessment to partial compliance because two of the five records reviewed lacked the necessary offsite service documents to allow for appropriate continuity of care onsite. We understand that there has been contact with the Women and Children's Hospital administration regarding providing the necessary documents. However, the staff at ECHC and ECCF must persist in obtaining these critical documents. It may be that in addition to another meeting with the leadership of these offsite services that a letter from the Department of Health or Correctional Health Services be brought by an officer to the offsite service provider which indicates the officer must return with the required documentation in an envelope in order to facilitate continuity of care onsite and in order for the service to be completed, thus allowing for timely compensation.

Recommendations

1. Develop an administrative strategy that facilitates timely retrieval of the critical offsite service documents.
2. The QI program should continue to track timeliness of initial ALP assessment after determination of pregnancy as well as timeliness of offsite service obstetric visit from time of diagnosis.

13. Dietary Allowances and Food Service

Compliance Status: Partial compliance.

Findings

We were impressed with the dietitian who has been hired on a part-time basis to guide the food services operations. We had an opportunity to talk with her and learned that she has been assessing whether there could be a transition to a heart-healthy diet. We were informed that at the ECCF there was a well-designed and equipped kitchen and therefore they could convert to such a diet. On the other hand, at the holding center, the kitchen, which was built with the building several decades ago, was only designed for potential population of 200 detainees. Therefore, the size of the kitchen does not currently allow for the type of food preparation for a heart-healthy diet and rather requires the utilization of a significant amount of processed foods. This creates a challenge, particularly with regard to the salt content of the master menu diet at the holding center. It would be problematic to have one master menu at one facility and a significantly different master menu at the other facility. We also found that the number of detainees for whom both a diabetic diet and a cardiac diet were ordered was substantially less than what one would project for the holding center. This suggests that there is continued need to attempt to move to a heart-healthy master menu because accomplishing that goal would eliminate the need for special diets for diabetes and hypertension and thus increase the likelihood that detainees with these problems would receive an appropriate dietary regimen.

Recommendations

1. Bring in an appropriate consultant to determine whether the existing holding center kitchen can be expanded and equipped sufficiently to allow for a heart-healthy diet.
2. Provide the medical monitor with an analysis of the existing food served both at the ECCF and at ECHC so that the dietitian can determine how big a change moving to a heart health diet would cause.

14. Health Screening of Food Service Workers

This area has been in compliance for 18 months.

15. Treatment and Management of Communicable Diseases

Compliance Status: Partial compliance.

Findings

The Director of Nursing, who has excellent prior experience, is currently functioning as the infection control nurse for both facilities. We discussed with her the infection control program in general and discussed in detail the TB surveillance program as well as the MRSA surveillance program. We also discussed data collection with regard to hepatitis A, B and C as well as HIV

disease. We would like to review the TB control policy which we had reviewed several years previously. We also learned that the ability to track skin infections presumptively treated for MRSA has not yet been implemented. The implementation of the electronic medical record should facilitate notification by clinicians to the infection control coordinator when such presumptive treatment occurs. This can be done internally through the EMR flagging system (internal e-mail).

Recommendations

1. Establish a system to monitor both culture proven and presumptively treated MRSA cases on a monthly basis.
2. Report both categories of MRSA cases at the QI meeting on a quarterly basis.

16. Sexual Abuse

Compliance Status: Partial compliance.

Findings

When we reviewed the records of patients who had historically alleged sexual abuse, we found that the documentation from the offsite services did not even mention the performance of a forensic exam nor the provision of rape crisis counseling services. We understood that discussions between the leadership of correctional health services and the leadership of ECMC have occurred and yet line staff from the offsite services are still not always providing the necessary documentation. We strongly urge a letter be drafted coming from the Department of Health to ECMC staff that describes the federal requirement that documentation of such services, including prophylactic treatment for sexually transmitted diseases and counseling regarding pregnancy, be included in the offsite service documentation. This letter should be brought by an officer for each and every patient who is to be assessed at the hospital via a forensic exam.

Recommendation

1. The Department of Health should develop a letter to the ECMC staff that documents the requirement of correctional facilities to be able to demonstrate documentation of the occurrence of both a forensic exam and rape crisis counseling along with the provision of sexually transmitted disease treatment and pregnancy counseling where indicated.
2. The QI program should track the receipt of this documentation for each and every allegation.

17. Quality Management

Compliance Status: Partial compliance.

Findings

In the absence of a Quality Improvement Coordinator, the Director of Nursing services is also attempting to perform these duties. We believe this is hindering the development of this program. Additionally, the Director of Nursing, in the absence of an assistant Director of Nursing for the ECCF, is also providing direct oversight to both facilities. Clearly, an Assistant Director of Nursing for the ECCF is also required. We reviewed the minutes of the quality improvement committee meetings and identified that the minutes read more like staff meeting minutes than QI meeting minutes in which data is presented and analyzed and, where indicated, improvement strategies are developed. We could not find these activities in the quality improvement committee minutes. On the other hand, we were shown some important studies performed.

1. A study of the timeliness of receipt by the patient of critical forensic medications. We found that 40 of 48 forensic medications labeled as critical were received within the forensic mental health definition of timeliness, that is within 24 hours. Eight patients received their medication later than 24 hours.
2. We also found a study of the timeliness of receipt of routine medications utilizing a definition of 48 hours. Thirty-seven of 44 patients received their medical medications within 48 hours. Seven patients had their medications delayed greater than 48 hours. Ten patients refused their medications at the time of receipt and all of these were referred to the advanced level provider.
3. There was also a completeness study of the elements during the intake process, such as the medical screen, patient consent, vital signs and detox referral where indicated along with medical classification, alerts and suicide screen.

These studies are important and helpful. However, in the recommendation section of this report we have also listed studies for the quality improvement program to perform dealing with care of the pregnant patients, sexual abuse cases, chronic disease cases, dental services, scheduled offsite services, unscheduled offsite services, and others. We believe it is not possible to perform all of these reviews without the addition of a Quality Management Coordinator.

Recommendations

1. Add both a Quality Management Coordinator and the Assistant Director of Nursing positions as soon as possible.
2. Work with the IT consultant regarding the ability to track critical elements through the EMR by re-customizing encounter forms where indicated.
3. Perform the studies referred to under the recommendations section consistent with the recommendations we have made.
4. Revisit the definitions for timeframe of receipt for critical medications for both medical medications and forensic medications. For medical medications that are critical, such as anticoagulants, anti-seizure meds and HIV medications, the goal is prevent dose discontinuity by insuring that the dose is received in a timeframe that mitigates the

probability of dose discontinuity. That is almost invariably in a timeframe significantly less than 24 hours. For routine medical medications, the goal should be receipt within 24 hours. Forensic medications may have a different timeframe and different targets. This should be worked out with the leadership of forensic medical services.

18. Review of Clinical Care by Responsible Physician

Compliance Status: Non-compliance.

Findings

Since the departure of the Medical Director there has been no review of clinical care by a responsible physician. Thus the assessment of non-compliance. We are hopeful that the Director of Correctional Health Services can work with the medical monitor to design a system for professional review. We are also hopeful that between receipt of this report and the beginning of September this review can be initiated.

Recommendations

1. The Director of Clinical Services should initiated communication with the medical monitor in order to develop a systematic review of professional performance.
2. The Director of Correctional Health Services should contact a physician to perform this service.

III. Protection from Harm

E. Training of Officers with Regard to Sexual Abuse and Policy on Handling Sexual Abuse

Compliance Status: Substantial compliance.

Findings

Both the policy and the training are consistent with an assessment of substantial compliance.

Recommendation None.

I. Training of Medical and Mental Health Staff

Compliance Status: Substantial compliance.

Findings

Both the medical and mental health staff have completed their training with regard to the handling of sexual abuse. The percent trained is well above 90%.

Recommendation None.

J. Suicide Prevention Program

e. Privacy

Compliance Status: Substantial compliance.

Findings

See number 3 under Medical Care section.

Recommendation None.

f. Assessment of Inmates in Detoxification

Compliance Status: Substantial compliance.

Findings

The detoxification unit continues to function as a well-designed program.

Recommendation

1. The QI program should continue to monitor the compliance of the nursing staff in performing the CIWA assessments.

D. Training of Officer Staff with Regard to Suicide Prevention Training

Compliance Status: Substantial compliance.

Findings

This area remains in substantial compliance and has achieved sustained compliance.

3. Detoxification Training Program

Compliance Status: Sustained substantial compliance.

Findings

All of the required medical staff have had this training.

Recommendation None.

Summary of Findings

Although when one reviews the section headings and the compliance status assessed one sees, if anything, in a few categories there have been some setbacks. However, within the partial compliance category we have observed improvement in some sections, particularly scheduled offsite services and chronic diseases as well as access to care and the quality improvement

program among others. The method of assessment, choosing one of three statuses, does not allow for the description of the progress other than in the findings section. We continue to be impressed by the efforts by both the Department of Health and the Department of Corrections to do what is necessary in order to achieve substantial compliance. We are particularly impressed with the work by the Director of Correctional Health Services and the Director of Nursing, without whose work the progress that we observed would not have been observed. This was accomplished despite the loss of the Medical Director. We would hope that with the hiring of a new Medical Director as well as the implementation of an electronic record that we will see significant improvements at the time of our next visit. We continue to encourage the leadership of the medical program to utilize our services whenever they deem appropriate. We look forward to substantial progress at the time of our next visit.

Respectfully submitted,

R. Shansky, MD
Medical Monitor

RS/kh

Seventh Monitoring Report

US Department of Justice v. Erie County New York

This report reviews the status of medical program conditions at the time of the Seventh Monitoring visit, which took place from November 17-21, 2014. This particular review was affected by a major snowstorm which fell heavily on southern Buffalo and prevented the team from accessing the Erie County Correctional Facility. Additionally, the storm created such disruptions to traffic flow that both correctional officers and health care staff found it difficult if not impossible to get to the facilities. Downtown Buffalo, which is where the Erie County Holding Center is located, did not have nearly as much snow, probably an accumulation of about 6-8 inches during the week. We were able to review all of the elements of the program at the Holding Center (except for medication administration) despite not being able to go to the Correctional Facility. The County staff were remarkably accommodating in assisting us through the process despite the multiple emergencies to which they had to respond. We are greatly appreciative of the efforts made by the Erie County custody and health care staff.

The major area affected by the weather in terms of my review was medication administration, which because of staff shortages due to the weather resulted in only emergency and critical medications being administered. The section related to medication administration will be described at that time.

B. Medical Care

1. Policies and Procedures

Compliance Status: Provisionally substantial compliance pending receipt and acceptance of modified policies.

Findings

The Director of Health Care Services informed me that there have been revisions to some of the policies and procedures within the past six months. These revisions are to be signed by the Commissioner of Health and the custody leadership. I was not able to be provided access to these changed policies and procedures; however, I will assess the compliance status as provisionally substantial compliance pending receipt of the modified policies and procedures.

The Chief Medical Officer or Medical Director should also participate in the promulgation and/or review of policies. Because this position has remained vacant there is no real opportunity for such participation. However, we will review the changes to the existing policies when we receive them.

Recommendations

1. Please forward the modified policies and procedures to the medical monitor when they are available.
2. Begin to implement per our discussion nursing professional performance enhancement reviews to expand on what you have already initiated.

2. Medical Autonomy

Compliance Status: Unable to assess.

Findings

Although the assessment was substantial compliance at our last visit despite the fact that the CMO position had been vacant for six months, I was modifying the method I used to make the assessment. Ordinarily I utilize discussions with both custody leadership and the CMO as well as the Nursing Director and any record reviews that raise questions in order to assess medical autonomy. Since medical autonomy had been in substantial compliance based on a very constructive working relationship between the clinical leadership and the custody leadership, I had reason to believe that this principle would not be violated. However, in the face of vacant clinical leadership for 12 months I am not able to fully assess medical autonomy. Custody cannot develop a relationship when there is a vacancy in the key clinical leadership position. I am not assessing partial compliance because I have no data that supports moving the compliance status backward. I have been apprised of the recruitment efforts made by the Department of Health over the last year. Those efforts have been significant. There may be a variety of reasons why the position has remained vacant for 12 months. The one apparent reason is that the compensation package has not been perceived as acceptable to the selected candidates. This suggests to the monitor that the Department of Health must use more creative strategies than sticking with the civil service system or a fee for service dollar figure that equals salary plus benefits. In this monitor's experience, correctional health programs can become fragile and deteriorate rapidly in the absence of dependable, constructive clinical leadership. This problem must be successfully addressed soon.

Recommendations

1. Fill the Medical Director position.

3. Privacy

Compliance Status: Substantial compliance.

Findings

Although we did not tour the areas where assessments are performed, we were assured that all assessments at both facilities are performed in an appropriate clinical space, both in the housing

units and in the clinic areas. I have also been assured that this program does not perform cell-side assessments.

Recommendations

1. Continue to emphasize with staff the obligation to insure that all assessments are performed in a manner that affords appropriate privacy.

4. Training of Custody Staff

This area has been in compliance for 18 months.

5. Management of Health Records

Compliance Status: Partial Compliance.

Findings

As a result of bureaucratic delays, the implementation of the electronic record has yet to begin. We do know that a contract has been signed and the vendor has been onsite and also remotely working with the correctional health staff in preparation for the implementation. These are encouraging signs. We also visited the record area and found the filing in both locations not excessively backlogged. During our record review, we did identify records, especially for people with multiple problems and incarcerated longer periods of time, to be somewhat disorganized, both with regard to the sections in which documents were filed and within a section with regard to correct chronologic order. We know these problems will be eliminated by the introduction of the electronic record. However, there remains a current obligation to maintain the records in such a way that they facilitate use by clinicians and thus facilitate better patient outcomes.

Recommendations

1. Have medical records staff focus on insuring appropriate record management, including filing, in those records which are thicker.
2. Continue the groundwork being laid with the selected vendor so that implementation goes as smoothly as possible.

6. Medication Administration

Compliance Status: Unable to assess.

Findings

As a result of the massive snowstorm resulting in up to eight feet of snow in some parts of south Buffalo, it became impossible to insure that both custody staff numbers and health care staff numbers were adequate for the medication administration. In light of this, critical medications were identified and these were administered, as far as we understand, on each and every day. However, without adequate staffing it became impossible to meet with routine medication

administration demand. Additionally, we discussed the issue of both the nursing and the health care staff response to repeated missed or refused medications. The policy requires the nurses to notify the clinicians regarding three doses refused or missed in a row. This notification should include scheduling the patient with the clinician. At that visit, the clinician is obligated to query the patient as to why this is happening and based on the response, either develop a plan that is likely to facilitate adherence or decide that this particular medication is no longer indicated. In our last review, when clinicians were informed of the sequence of refusals or missed meds, nothing was changed. An internal study was performed by the Office of Health Services and a separate study was performed by forensic mental health. Both studies showed some improvement but the problem had not yet been resolved.

Recommendations

1. Continue working with both nursing staff and clinician staff about their responsibility to respond to a sequence of missed or refused medications.
2. The quality improvement program should select MARs that reflect the work of a variety of nurses, selecting MARs for patients who are on multiple medications multiple times per day. In reviewing these medication administration records a calculation should be performed of the error rate, meaning the rate of blank spaces versus the total number of expected doses administered. This error rate should not only be used to improve performance but it should also be reported in the quality improvement minutes at least quarterly.

7. Access to Care

Compliance Status: Partial compliance.

Findings

We have good news in that in our review of records of patients who have submitted sick call requests, they were almost always seen within one day. However, the infrastructure to monitor timeliness has still not been developed because the logbook that would allow visual tracking from fields that list date of receipt versus date of face-to-face assessment has not yet been set up. As indicated previously, this allows very rapid review of a substantial amount of data without a great deal of effort. We strongly encourage setting up this methodology. Additionally, we found the professional performance by the nurses inconsistent. Some performed well and others performed not as well. The problems we identified included inadequate history taking, inadequate assessment and inadequate plan. The types of inadequate history included not querying regarding all of the symptoms listed on the sick call slip but also not querying sufficiently with regard to specific types of symptoms. The problem of not reviewing with the patient the specific symptoms listed on the request stems from an urgent care type of approach in which the patient is seen without any records. Sick call is not an urgent care encounter because

there is a written request from at least one day earlier and that request has to be addressed. This should be reviewed with all nurses who perform sick call.

Recommendations

1. Set up a log book that allows visual tracking of symptom complaints for date of receipt, presenting complaint, date of nurse assessment as well as disposition (referral to ALP or not).
2. The QI program should present data from these logbooks with regard to average timeframe between receipt of request and nurse face-to-face assessment.
3. The QI program should monitor the average timeframe from nurse referral to advanced level clinician with a timeframe target of no more than five business days for the referral to be accomplished.

8. Emergency Care

Compliance Status: Substantial compliance.

Findings

We again reviewed seven records of patients seen urgently and all except one were sent offsite on an emergency basis. Overall, these patients were assessed timely prior to send out. An advanced level provider was notified and recommended the patient be sent out. When the patient returned, the appropriate offsite documents were available and the patients were seen by a nurse and subsequently by an advanced level clinician within a few days after return. In most of these follow-up visits there was documentation of a discussion regarding the findings and plan. However, we continued to find a record in which there was no emergency room report, another record in which there was a missing nursing note upon return and one or two records in which either the follow-up visit did not occur or what should have been a follow-up visit that included a discussion of the findings and plan lacked that discussion. Because we did not find a pattern of any of these deficiencies, we continue to rate the service as being in substantial compliance. We continue to believe that the quality improvement program could identify explanations for why these things are happening and from that analysis could lead to improvement strategies which would eliminate the problems.

Recommendations

1. The QI program should be monitoring emergency offsite visits and insuring that the offsite service reports are retrieved timely, reviewed by the clinician and then discussed with the patient at a visit shortly after the emergency room trip.

9. Follow-Up Care

Compliance Status: Partial compliance.

Findings

We reviewed eight records of scheduled offsite services, including a mixture of both consultations with specialists as well as procedures. We continued to find a mixture of quite common deficiencies; in fact, a majority of the eight records contained one or more of the following deficiencies. Those deficiencies included the absence on return of a note by a nurse, the absence of a follow-up discussion between an advanced level provider and the patient and in a few instances, the absence of the offsite service report. This area continues to be a problem and merits special attention by the QI program. We did not review records from the correctional facility which, in our previous visit, contained even a higher percentage of deficient records. We are concerned that not only has this service not progressed but in fact it may have taken a step backward.

Recommendations

1. The quality improvement program should monitor at each site a sample of patients sent offsite for scheduled offsite services. The monitoring should include the timeliness of the appointment, the presence of the offsite service report upon return and the follow-up visit with an advanced level clinician in which they document a discussion of the findings and plan with the patient. When there is a breakdown in any of these steps, the QI program should assess the contributing factors and develop improvement strategies to mitigate the occurrence of these factors.

10. Chronic Disease

Compliance Status: Partial compliance.

Findings

It is not surprising with a vacant Medical Director position for the last 12 months that we are not seeing substantial progress in the area of chronic disease management. This is an area that requires the Medical Director to review and work with the advanced level clinicians in order that their performance be improved. During this visit we looked at a variety of diseases, focusing as we had before on diabetes as well as HIV, asthma and seizure disorder. We also reviewed a record of a patient receiving anticoagulation. Of the 11 records we reviewed, four were of patients with diabetes. Among the records reviewed were patients with both type 1 and type 2 diabetes; however, it was common for the problem list and the notes not to reflect the type of diabetes that the clinician was addressing. Given the difference in physiology between the two types of diabetes, not appreciating this difference is likely to lead to care problems. We found that in the initial chronic disease history there was no effort to identify the age of onset of the disease, which is very important in determining whether the patient has type 1 or type 2 diabetes. We also found that patients with asthma did not have a peak flow measurement whether they were being assessed during an acute attack or whether they were being assessed when they were stable during a chronic clinic visit. In fact, one patient who by history was having 2-3 nighttime

awakenings per week and was on inhaled steroids did not have his degree of control assessed nor was the patient given a follow-up visit sooner than three months. With regard to HIV disease, it is not clear why at the first chronic clinic visit, although a CD4 count was ordered, no viral load was obtained. When the patient was sent to the offsite clinic, the clinic recommended to have the patient return with a viral load. Also, it was not clear that the primary care chronic clinic clinician was querying the patient regarding side effects of the treatment regimen. On the positive side, when we reviewed significantly diminished serum Dilantin levels, each patient was seen by a clinician after the lab test was reviewed and discussions regarding adherence and/or changing doses were documented. It is critical to fill the Medical Director position so that the advanced level clinicians can improve their clinical performance. In the absence of feedback and discussion, it is guaranteed that performance will not improve.

Recommendations

1. Have the lab send a list of individuals who have had a hemoglobin A1c within the prior month along with the name of the patient, the specific results and the date that the lab test was performed.
2. Have the consulting Medical Director review the records of patients whose hemoglobin A1cs are above 9.0, indicating poor control.
3. Reinforce with the nursing staff and the clinicians the importance of assessing asthma by use of the peak flow meter.

11. Dental Care

Compliance Status: Provisional substantial compliance.

Findings

We learned that the x-ray equipment at the correctional facility is broken and needs to be repaired. As a result, certain procedures such as extractions cannot be performed, since it is a standard of practice to have an x-ray prior to any extraction. We discussed with the dentist and the Director of Correctional Health the possibility of utilizing the x-ray unit at the holding center on a weekend day and bringing 10 patients a week from the correctional facility to the holding center to obtain these x-rays. Custody indicated they would be fully supportive of this strategy to be used on an interim basis until the x-ray equipment at the correctional facility is in fact repaired. The provisional substantial compliance is based on implementing this strategy and in addition, repairing the equipment so that it is ultimately functional.

Recommendations

1. Get the x-ray equipment repaired.
2. Implement a system to have x-rays performed on correctional facility patients at the holding center on weekends until those services are no longer needed because the x-ray equipment at the correctional facility has been repaired.

12. Care for Pregnant Prisoners

Compliance Status: Substantial compliance.

Findings

We reviewed the two records of pregnant patients currently housed at the holding center. In both cases, the pregnancy was identified during intake, the patient was seen by an advanced level provider onsite and then followed up at Women and Children's Hospital in the prenatal clinic. In addition, in both cases the relevant documents from the prenatal clinic were available and reviewed by the onsite clinicians. One patient, during the course of her stay, delivered a baby and the records reflect both the prenatal and post-delivery care.

Recommendations

1. The quality improvement program should continue to track the timeliness of initial advanced level provider assessment after determination of pregnancy as well as timeliness of offsite service obstetric visits from time of diagnosis.

13. Dietary Allowances and Food Service

Compliance Status: Substantial compliance.

Findings

We toured the kitchen at the holding center and interviewed the Director of Food Services. We were unable to go to the correctional facility and also unable to interview the dietitian. We hope to interview the dietitian during our next visit. In looking at the special diets currently assigned, we queried the Food Service Director as to which items from the standard menu would have to be substituted for, as an example, a diet for diabetics. He appeared knowledgeable and answered our questions both timely and correctly. Although we would have liked to have discussed this with the dietitian, we will await that interaction for our next visit. The Director of Food Services appeared knowledgeable enough to appropriately make the special diet substitutions.

Recommendation None.

14. Health Screening of Food Service Workers

This area is in sustained compliance.

15. Treatment and Management of Communicable Diseases

Compliance Status: Partial compliance.

Findings

We were informed by the Director of Correctional Services that there has been approval of a nurse to be hired with responsibilities to both direct the quality improvement program and

function as the infection control nurse. We are encouraged by this since there are several functions which need to be better organized. The infection control nurse should collect data presented at a quarterly quality improvement meeting with regard to both the TB surveillance program as well as the skin infection program. In addition, there is a requirement to summarize the data on reportable cases also. Finally, the areas in which assessments are performed need to be monitored at least monthly and assurance be provided that effective sanitary procedures have been implemented. We look forward to the hiring of this nurse, both for the infection control program and for the quality improvement program.

Recommendations

1. Hire the person who will be responsible for both infection control and quality improvement leadership.
2. Establish a system to monitor both culture proven and presumptively treated MRSA cases on a monthly basis.
3. Report both categories of MRSA cases at the QI meeting on a quarterly basis.

16. Sexual Abuse

Compliance Status: Partial compliance.

Findings

We were provided with the sexual abuse allegation log and attempted to identify cases which were sent offsite and for which a SANE exam was provided. It was extremely difficult to read the log and it would have helped if the log contained a field for “sent to the hospital” and a second field for “SANE exam completed.” The sexual abuse coordinator indicated he would modify the log in the future. We reviewed two records of patients sent offsite for which a SANE exam was performed. It is not clear whether others may have been performed but we were unable to discern them. The sexual abuse coordinator believes that is the case. Of the two cases we reviewed, it was clear that a SANE exam had been performed; what was not clear was any direction given to both the medical and mental health staff with regard to follow up. The PREA standards specifically require follow up based on the nature of the assault and gender of the victim with regard to sexually transmitted disease treatment as well as pregnancy counseling. When you receive a report from a hospital that only indicates “exam performed,” you have no guidance as to what their recommendations are. In addition, we had no documentation that rape crisis counseling was provided and whether more mental health services were recommended. Because of the absence of guidance from the hospital this area remains in partial compliance. We discussed with the Director of Correctional Health Services his need along with relevant custody staff to meet with the leadership at the hospital so that the communication back to the holding center does provide the necessary guidance.

Recommendations

1. Modify the sexual abuse assault log to add fields for both sent out to hospital and SANE exam done.
2. Meet with the leadership of the hospital and convey to them the need for follow-up guidance to be provided as a result of the SANE exam and/or the rape crisis counseling. This guidance should be part of the paperwork that returns to the facility.

17. Quality Management

Compliance Status: Partial compliance.

Findings

Although there is no Quality Improvement Coordinator, we have been assured by the Director of Correctional Health Services that a position has been approved and he intends to hire after the first of the year. Not surprisingly, the quality improvement program is substantially underdeveloped. There have been studies which we have reviewed with regard to medication errors, medical incidents, completeness of nursing documentation, CIWA assessment performance and missed medications. The studies that I reviewed were incomplete in that they contain data but no analysis against a standard, no determination of whether the performance was satisfactory and if the performance was not satisfactory, no development of an improvement strategy. These are all the requirements of an adequate quality improvement program. I will be happy to spend time with the Director of Correctional Health Services, the Director of Nursing and the new Quality Improvement Coordinator indicating my expectations with regard to the requirements of the quality improvement program as it addresses the areas in this Memorandum of Agreement. I look forward to working with the leadership team and expect that progress will be made soon.

Recommendations

1. Fill the Quality Improvement Coordinator position and the Assistant Director of Nursing position as soon as possible.
2. Work with the IT consultant regarding the ability to track critical elements through the electronic medical record by recustomizing encounter forms where indicated.
3. Perform the studies referred to under the recommendation section consistent with the recommendations we have made. If necessary, please feel free to contact the medical monitor.

18. Review of Clinical Care by Responsible Physician

Compliance Status: Non-compliance.

Findings

The 12 month vacuum in this position creates potential insecurity for the advanced level clinicians as well as lack of oversight of significant clinical decision making. This position needs

to be filled as soon as possible with the appropriately credentialed clinician. The County must become creative in designing an attractive package for any applicants.

Recommendations

III. Protection from Harm

E. Training of Officers with Regard to Sexual Abuse and Policy on Handling Sexual Abuse

Compliance Status: Sustained substantial compliance.

Findings

Both the policy and the training are consistent with the continuation of substantial compliance.

Recommendation None.

I. Training of Medical and Mental Health Staff

Compliance Status: Substantial compliance.

Findings

Both the medical and mental health staff have completed their training with regard to the handling of sexual abuse. The percent trained is well above 90%.

Recommendation None.

J. Suicide Prevention Program

e. Privacy

Compliance Status: Sustained substantial compliance.

Findings

See number 3 under Medical Care section.

Recommendation None.

f. Assessment of Inmates in Detoxification

Compliance Status: Substantial compliance.

Findings

The detoxification unit continues to function as a well-designed program.

Recommendation

1. The QI program should continue to monitor the compliance of the nursing staff in performing the CIWA assessments.

D. Training of Officer Staff with Regard to Suicide Prevention Training

Compliance Status: Sustained substantial compliance.

Findings

This area remains in substantial compliance and has achieved sustained compliance.

3. Detoxification Training Program

Compliance Status: Sustained substantial compliance.

Findings

All of the required medical staff have had this training.

Recommendation None.

Summary of Findings

This monitoring visit was clearly affected by the challenging weather conditions. We were impressed with the ability of the custody staff and their leadership team to respond to the challenges with which they were presented. We appreciated the accommodations in their schedules in order to facilitate our review. Although this monitor was unable to review the program at the correctional facility and also unable to review medication administration under normal conditions, nonetheless the rest of our monitoring visit was completed within the expected timeline. We cannot emphasize enough the need to fill the Medical Director position and use some flexibility and/or creativity in developing a compensation package that is satisfactory. We also want to emphasize the importance of filling the Infection Control/Quality Improvement Coordinator position as well as the Assistant Director of Nursing. Although only two areas moved from partial compliance to substantial compliance, we were encouraged that in the absence of clinical leadership, greater deterioration had not occurred. We look forward to working with the team including the new leadership when these key positions are filled and also witnessing the implemented electronic record system.

Respectfully submitted,

R. Shansky, MD
Medical Monitor

RS/kh