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RE: Report on Audit Findings, Dauphin County Prison Harrisburg PA

First, I would like to convey my heartfelt appreciation to those involved with my onsite visit to the Dauphin County Prison from February 19 through February 21, 2024. Administrative staff could not have been more helpful or accommodating. Security officers were very pleasant, and I never felt unsafe as they escorted me around the facility. I observed the officers while they conducted their daily routines and noted their interactions with your population to be consistently respectful and polite. Witnessing them in action during a medical emergency was quite impressive as they did not seem to miss a single detail in stabilizing the individual until medical staff arrived. Going into a medical unit unannounced as an "auditor" can create some awkward and unpleasant situations. That was not the case at your facility. PrimeCare's direct care and administrative staff were informative, cooperative, pleasant, helpful, and receptive.

REPORT

This report is generated at the request of the Dauphin County Prison and intended to fulfill the contractual agreement, specifically those items outlined in Schedule A of the Consulting Agreement dated June 14, 2024. The Agreement was initiated with Dr. Absolam Tilley, the former Medical Director at Heritage Health Solutions (HHS). Dr. Tilley conducted a preliminary documentation review. Unfortunately, Dr. Tilley left employment with HHS prior to having an opportunity to conduct staff interviews and onsite observations.

I am a master's prepared Registered Nurse and experienced Legal Nurse Consultant certified in correctional healthcare. I am currently employed as the General Manager for the Risk Mitigation Division at Heritage Health Solutions. With sixteen years' direct care experience in correctional nursing in over four hundred jails in multiple states, I feel comfortable and confident in incorporating Dr. Tilley's information with my onsite observations and interviews to create a summary of findings and recommendations to further enhance the medical program at the Dauphin County Prison.

GENERAL RECOMMENDATIONS

Having had the opportunity to observe medical care being delivered inside the Dauphin County Jail, my overall perception is that the individuals housed at the facility receive compassionate, appropriate health care services structured to meet their needs. In review of documentation, it is unfortunate that the care delivered is not always reflected to the extent it should be. It is in the documentation (proof), not in the level of care provided, that might expose the facility to unnecessary litigation.

Below is a list of recommendations that I feel might help facilitate risk reduction strategies and further enhance the delivery of quality correctional health care:

1. Revise the “Clearance to Incarcerate” procedure. Clarify that individuals experiencing any of the listed symptoms (without regard to intoxication) should be cleared at the emergency room prior to booking.
2. Utilize nurses to conduct an initial sick call visit to gather, document and report data (vitals, history, basic symptomatic assessment, etc.).
3. Allow nurses to follow established protocols with over-the-counter medications to treat minor illnesses in response to sick calls.
4. Providers review sick calls completed, including actions taken by the nurse. Then, document any additional changes or intervention he or she feels are appropriate.
5. Nurses refer individuals requiring a higher level of care to the provider.
6. Providers review the collected data on sick calls referred to him or her and either document orders for additional care or request the individual be brought to medical for a face-to-face provider visit.
7. Review existing nurse protocols to ensure the nursing interventions, education, and over-the-counter medication protocols are appropriate to manage minor ailments.
8. Whenever possible, house suicidal individuals with another person (Dr. Tilley).
9. Collaborate with community MAT/MOUD providers to reschedule appointments and prescribe controlled medications when an individual is released earlier than anticipated.
10. Review documentation to ensure a HIPAA compliant release is signed by the individual prior to discussing medical needs with external or community agencies.
11. Create current, written procedures and workflows for delivering MAT/MOUD services.
12. Train medical and mental health staff on the necessity of brief, concise, clear, and factual documentation of all healthcare encounters (medical and mental health).
13. When monitoring deadline compliance, expand the review to include content quality and create a performance improvement plan when deficiencies are noted.
14. An individual of equal or greater license within the same discipline should conduct the documentation reviews.
15. Work with the EHR provider to ensure that reasons for referral no longer appear as a documented progress report. Medical appointment referral reasons need to be clearly indicated as such.
16. Medical assistants should create a written entry in the EHR when they notify the qualified health care professional of abnormal and unusual findings and events. These entries should include at least the date, time, and title of the person notified.
17. A licensed or registered nurse should conduct an in-person, focused assessment of all individuals returning from a hospital stay or emergency room visit. The findings and provider notification are to be documented.
18. Nurses document communication and reports of abnormal findings with a facility provider.
19. Mid-level providers and physicians document a rationale for medication decisions. This is particularly important when the order deviates from what might be considered a “usual” treatment regimen.
20. Mental health document the referral of individuals to a professional of higher-level licensure and expertise when indicated. (Dr. Tilley). This might include patient-specific information obtained during team discussions and regular case reviews.
21. At least during the next scheduled rounds, medical and mental health determine and document the disposition of individuals being closely monitored. This includes those being reclassified from special housing and when they leave the facility.

22. Work with the existing EHR company to create a method for automating a daily movement and release reports of those on special housing.
23. Create or revise policies and procedures to allow for prioritization of unplanned security events affecting medication pass times and other healthcare procedures.
24. Medical director review medications prescribed more than twice a day or administered during the noon medication pass for necessity and possible comparable alternative medications.
25. Custody staff assist control and minimize environmental distractions that occur during medication pass. (Example: turn off the TV and entertainment radios, redirect chatter).
26. Medical director to establish and monitor general guidelines for noncompliance and the continuation or discontinuation of chronic care medications.
27. Reconsider the practice of requiring a nurse to do cell-side checks when an individual is a no-show. (I do not know if this is a medical or security policy).
28. Crosstrain medical and mental health staff of symptoms that could indicate a potential decline in condition.
29. Train medical and mental health staff to remain mindful, communicate and document subtle changes in behavior or level of function.
30. Train medical and mental health staff to conduct a look-back at recent documentation across all disciplines.

OVERVIEW

Below is a summary of findings generated through a review of medical documentation, policies and procedures, staff interviews, and direct observation of health care staff as they perform their duties. The findings below include comments and examples provided by Dr. Tilley as well as my own findings.

The information concerning adverse events was obtained through records obtained from PrimeCare Medical, Inc. which were reviewed by Dr. Absalom Tilley formally of Heritage Healthcare. The assertions and information included in the report related to those events were made exclusively in reliance upon information provided by Dr. Tilley as part of his review.

INTAKE POLICIES AND PROCEDURES

Summary: Correctional and medical staff conduct the initial health screenings. Correctional officers complete a medical questionnaire at the time of booking. Within four hours after booking, the medical assistant (MA) conducts an expanded healthcare summary that is approved by the medical director. Abnormal results are communicated by the correctional officer or medical assistant to a licensed health care professional (nurse, physician, mid-level provider), who provides guidance for additional monitoring or care actions. This medical intake process is comparable to other facilities of equal staffing levels and is appropriate.

Discussion: In direct observation of intake screenings being conducted by the medical assistant, I noted compliance with the established policies and procedures (P&Ps). Communication of abnormal findings is not consistently documented. Dr. Tilley expressed a concern that in one situation, the medical assistant

did not report abnormal findings to a higher level of care. After further investigation onsite, I found that abnormal findings were consistently being reported to the nurse and then passed off to the provider when indicated. However, those notifications were often not documented, leaving an inaccurate impression that they were not made.

CLEARED FOR INCARCERATION PROCEDURE

Summary: PrimeCare policy outlines a list of criteria intended to identify individuals with certain obvious conditions that could indicate he or she is not medically appropriate for housing in the jail. The policy stipulates that these individuals should be denied admittance until the arresting agency transports the individual for a medical exam and clearance by a licensed provider, which usually occurs in the emergency room. The MA completes "Release of Information" forms when the individual reports medical issues. There is a system in place to obtain medical records and verify medications.

Discussion: In interviews with members of both the correctional and medical staff, it was obvious that they are familiar with signs and symptoms requiring medical clearance at the emergency room. Staff report that the policy is being so consistently enforced that most arresting agencies are aware of the criteria and obtain clearance prior to presenting the individual for booking a first time. Correctional staff report that they are not intimidated and do not waiver in a decision when the occasional arresting officer becomes displeased with the decision to transport for clearance.

In review of the written policies, both Dr. Tilley and I noted that most examples on the clearance for confinement criteria list include symptoms specifically related to intoxication (example: unable to stand due to intoxication). My understanding is that the clearance policy was updated in response to a steadily increasing volume of intoxicated individuals presenting at booking. The intent was to focus staff and reinforce the need to remain on high alert for those individuals. While revised with the best intent, the word changes could be problematic. In practice, the officers absolutely do deny an individual meeting the criteria for any reason. However, the revised wording could create confusion and allow the admission of a person facing these same issues when they are not related to intoxication.

In all the charts reviewed, it is apparent that the Release of Information form is being obtained as directed. It should also be noted there is a follow-up procedure in place to retrieve any missing information.

PROVIDER/NURSE WORKFLOW

Summary: There is a system in place for incarcerated individuals to request and receive healthcare for emergent, urgent, and routine needs. Sick call requests are received directly by the health care staff and a face-to-face triage occurs within 24 hours. Emergency requests are tended to as they arise and are often reported to health care staff through correctional officers. Appointments are scheduled for a face-to-face encounter with qualified health care professionals based on immediacy of need.

Discussion: In the general practice of correctional healthcare, licensed and registered nurses address the initial sick calls. Simple health care complaints such as a runny nose or minor aches and pains are

addressed by the nurse through use of provider-approved, over-the-counter medication protocols and nursing intervention. For more complex ailments, such as high blood pressure or general complaints with additional symptoms, the nurse contacts the provider (physician, nurse practitioner, physician's assistant) to discuss the individual's presentation and treatment orders are obtained. The collection of sick call data and nurse interactions are documented, allowing the provider to take a second look at any additional areas of concern and changes in the treatment plan. Provider time is typically reserved to focused on non-emergent but complicated sick calls and those not resolved through nurse protocol and/or remote treatment orders from the provider.

At the Dauphin County Prison, the medical vendor has initiated a system whereby nurses generally do not conduct sick call visits. Instead, the provider conducts all sick calls. Additional provider staff have been retained to implement this system. While at first thought, this could appear to create the ideal situation. That does not seem to be the case in real practice. Sick calls are conducted when the provider is in the facility, which is a limited number of hours. While sick calls are addressed "timely" by regulatory standards, allowing the nurses to conduct the initial sick call would open more available slots for appointments and provide even quicker access to treatment, preventing the need for a higher level of care later. For example, a patient who complains of burning with urination can be quickly addressed by the nurse conducting a urine dipstick test and if indicated, contacting the provider to obtain an antibiotic order several hours before the provider is next onsite. Minor ailments without other abnormal signs do not always require treatment with medications. Having the nurse do the initial sick call allows for the teaching of self-care techniques for use at home, thereby reducing the reliance on prescription medications. Several examples come to mind: minor headaches may be relieved with a cool compress to the back of the neck; stress relief techniques may help with an inability to sleep and situational anxiety; minor back pain can be addressed through passive exercise.

A high percentage of sick calls are for issues that one normally would not make an office appointment for when living in the community. Reducing the higher cost positions for ailments that do not require a provider level service could be used to increase the hours devoted to the delivery of direct nursing care. Based on research into area pay rates, eight hours of mid-level provider care equates to about twelve hours of direct care by a registered nurse and fifteen hours of a licensed practical nurse.

As communicated by healthcare staff and observed by me, the primary purpose for initiating this change was to allow nurses additional time for medication pass (discussed in another area of this report).

ADVERSE EVENT REVIEW

Summary: A review of adverse events including deaths that occurred at the Dauphin County Prison between February 2019 and June 2024 was completed. Dr. Tilley conducted an extensive review of documentation in the facility's electronic medical record (CorEMR), available hospital records, and coroner's reports. In reviewing these files, Dr. Tilley provided related comments, which are incorporated in the summaries below.

2019 – Eight deaths

- Four were listed by the corner as natural deaths (#1 atherosclerotic heart disease with arterial occlusion, #2 multiple blood clots to the lungs, #3 brain inflammation with renal failure related to chronic cocaine use, #4 blood clot in the lungs).
- Two were by suicide by hanging.
- One was related to a cocaine overdose.
- Records for one individual were not retrievable.

2020 – Three deaths

- Two were considered natural and related to medical issues (#1 acute complications of bowel inflammation and short bowel syndrome, #2 Duodenal rupture).
- One was a homicide (subdural hematoma)

2021 – Three deaths

- There is no coroner's report for one individual, who was admitted to the facility with multiple medical diagnoses causing him to be wheelchair dependent requiring the assist of four to transfer. He was also bathed, fed, and repositioned in bed by staff. It is unclear in the documentation, but he may have been transferred to a different living facility in May 2021, where his December 2021 death occurred.
- One listed the cause of death as cardiac dysrhythmia with renal failure and brain anoxia. This individual was in a restraint chair at the time of his death. Any sign of blunt force trauma related to placement in the restraint chair was ruled out as a potential factor in his death.
- One death was related to suicide by passive hanging.

2022 – Five deaths

- Four were listed as natural deaths (#1 liver failure related to cardiac disease, diabetes, and renal failure requiring long-term dialysis, #2 Liver failure related to unknown liver cancer and history of Hepatitis C, #3 unknown brain tumor, #4 complications of lung disease and history of alcoholism).
- One listed no specific cause of death on the coroner's report. Review of hospital records note myocardial fibrosis and multiorgan system failure. Dr. Tilley suspected these conditions might have been attributed to the weakening of organ systems by a previous history of COVID treatment and an adverse medication reaction.

2023

- One had no coroner's report available. This individual had a history of cardiac issues including ischemic heart disease and recent placement of an internal defibrillator for congestive heart failure. He had been receiving hemodialysis in the preceding three months due to renal failure, which was thought to be caused by complications of recent hip surgery. Notes in the chart indicate this individual may have been transferred to another facility in March 2023, prior to his April death.

- One was listed as hypertrophic cardiomyopathy and myocardial fibrosis, which led to an acute myocardial infarction (heart attack).
- One was listed as a suicide by passive hanging.

Discussion: As mentioned throughout this report, it appears that the appropriate care was provided in each situation, but the documentation does not reflect the care rendered.

MENTAL HEALTH SCREENING AND FOLLOW-UP

Summary: The facility has written procedures in place for mental health (MH) care. I was able to speak with a Qualified Mental Health Professional (QMHP) involved in the direct care of individuals and asked several questions about mental health (MH) related inquiries during intake and the system for triggering a face-to-face encounter. We also discussed typical caseloads, referrals within the MH department to higher level individuals, procedures for putting a person on suicide or MH watch and the tiered levels for removing them, procedures for chronic care follow-ups for those diagnosed with serious MH issues. Through their medical vendor, PrimeCare, the facility provides case managers, counselors, QMHPs, and a licensed psychiatrist.

Discussion: Following my conversation(s) with the QMHPs, I was able to review active charts for individuals that would have triggered an assessment, received psychotropic medications, and have been on a recent MH observation or suicide watch status. I found documentation dates to be compliant with the written and verbally reported procedures. It is also important to note that the facility recently passed a survey by the National Commission on Correctional Health Care, which includes audits for documentation timeliness.

The number of successful suicides at the Dauphin County Prison is about one per year with two occurring in 2019, one in 2021 and 2023, and none in 2020 or 2022. Although still a tragic event we always hope to prevent those events. Based on the volume of individuals processed into the facility, data reflects a suicide rate below the national average. This indicates that suicide prevention is a primary focus of the facility. Dr. Tilley noted that in every case of a successful suicide, the level of suicide watch was appropriate.

Understanding that logistics are an obstacle, Dr. Tilley notes that not housing suicidal individuals alone could be the single be the single most important step in deterring the completion of a suicide attempt.

The content and quality of MH documentation and communication between the MH and medical departments was noted by both me and Dr. Tilley to be lacking. In some instances, the documentation is confusing and could appear to be conflicting.

CURRENT MAT PROGRAMS

Summary: The facility has programs in place for Medication Assisted Therapy (MAT), or Medications for Opiate Use Disorders (MOUD). Individuals who are actively involved in an MAT or MOUD program continue to receive prescribed medications using methadone, buprenorphine, Sublocade or other

comparable opiate replacement medication. Individuals who are not enrolled in an active MAT/MOUD program are evaluated by a licensed provider and are either started on MAT/MOUD or safely withdrawn from the medication. Those determined dependent on benzodiazepines without an appropriate diagnosis and prescription, and those with alcohol use disorders are typically placed on medication to facilitate their safe withdrawal. Individuals who use other illicit drugs are placed on medications to ease symptoms during the withdrawal period. Detox watch procedures are in place. The facility expanded their MAT/MOUD program to include work with community agencies during incarceration and beyond release in hopes of reducing recidivism. I did not locate written procedures for this program.

Discussion: In review of the chart documentation, the above-mentioned procedures are in place and being consistently followed. The NCCHC has moved away from an MAT to an atmosphere of MOUD, which no longer requires adjunct behavioral health therapy to receive an opiate replacement medication. However, the Dauphin County Prison has chosen to continue substance use disorder counseling and education while incarcerated, which is admirable.

The expanded program creates an avenue for weekly discussions between facility medical and correctional staff and outside agencies geared towards drug and alcohol use disorders. This allows for continued treatment and an easier transition after release to the community. During the meetings, progress regarding current and previously incarcerated individuals is discussed. A full-time case manager employed through PrimeCare tracks the individuals receiving opiate replacement medications throughout their incarceration, release, and if indicated, to reincarceration. Results reported by the case manager are promising in that data shows a decrease in recidivism for individuals in the MAT/MOUD program.

While the program is an innovative approach with a positive outcome, there are cautionary concerns that come to mind.

- Because discharges are often unplanned and releases may occur earlier than anticipated, the supply of opiate replacement medications ordered by the jail provider is not always sufficient to cover the individual until their community appointment date. This means that the individual might experience a gap in days without medication. Currently, the formerly incarcerated individual relies on the jail's case manager to contact the jail provider to prescribe the additional days' supply of medication. While obviously a well-intended and compassionate desire by the facility, I feel the external agency should take a more responsible role by ensuring the appointment is rescheduled or medications are provided post release.
- I do not recall seeing a HIPAA compliant consent allowing the discussion of medical issues (MAT/MOUD treatment) with external agencies. This is an important step prior to referral. It is possible this is already being completed, and I simply did not find it in the record. That said, the release should be easily retrievable from the EHR by storing it with all other consents being obtained.
- There did not seem to be a written program or workflow in place for this program. It is important that the workflow be documented in a procedure and updated as changes are made. In general, the direct care health staff were not able to verbalize even a high-level overview of

the MAT/MOUD program. Training and enlisting buy-in from the direct care staff will encourage support for the concept.

OTHER

During my onsite visit and in Dr. Tilley's documentation review we noted some additional general areas that warrant bringing to your attention.

DOCUMENTATION

Summary: This is the most significant area of concern. While deadlines are being met and there is documentation to reflect compliance, the content and quality of documentation is lacking. This is a potentially serious issue for the facility. Although an experienced nurse or physician can logistically follow the care, there was a significant amount of time spent figuring out what actually happened. While Dr. Tilley commented that none of the death cases were directly contributed by the lack of documentation, the record at times appeared in conflict and was confusing. The lack of complete, concise documentation increases the potential for unnecessary litigation for the facility. Below are a few examples.

- In one death case specifically, there is a note in the electronic medical record (EMR) stating "Pt is reporting symptoms of depression characterized by…" The entry in the record was dated three weeks after an individual's death, making it appear that the MH staff fabricated an assessment. After further investigation, this was a note (a memory prompt) for the reason a future MH follow-up appointment was being scheduled. While this could be uncovered by any other person taking the time to disprove the inaccurate assumption, it certainly leaves the facility open to allegation.

- A medical assistant (MA) completes intakes, routine vital signs, blood sugars, etc. which is appropriate to their trained skill level. The policy/procedure instructs the MA to report abnormal findings to a licensed health care professional qualified to assess and take action. In direct observation, I witnessed this consistently occurring. In most instances, I did not find a note reflecting those to whom the information was reported. I consistently did not find readily available documentation to indicate that a nurse saw the individual. In some instances, there was no documentation of action(s) taken. One of the examples I discussed with direct care and administrative nursing staff on-site, was an individual recently hospitalized for congestive heart failure. At intake as a recent hospital return, the MA recorded abnormal vital signs. Based on the chart review, the only information in the chart was the abnormal vital signs and a medication order. This led to a few quick assumptions: 1) the MA did not report abnormal values to anybody, 2) a qualified individual did not put eyes on the individual returning to the facility with a serious medical condition, and 3) hospital medications were continued in absence of a clinical assessment, despite having abnormal values. After investigation I found that all aspects of care

were addressed appropriately. The MA notified the registered nurse (RN) on duty. The RN conducted a face-to-face assessment and then contacted the provider to secure medication orders. MAs need to document their notifications. This can easily be done in the "notes" section when documenting their data. A nurse's reliance on an MA to document is inefficient. Nurses should always document all assessments and actions taken.

- There are numerous, valid reasons for why a provider may choose to add or delete a medication to an individual's profile. Especially in a correctional environment where non-clinical individuals are likely to be among the first to review charts after an adverse event, it is important for the provider to state a rationale for his or her decision(s). Dr. Tilley noted that this is not done consistently, leaving room for unanswered questions with the likelihood that the provider will not recall his or her rationale when questioned years later. One example was when an over-the-counter medication (aspirin) commonly used in conjunction with another to facilitate treatment for a specific issue was not continued. Although Dr. Tilley stated, the medication did not affect a negative event that later occurred, it did leave him to "wonder" why. Documenting a reason for a medical treatment solidifies the rationale and removes the need and tendency for imagination.

- Dr. Tilley found that in general, it seemed that the MH workers should have consulted a person within their department who has a higher level of education. Dr. Tilley notes that the overall lack of documentation by MH staff created an obstacle to his ability to determine whether a consultation was done but not documented. There is a regular meeting involving all levels of MH staff to review and discuss case load, which may be where these discussions take place. However, a note in the individual's medical record is necessary not only to verify care, but also for other clinicians to read and follow the flow of care.
- There is little, if there is any, documentation recorded when an individual leaves the facility. As noted above, there were two charts leaving the impression that an individual might have been transferred to another facility prior to their death. One stated that documentation was sent to another facility. The second stated that custody staff asked medical to prepare three days of medication for release. Documentation stopped in both charts except for an MH note in one chart reporting later notification by in-house custody staff that the person expired. It is a mystery as to where either person was when their death occurred. I do understand that healthcare staff frequently have no idea when a person leaves. However, if the person requires additional medical or MH care, staff will be aware when the person is no longer at the facility and can/should ask and document their disposition. This could easily be corrected by adding a disposition field to the EMR that defaults to "release from custody" and allows medical/MH personnel to modify. In the meantime, a note regarding disposition should be documented if being actively being clinically monitored.

POLICIES AND PROCEDURES

Summary: The facility has a current Policy and Procedure (P&P) manual that is approved and signed by the medical director annually and as updates occur. The procedures are readily available to all staff by clicking an icon placed on the desktop of each computer. Paper copies are kept in the Health Services Administrator for access in the event of power or internet failure. Administrative nursing staff and the medical director are also on-call outside of business hours and available to answer questions.

Discussion: In interviews with several staff members, they are aware of the P&P manual location and know how to access them when needed. The P&Ps are site-specific and meet the guidelines established by the National Commission on Correctional Healthcare (NCCHC).

The medical P&Ps are extremely specific in terms of deadlines for the provision of medical care and monitoring procedures such as high blood pressure, detox watch, medication pass, etc. In the jail environment, unpredictable incidents sometimes occur that cause all departments to fall behind on expected routine tasks. The P&Ps do not seem to leave room for when unexpected events occur that are outside the control of anyone. These scenarios can set the stage for allegations that the healthcare P&Ps were not followed and increase the risk for unnecessary litigation. This could potentially be prevented by having a policy or workflow that describes how routine tasks should be prioritized when it happens, or by including a plan for reworking the procedure as indicated.

MEDICATIONS

The plan of care, including prescription and non-prescription medications are ordered and delivered during scheduled medication times. I found no errors in administration or storage of medications.

Discussion: During my time onsite, I observed that the nurses spent about ten of their twelve working hours preparing or passing medications, which is unusual to me. In review of the medication administration records, I noted several medications were ordered three and four times daily, which also seemed unusual to me. Medication passes are generally conducted twice daily in the jail setting. While there will be some medications required more often to reach a therapeutic effect with no comparable alternative, the incidence is usually quite low. Medications specifically ordered twice daily typically follow an established pattern such as taking them once in the morning and once in the evening at about ten to twelve hours apart. I found the volume of medications being passed more than twice a day and being given “off schedule” was incredibly high at the facility.

In conversation with four nurses regularly assigned to pass medications, I learned that the volume and inconsistent schedule of medication pass has been an ongoing issue. The nurses unanimously reported that this prevents them from doing any nursing duties beyond medication pass. Nurses reported that they previously discussed this with the medical director and some corrections are made. The issues seemed to “level off” for a while but each time, they started happening again. The nurses reported that even though some of the medications are ordered twice a day, the provider ordered them to be given at noon and in the evening. The nurses stated that the time changes are made by the provider at the request of the incarcerated individual because he or she did not want to get out of bed for the morning med pass. This is clearly documented in the medical record of at least three people.

Nurses report that there are days when unexpected security issues arise, and they are delayed in getting the medications passed. Because of the heavy volume of medications at each of the three medication passes, the medication times sometimes run into each other. This requires the nurses to stay longer hours to get them passed safely. At times, the provider is contacted to determine whether two of the scheduled times can be combined, or if the a.m. and noon medications can be given at one medication pass. The request is consistently approved. This occurred while I was onsite. This leads me to believe that except in rare circumstances, there is no reason, the same could not be done every day.

If the noon medication pass could be utilized only when absolutely necessary (as described in the practice at most jails), the nurses would be better able to distribute the medications even when unexpected events occur. Additionally, the nurses could devote more time to other duties, such as completing sick calls and providing direct patient care.

I accompanied a nurse on a medication pass for two areas of the facility. The security officer escorted the nurse to each cell or area of distribution. I noted that the television, which is situated in the hallway and must be kept at a high volume for all to hear it, remained on throughout the med pass. In my opinion, this was distracting and interfered with the nurse's ability to communicate with the individuals receiving medication. It would be my recommendation that when medication pass is being conducted, the television and other distractions be eliminated or reduced. This might also facilitate the speed of individuals reporting to the cart.

REFUSALS

The facility has a system for documenting refusals in place. Each time an individual refuses a procedure, including medication pass, he or she is asked to sign a refusal form. In the event the individual refuses to sign the form, an officer may sign as witness on the form to indicate that the service was offered and refused.

Discussion: When an intake is refused, the staff is diligent about repeating the intake attempt until the individual agrees to participate in at least enough information to obtain a history and current treatment list. The refusals were consistently documented.

Dr. Tilley discussed the issue of medication refusals. In his opinion, medications for chronic care issues should not be discontinued but should instead be offered every day with the ongoing refusals documented each time. I have seen this practice in some facilities. In other facilities, I have seen a procedure for documented education and eventual discontinuation. Once noncompliance becomes a pattern, the nurse meets with the refusing individual in a face-to-face encounter. The encounter includes a discussion about why the individual is refusing the medication and a general education about the purpose, side effects, benefits of the medication, and potential consequences of not following the prescribed treatment plan. The conversation is documented and conveyed to the provider. If the provider does not decide to alter the plan of care and the refusals continue, then a face-to-face discussion is held between the provider and the refusing individual. Based on that conversation and data recorded in the chart (vitals, labs, symptoms, etc.), the provider decides how to manage the care plan going forward. If the provider decides to discontinue the medication, then the individual remains in

chronic clinic for routine labs, monitoring, and encouragement. The decision on how to manage the refusals for chronic medications is left to the discretion of the medical director at the facility.

Nurses report that when an individual is a "no-show" for medication pass, a well-being check is to be conducted. I whole-heartedly agree and make the same recommendation in all jails. In my experience, going cell-side to conduct the checks is usually the responsibility of custody staff. Nurses report that at the Dauphin County Prison, they are tasked with doing cell-side checks. This slows down the medication passes tremendously. I am not sure if this is a facility or medical vendor-imposed requirement of the nurses.

TRAINING

The facility currently has an education program for new and existing healthcare staff. New staff spend the first week learning the policies, procedures and nuances of their department and the correctional environment. This is usually conducted at an off-site location. This prevents them from being pulled away from training to assist on the floor, a common issue in most healthcare training conducted inside the facility and in all fields of nursing. The program also includes a period of on-the-job training with direct observation. Ongoing training for medical staff is conducted at least monthly using a mix of simulation and instruction. Each training (ongoing and new hire) is tracked for completion by the Health Services Administrator. I was not able to gather information regarding the ongoing training of mental health staff, though I feel certain it is similar.

The facility is to be commended for establishing a program for recognition and reward. Lapel pins are awarded when Narcan is administered and when CPR is performed. Correctional healthcare staff often go unnoticed for the excellent work they do. Even when they do their best to do everything "right," patients are unsatisfied and bad outcomes still occur. A small token of appreciation, such as the lapel pin, is more important than most will ever realize. I was able to speak with one of the nurses who recently received the pin after administering Narcan and resuscitating an overdosed individual (who was back at the jail in general population). The nurse was extremely proud of her accomplishment and the token of the reward was very much appreciated.

COMMMUNUCATION

Summary: The Electronic Health Record (EHR) is the primary vehicle used for healthcare documentation. In some instances, it is used to print special needs for communication to custody.

Discussion: Routine and emergency needs are communicated effectively. It is not as obvious that subtle changes in a person's behavior or level of functioning are being effectively communicated between the medical and mental health departments. These things are important for the development and revisions in an individualized and overall plan of care. A lack of communication and documentation can also create an illusion of confusion and conflict in the medical record. New or changed behavior is often seen as a mental health exacerbation but could instead be key to recognizing a medical issue on the horizon. Medical and MH staff should be communicating verbally and through chart documentation when a new

event, symptom, or pattern is identified. Certainly, any significant changes such as a refusal to eat, incontinence, an unusual inability to sit still, pacing, hallucinations, etc. should be discussed right away.

Without regard to the reason for an individual encounter, a quick review of chart documentation from both disciplines should be completed and considered. A tendency not to pay attention to things seemingly related to another discipline is problematic at best. Using a team approach, interdisciplinary communication is critical. When occurrences happen that "do not make sense," the highest level of practice should be consulted, which includes onsite providers and specialty care when deemed appropriate by the provider.

Communication between custody and medical/MH staff appears to be quite good. Better than I have seen in most facilities. There was one incident highlighted by Dr. Tilley related to an altercation with a person being hit on the head with a clipboard. The altercation and subsequent blow to the head was mentioned only in the hospital record. There was no medical incident report or documented follow-up in the EHR. Due to the general lack of clinical documentation, we were not able to determine with any certainty whether the incident was communicated by custody, or not.

PRE-EXISTING ILLNESS

The intake screening is completed by a medical assistant within four hours and abnormal findings are communicated to a qualified health care professional, then elevated to a higher-level medical professional as indicated. A more comprehensive medical assessment is conducted by an RN, typically within five days of booking and reviewed by a licensed provider.

Discussion: It is important to recognize that not all existing conditions can be identified during the booking or assessment process. In example of at least two death cases, the individuals had a terminal condition (lung cancer, brain tumor) of which they were completely unaware. In another case, the obvious symptoms of a typical cardiac event (heart attack) were not present. Dr. Tilley felt it important to convey that it can be virtually impossible to identify some conditions. Additionally, Dr. Tilley stated that it should always be kept in mind that people with multiple existing diagnoses or co-morbidities will remain at elevated risk for adverse events and require monitoring.

CONTRACT COMPLIANCE

In reviewing the language in the contract, I found discrepancies in the number of nurses and providers currently being used to staff the facility. Additional provider hours (physician, nurse practitioner, physician's assistant), nurses, and medical assistants were added to the staffing plan. During my days onsite, I found nearly double the number of nursing hours being worked on the day and evening shifts. It does appear that the number of nursing hours needed to be increased beyond what the original contract required. However, there is an issue within workflow processes that could have been addressed to improve efficiency. Had those adjustments been made, the number of hours might not have needed to increase to the level they are at now. The contract should have been amended as the hours were increased.

The contract called for two psychologists working each day during the work week (80 hours per week). PrimeCare does not have a psychologist staffed at the facility. Qualified mental health professionals (master's degree versus doctorate degrees) are staffed in place of the psychologist. It is my understanding that the use of a QMHP versus a psychologist is usually appropriate. However, it does not appear that the full 80 hours of work are consistently replaced. There was no contract amendment to approve replacing the psychologist. The contract should have been amended, and the facility made aware of unfilled hours in the required weekly report.

A contracted medical vendor has a responsibility not only to provide the care, but also to have documentation of care being rendered. This is not specifically required in the contract, but it is a standard expectation in the healthcare field. Documentation is also required under the scope of practice for all licensed healthcare professionals. The documentation at the facility is significantly lacking to the extent that it easily leads to false assumptions and inaccurate conclusions. That was evident in Dr. Tilley's initial thoughts. PrimeCare failed to exercise due diligence in the training and monitoring of staff in this critical task.

CONCLUSION

As stated from the beginning of this report and reflected throughout, it was obvious to me that those housed at the Dauphin County Prison receive quality healthcare services. The recommendations made are intended to further enhance care and facilitate risk reduction. Thank you for allowing me to represent Heritage Health Care Solutions during the audit. Please do not hesitate to contact me with questions and clarifications.

Thank you,

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