INTEROFFICE COMMUNICATION
COUNTY OF MILWAUKEE

DATE: November 22, 2016

TO: Milwaukee County Board Chairman Theodore Lipscomb

Chair, Committee on Judiciary, Safety and General Services
Chair, Committee on Finance, Personnel and Audit

FROM: Colleen Foley, Interim Corporation Counsel

SUBJECT: Status update on pending litigation

The following is a list of some of the significant pending cases that may be of interest to the Committees. New information and additions to the list since the last committee meetings are noted in **bold.** However, our office is prepared to discuss any pending litigation or claim involving Milwaukee County, at your discretion.

1. *DC48 v. Milwaukee County* (Rule of 75)
Case No. 11-CV-16826 (Judge Rothstein issued 5/27/16 decision against county on renewed motions for summary judgment holding that plaintiffs were not covered by terms of a CBA as used in Ordinance 11-15 for purposes of evaluating Rule of 75 eligibility; final order issued by circuit court on 6/17/16; Order to stay execution of judgment issued on 6/27/16; Notice of Appeal filed with Wisconsin Court of Appeals on 7/19/16)

2. *Trapp et al. v Milwaukee County et al.*
Case No. 15-CV-0019 (Milw. County Circuit Court; stayed pending IRS approval of pension ordinance amendments)

3. ***Wosinski et al. v. Advance Cast Stone et al.*** **(O'Donnell Park)**
Case No. 11-CV-1003 (Jury Verdict; appeals filed by ACS and Liberty; County et al. response brief filed on 2/25/16; Attorney Michael Brennan of Gass Weber Mullins filed notice of appearance (along with Corporation Counsel) to Wisconsin Court of Appeals on 8/1/16; 10/24/16 mediation; Court of Appeals oral argument scheduled for 1/19/17 at 9:00 a.m.)

4. ***Christensen et al. v. Sullivan et al.*** **(jail population and health care)**
Case No. 96-CV-1835 (May 2016 status report on Jail/HOC following 5/16/16 jail tour and 5/18/16 HOC tour; 10/31/16 jail and HOC tour; 11/21/16 status conference at 3:00 p.m.; 2/2/17 status conference at 10:00 a.m. on staffing issues)

5. ***Milwaukee Riverkeeper v. Milwaukee County, et al. & Nenn, et al. v. Milwaukee County Board of Supervisors*** **(Estabrook dam public nuisance case**

& declaratory judgment/injunction case) Cases No. 11-CV-8784 & 16-CV-2268 (court found dam a nuisance and ordered repair or removal; 6/30/16 status conference; 8/12/16 hearing held at which court ruled no evidentiary hearing required to test viability of abatement issue; no special district required; 11/22/16, 3:00 p.m. hearing on public purpose doctrine and 4:00 p.m. hearing on status of rezoning by City of Milwaukee and authority for CEX to sell parcel to MMSD; 12/22/16, 11:00 a.m. status conference)

6. *Nenn and Milwaukee Riverkeeper. v. WDNR, et al. (*Judicial review of WDNR plan approval for county plans to repair dam) Case No. 16-CV-4669 (RK seeks judicial review of WDNR's Plan Approval; WDNR defending; county intervening; briefing schedule set (RK by 9/15/16; WDNR & county by 10/17/16; RK reply by 11/7/16); unless otherwise directed by court, case will be decided on record)

7. *Milwaukee Riverkeeper v. WDNR* (Estabrook Dam permit)
Case No. 16-CV-1396 (filed 5/23/16 in Dane County, seeking judicial review of WDNR's environmental impact statement/permitting process; does not halt work toward repair remedy; stipulation by parties to change venue from Dane to Milwaukee County; Milwaukee County and City of Milwaukee are intervening parties)

8. *Nenn and Milwaukee Riverkeeper v. Milwaukee County Board of Supervisors (*open meetings) Case No. 15-CV-5131 (3/24/16 jury demand; 8/31/16 pretrial conference; 9/29/16, 1:30 p.m. motion hearing on motion to compel)

9. *Midwest Development Corporation v. Milwaukee County* (Crystal Ridge)
Case No. 12-CV-11071 (court dismissed both side's claims; Midwest filed appeal; County cross-appeal filed)

10. Froedtert Hospital petition to disturb burial sites – petition granted by State.

11. *Orlowski v. Milwaukee County* (2007 death of inmate in HOC)
Case No. 13-C-994 (E.D. Wis. federal court; court granted County's motion for summary judgment on 4/21/16. Oral argument before 7th Circuit on 11/7/16.)

12. *Jane Doe v. Milwaukee County (*sexual assault by CO in jail*)*
Case No. 14-CV-200 (E.D. Wis. federal court; County motion for partial summary judgment filed; jury trial 9/12/16; 3/25/16 decision allowing plaintiff to amend complaint to add class action allegation)

13. *Aikin v. Milwaukee County (*sex and retaliation discrimination*)*
ERD Case Nos. 2006-01096; 2011-04458 (hearing 10/27-10/30/15; post-hearing briefs filed in 4/2016)

14. *Johnson v. Milwaukee County et al. (*patient care at BHD*)* 14-CV-1408 (E.D. Wis. federal court) (discovery phase)

15. *Johnson v. Milwaukee County et al*. (2012 patient death at BHD) 16-CV-01043 (E.D. Wis. federal court) (complaint filed 8/8/16)

16. *Estate of James Perry v. Wenzel et al. (*death in booking room of jail*)* Case No. 12-C-664 (E.D. Wis. federal court; 5/6/16 order granting county's motion for summary judgment and for sanctions; appeal filed by plaintiffs with 7th Circuit Court of Appeals; county brief due by 9/8/16)

17. *Lipscomb and Milwaukee County Board of Supervisors v. Abele (*County Board and Executive authority*)* Case No. 2016-CV-2888 (Action filed 4/15/16; Answer and Counterclaims filed on 6/13/16; Scheduling Conference held 8/11/16; amended counterclaim filed by CEX on 8/15/16; summary/declaratory judgment motions by 12/9/16; summary/declaratory judgment replies by 1/10/17; hearing on all motions for summary/declaratory judgment on 2/7/17 at 1:30 p.m.)

18. *Voces de la Frontera, Inc. v. Clarke, L.C.* (public records claim) Case No. 2015CV2800 (June 15, 2016 Order from the Wisconsin Supreme Court granting petition for review; briefs filed by county on 8/11/16; oral argument before Wisconsin Supreme Court scheduled for 11/3/16)

19. ***State v. Dennis Dietscher* (official misconduct) Case No. 2014CF3620 (Defendant pled guilty to accepting bribes and making false statements on 7/1/16; sentenced on 10/7/16 to 18 months in prison with 24 months on probation/supervision thereafter; On 10-0 reconsideration vote on 11/16/16, Pension Board suspended pension and recommended recovery of backdrop benefit and monthly payments paid out to date.**

20. ***Shade Swayzer and her deceased child v. Milwaukee County, et al.; Terrill Thomas v. Milwaukee County, et al.* – Notices of Claim/Circumstance filed with the County Clerk (precursors to state court lawsuit).**

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Kimberly R. Walker
Executive Director

November 15, 2016

The Honorable Marshall Murray
Milwaukee County Circuit Judge
Milwaukee County Courthouse
901 N 9th Street
Milwaukee, WI 53233

Re: *Christensen et al. v. Sullivan et al.* 1996 CV 1835
Medical Monitor's Report October-November 2016

Dear Judge Murray:

Enclosed please find the most recent report of Ronald Shansky, M.D., the court-appointed medical monitor, regarding the Defendants' compliance with the health care provisions of the consent decree in the above action. The report describes Dr. Shansky's findings during a site visit to the Milwaukee County Jail and House of Correction from October 31 through November 4, 2016. It identifies potentially dangerous deficiencies in the Defendants' performance under the decree and makes recommendations for bringing health care services into compliance with the terms of the decree.

Plaintiffs encourage the Court to review the entire report prior to the status conference scheduled for November 21, 2016. However, we wish to highlight several of Dr. Shansky's most troubling findings:

- **Worsening health care staffing shortages contribute to delays in access to care and deterioration in quality of care for prisoners.** The overall rate of vacancies in health care positions rose from 30% in May 2016 to 37% in November 2016. (Report at 1.) This vacancy rate makes it "extremely difficult to provide timely and appropriate services." (Report at 4.) Dr. Shansky recommends the total rate of vacancies be brought to less than 20% of positions. (Report at 5.) The most disturbing shortages are in nurse practitioner positions and RN positions.
  - Nurse practitioners have the ability to provide a higher level of treatment, including prescribing of medications, than other nurses can, and thus play a crucial role in health care delivery in a jail with limited physician time. *Four of the 10 primary care nurse practitioner positions are currently vacant and three of four psychiatric nurse practitioner positions are vacant.* (Report at 4.) The shortage of primary care NPs means

that it is not "possible for the timeliness of required assessments to reach compliance." (Report at 5, 6.) It also appears to be contributing to deficiencies in the quality of chronic care services (Report at 7-8 ("[D]elays occurred with regard to the first chronic care visit and sometimes with follow-up visits. In addition, there were some performance issues.")) and follow-up of patients who return from the hospital or specialists (Report at 8-9 ("We continued to find records in which no practitioner follow-up visit occurred.")). The shortage of psychiatric nurse practitioners, who can prescribe and monitor psychiatric medications, puts greater pressure on the small number of psychiatrist hours available.

• RNs are the first line of response to prisoners' health care needs. *Nineteen of 31 registered nurse positions are vacant* – a staggering 61% vacancy rate. (Report at 1.) This staffing shortage has resulted in "substantial delays in timeliness, including a matter of weeks and as long as a month," in responding to prisoners' reports of symptoms and requests for medical attention. (Report at 7.) The shortage has also resulted in "serious quality issues with regard to the conscientiousness of the [nurses'] assessment" of patients' symptoms. (Id.) Specifically, nurses failed to use the appropriate forms to guide their evaluations and plans, resulting "possibly in greater speed but at a major sacrifice in the quality." (Id.)

• **Reductions in the number of correctional officers contribute to dangerous lack of access to health care and inability to detect health crises, and may have played a role in some of the recent deaths at the Jail.** In apparent recognition that correctional officer staffing reductions have created dangerous conditions, leadership has promised that at least 70 additional correctional officers will be deployed at the Jail by January 1, 2016. (Report at 1.) Dr. Shansky notes that the CO staffing shortages resulted in early 5:30 pm lockdowns of housing pods and administration of night-time medications at 4 pm, rather than the appropriate 7 pm. (Report at 2.) It also resulted in lack of access to dental services, particularly for those held in "maximum security" status. (Id. at 2, 11.) Dr. Shansky also observed that the "shortage of officer staff at the jail . . . leaves open to question whether more careful monitoring of" a prisoner who died of dehydration in the disciplinary housing unit "might have altered the outcome" (Report at 14), and "how thorough the monitoring was" of a prisoner who gave birth or miscarried without detection in the psychiatric observation or disciplinary unit of the jail (Report at 15).

• **Continued turnover in health care leadership positions appears to contribute to lack of oversight of quality of care.** Although Dr. Shansky is impressed with the leaders of the health care program in those positions that are filled, including the program administrator, the medical director and the chief psychiatrist, he notes the recent losses of the Director of Mental Health Services, the Quality Improvement Coordinator, and the Communicable Disease/Infection Control Nurse. (Report at 1.) This chronic turnover in leadership seems to be limiting the ability of the program to provide monitoring of and feedback on the quality of care delivered by the nurses and clinicians. (See, e.g., Report at 2 (noting electronic medical record's inability to produce "reports that facilitate self-monitoring"); 3 (noting lack of "professional performance enhancement reviews" and need to "hold staff accountable to certain performance standards," as well as need for "onsite consultation and supervision for nurse practitioners who work at the

House of Corrections"); 4 (noting need for "methodically reviewing the services provided by each of their nurses"); 5 (noting "disappoint[ment] that there was no self-monitoring with feedback" of intake triage by nurses and nurse "practitioner assessments").

Dr. Shansky's report accentuates the need for Defendants to take prompt action to reduce the risk to prisoners at the Jail and House of Correction and move toward compliance with the consent decree. We look forward to discussing on November 21, these and other issues raised in our letter to the Court of October 12, 2016.

Sincerely,

Peter M. Koneazny
Litigation Director
Legal Aid Society of Milwaukee

Laurence J. Dupuis
Legal Director
ACLU of Wisconsin Foundation

cc:
Ms. Colleen Foley, Interim Corporation Counsel
Mssrs. Charles Bohl and Andrew Jones, Husch Blackwell LLP
Mr. Ronald Stadler, Mallery & Zimmerman, S.C.
Mr. Michael A.I. Whitcomb

REPORT ON SETTLEMENT AGREEMENT IN THE CHRISTENSEN CASE

MILWAUKEE COUNTY JAIL AND THE HOUSE OF CORRECTIONS

October 31-November 4, 2016

Introduction

Since the May 2016 visit there has been stability in the Health Service Administrator position as well as the Medical Director position. However, there is an administrative structural change in that there are now a DON for each facility. I managed to meet with each DON and I was impressed with their commitment to improving the quality of the services. Unfortunately, the Director of Mental Health Services and the Infection Control Nurse have departed. The Quality Improvement Coordinator is also departing. Thus, it has proven challenging for the program to maintain stability in leadership positions. The company continues to provide support with senior staff from other sites. The recent deaths, four within six months, as well as other newspaper articles continue to challenge the program.

Within the mental health program there is an acting Director of Mental Health Services who is also an applicant for the job of Director of Mental Health Services. He is a senior psychiatric social worker. However, the job as currently configured requires a Ph.D. in psychology. The mental health program is challenged by the reality that only one of four psychiatric nurse practitioner positions are filled and only 0.8 psychiatric positions are filled by the Chief Psychiatrist. I met her and was very impressed with her commitment to the patient population and providing quality services. The remaining psychiatric hours are pieced in by two or three part-time psychiatrists. I believe the program would be better served if there were greater stability and continuity in the psychiatric positions. The psychiatric social worker positions are all filled except for one and they are an island of stability for the program.

With regard to staffing in general, based on a report provided to me with vacancies as of October 20, 2016, out of 128.80 positions, there were 47.5 positions vacant. This results in a vacancy rate of 37%. This is actually a deterioration since the May visit. In particular, there are four of 10 primary care nurse practitioner vacancies. There are also 15 of 26 licensed practical nurse vacancies. There are also three of four psychiatric nurse practitioner vacancies and 19 of 31 registered nurse vacancies. Finally, there is a 0.5 physician vacancy. This vacancy rate results in a substantial amount of nursing being provided by agency vendors. That results in greater turnover or less long-term commitment. Some shifts are filled by overtime and some by an as needed pool comprised of former employees. Many of the problems that we will describe later in this report are based on the extremely large number of vacancies.

Additionally, I continue to have concerns about the electronic record, which staff have described as not user friendly and thus reducing their efficiency and productivity when seeing patients. We have yet to see reports that facilitate self-monitoring. In fact, the software would have to be modified substantially in order to support those efforts. As described in my most recent report, the electronic record allows staff to make a choice of which form to use when assessing a patient. There is a form that includes a protocol which should be used for all nurse sick call. Unfortunately, all too frequently nurses were using a form which just provides free text space and the result is a much less complete and conscientious assessment. This profoundly impacts the quality of service provided. The absence of a lab interface continues to be a problem, in that instead of an interface between the laboratory and the electronic record software resulting in the results flowing into the record, the lab reports are produced on paper and those paper reports are scanned into the electronic record. In 2016, this is not the way laboratories and electronic records should interface.

I continue to believe that the problems of the electronic record software must either be fixed or the electronic records software must be replaced. This software is an impediment to achieving substantial compliance. On the other hand, I had a very positive meeting with custody leaderships at both sites. In particular, I was informed by leadership at the jail that by January 1 there will be at least 70 additional correctional officer staff and this will result in the ending of the ongoing lockdown after 5:30 or 6:00 p.m. One of the issues I raised was that this early lockdown was resulting in unacceptable timing for the evening medications. Instead of medications being administered at 7:00 a.m. and 7:00 p.m., they are being administered at 7:00 a.m. and 4:00 p.m. Some of the medications that are supposed to be administered in the evening have soporific side effects. Administering those medications in the evening means people will be going to sleep soon afterwards. Administering them at 4:00 p.m. means that a number have refused the medications rather than miss other activities. Additionally, I was assured by custody leadership that they will improve access to the dental program and especially access for maximum security inmates, which has been nonexistent for some time. The dentist reassured me that he would work with custody in whatever way they wanted in order to provide services for these patients. I was encouraged by the response of the custody leadership at the jail but will wait to see whether access improves, especially for maximum security inmates, and also, whether as of January 1, the early lockdown is removed permanently.

I. HEALTH SERVICES PROGRAM STRUCTURE

Compliance Status: Partial compliance.

Findings

A. Program Administrator

The new Administrator has an excellent attitude towards providing quality services for the entire population. She seems to be learning how to accomplish things in

the correctional environment. The vendor continues to provide senior staff from other locations in order to support her efforts.

During this visit, although I did receive Attachment B, which is the list of vacancies based on the required staffing provisions, I have not yet received Attachment A, which requires, on a monthly basis, the number of shifts that were understaffed based on the credentials, the shift and the facility. I have asked her for March 2016 and September 2016 and she has promised to forward them to me when she completes the data collection.

Recommendations:

1. Provide Attachment A data, which is the number of shifts each month in which there was less than the required number of staff for each position and provide that for March 2016 and September 2016.
2. Provide for me Attachments A and B for March 2017 after that month is completed.

B. Medical Director

I continue to be impressed with the approach of the Medical Director to her work with both custody and nursing staff. She has indicated to me that she will provide the professional performance enhancement reviews that have been requested. What I am saying to her as I am to the other leadership team members is that they must hold staff accountable to certain performance standards. The staff must clearly understand her expectations based on her meeting with them, reviewing their work with them and discussing how performance can be improved as well as work that was done well.

Recommendations:

1. Continue to document clinical performance enhancement reviews of the clinicians providing chronic care services, that is sick call services and urgent care services as well as follow ups for scheduled and unscheduled offsite services.

C. Physician HOC

The prior two physicians at the House of Corrections have now departed and there is one nurse practitioner who is working at the House of Corrections. There have been piecemeal physician staffing filling in some of the hours. It would be important to at least fill in one half-time physician who can provide some onsite consultation and supervision for nurse practitioners who work at the House of Corrections.

Recommendations:

1. Fill the half-time physician position at the House of Corrections and insure that there is adequate primary care coverage.
2. The Medical Director should perform clinical performance enhancement reviews of both the physician and the practitioners.

D. Psychiatrist

The Chief Psychiatrist position has been filled and the psychiatrist is working four days a week, one of which she spends at the House of Corrections. In my meeting with her I was extremely impressed with her commitment to providing quality services for this population. I believe she works well with the other mental health staff and she is committed to improving the quality of the services.

Recommendations:

1. Continue to recruit for the psychiatric ARNPs that are vacant.

E. Nursing Director

There are two new Directors of Nursing, one for the House of Corrections and one for the downtown jail. I have met with each of them and both have experience working in corrections, including working in the Milwaukee County Department of Corrections. Each of them impressed me in that their understanding of what the job required was quite consistent with what I expected. They both are committed to improving the quality of services and each of them is committed to holding staff accountable to professional standards.

Recommendations:

1. The nursing leadership team should develop a calendar for methodically reviewing the services provided by each of their nurses. Those services include intake screen, sick call, medication administration (by LPNs), urgent/emergent services and infirmary rounds. I remain available to provide any consultation on how to accomplish this.

F. Nurse Practitioners

There are 14 ARNP authorized positions of which of which 10 provide primary care services and four are psychiatric nurse practitioners. Four of 10 primary care positions are vacant and three of four psychiatric nurse practitioner positions are vacant.

Recommendations:

1. Fill the ARNP positions of which there are seven vacant, four primary care positions and three psychiatric nurse practitioner positions.

G. Staffing

This program will not come into compliance with such a high rate of vacancies. It becomes extremely difficult to provide timely and appropriate services under those constraints.

Recommendations:

1. Improve the vacancy rate so that it is down to less than 20% of the total number of positions.

II. MEDICAL SERVICES

Compliance Status: Partial compliance.

Findings

A. Intake Screening

1. Triage

This time we reviewed records, most of which were consistent with good performance. We did find some records in which the acuity level was not appropriate and others in which the timeliness of the follow-up visit was inconsistent with the appropriate leveling. We were also disappointed in that there was no self-monitoring with feedback of the intake screening program. This is a critical component of the required services and must be monitored with feedback in an ongoing way. This process requires regular feedback.

2. Referrals

It may not be possible for the timeliness of the required assessments to reach compliance as long as at least four of 10 primary care positions are vacant. However, we did see delays and a few issues with regard to the quality of the assessments. We also were not provided any self-monitoring, not only with regard to the nurse screen but also with regard to the practitioner assessments. These areas have to be improved in order to achieve compliance.

Recommendations:

1. In looking at the length of time until seen by a primary care provider, in addition to the average which is currently presented, the range of shortest to longest for each level would also be useful so we can see to what extent the timeliness of the average length is affected by a dramatic quantity in terms of a single case of a very long delay affecting the range. The average time should be by designated level.
2. The QI program should review the appropriateness of the nursing supervisor reviews and provide feedback to the supervisors with regard to opportunities for improvement. The QI program should also review the timeliness of the nursing supervisor reviews and the timeliness of the corrective action intervention.
3. The QI program should review a sample of 10% of the level 1s, 10% of the level 2s and 20% of the level 3s every other month. This review should occur every other month with feedback and coaching in the alternate months.
4. A method for quantifying the performance scores should be developed and used for each nurse and displayed so that performance and improvement is measureable.

5. The Medical Director should, as part of the QI program, continue to review the performance of the practitioners with regard to the adequacy of the subjective and objective data collected as well as the appropriateness of the assessment and the appropriateness of the plan. These reviews should include feedback with the clinicians. To the extent that this can also be quantified, this will help the clinicians perceive performance improvement.

B. TB Screening

Compliance Status: Partial compliance.

Findings

The infection control nurse who was understanding what was expected of her has departed from the program. Thus we were not provided with any data with regard to either TB control or with regard to skin infections.

Recommendations:

1. When you find a replacement have the replacement study, utilizing the offender tracking system, 10-day release data in order to insure that all eligible people are tested for TB.
2. Implement weekend skin testing and reading at the HOC and then repeat the TB study.

C. Physical Examinations

Compliance Status: Partial compliance.

Findings

We continue to be concerned about the primary care nurse practitioner vacancies since the current vacancy rate is 40%. This clearly compromises the ability to provide timely assessments. Every patient who is identified as a level 1, 2 or 3 must be seen for an assessment within a required timeframe based on level.

Recommendations:

1. The Medical Director, as part of the quality improvement program, should review a sample of health appraisals performed by each practitioner on a regular basis. This review should include whether all of the relevant positives in the nurse intake screen were addressed and whether an appropriate diagnostic and therapeutic plan were in fact generated for each problem identified.

D. Sick Call

Compliance Status: Partial compliance.

1. Nurse Sick Call

Findings

The departing Quality Improvement Coordinator performed an excellent study looking at both timeliness of sick call services and at professional performance. The data demonstrated substantial delays in timeliness, including a matter of weeks and as long as a month in a few instances. Clearly, the staffing issues may have effected this but there is in all probability a bigger problem. When I discussed this with the nursing staff they perceived the problem to be the fact that the sick call responsibility was shared by a substantial number of nurses, some of whom may have had lesser or greater commitments to providing the service. In addition, there were serious quality issues with regard to the conscientiousness of the assessment. In many of the records reviewed, nurses chose an alternative encounter form than the one they were supposed to use. This resulted possibly in greater speed but at a major sacrifice in the quality of the assessment. The required form has prompts with regard to both subjective data collected as well as objective data collected. The form chosen as an alternative lacked these prompts and therefore the completeness of the assessment suffered as a result.

Recommendations:

1. Select two nurses at each facility who will be responsible for the sick call program. If it only requires one nurse at each facility, you may choose to alternate months but two nurses should know how to perform the sick call service correctly.
2. Each month, collect 20 symptom requests to be reviewed by the QI program for both timeliness and professional performance. Included in the review of the nursing performance is the appropriateness of the nursing protocol selected, completeness of the subjective and objective data collection and appropriateness of the assessment and plan. Provide feedback to those nurses selected for this responsibility.
3. A method for quantifying the results should be developed and utilized over time so that performance improvement is measureable.
4. Send to me the March review of the nurse sick call, both timeliness and professional performance, at each institution.

2. Advanced Level Provider Sick Call

Findings

I was not provided the reviews of the practitioners with regard to sick call.

Recommendations:

1. The Medical Director should at least quarterly review the performance of the practitioners when providing sick call services. If the performance is reviewed and it is determined that a particular practitioner is performing in a substandard manner, this practitioner's performance must be reviewed monthly with feedback until adequate performance is achieved.

E. Chronic Care

Compliance Status: Partial compliance.

Findings

We again reviewed records in which delays occurred with regard to the first chronic care visit and sometimes with follow-up visits. In addition, there were some performance issues. With regard to the timeliness of the initial chronic care visit, it must be scheduled and occur within 30 days of the intake screen. Also, it should be sooner when assessed disease is not in good control. Patients in fair control should have their initial visit within two weeks of intake screen and those in poor control should have their initial chronic care visit within one week of intake screen.

Recommendations:

1. Review a sample of patients with chronic diseases whose services are provided by each of the practitioners for compliance with policy and guidelines.
2. Perform a review in March and then document feedback provided to the clinicians and re-review in April in order to be able to demonstrate whether improvement has occurred.

F. Urgent/Emergent Care

Compliance Status: Partial compliance.

Findings

We reviewed several records and a few of those lacked required documents, including emergency room reports. The responsibility for obtaining these documents must be assigned to a specific staff person. In most programs the nurse who receives the patient on return accepts that responsibility. If patients who return from an emergency room or hospital discharge are housed in the SMU, the visit by the practitioner must document a discussion of the findings and plan for the patient.

Recommendations:

1. The leadership team should work with hospitals to insure that for every offsite service there is a document that contains the relevant clinical information, either from the emergency or if admitted, a discharge summary. These should be utilized by the clinicians to insure appropriate follow up.
2. A staff member needs to be assigned the responsibility for insuring timely availability of relevant offsite service documents.
3. The QI program should be monitoring the timeliness of the occurrence of clinician follow up in which there is a discussion of the relevant findings and plan as identified by the offsite service.

G. Specialty Services

Compliance Status: Partial compliance.

Findings

We continued to find records in which no practitioner follow-up visit occurred. In records that we reviewed there was no required follow-up visit that documents a discussion by the clinician with the patient regarding the findings and plan.

Recommendations:

1. This area must be reviewed by the QI program with data available at my next visit.

H. Infirmary

Compliance Status: This area was previously in substantial compliance.

Findings

This area was not assessed. The QI program did not provide me with any internal reviews of the infirmary.

Recommendations:

1. This area should be reviewed by the QI program with data available at my next visit.

I. Medication Distribution

Compliance Status: This area was in substantial compliance.

Findings

This area was not assessed. However, I did learn that patients were refusing their required evening meds because the medication administration occurred at 4:00 p.m. This, I am told, will be eliminated as of January 1, 2017. At that time, medication administration will be at 7:00 a.m. and 7:00 p.m.

Recommendations:

1. The Health Service Administrator should send me an email notifying me when the time of evening administration changes to 7:00 p.m.
2. The area of medication administration should be reviewed by the QI program with data available to me at my next visit.

J. Women's Health

Compliance Status: This area was previously in substantial compliance.

Findings

This area was not assessed, although I did talk with the Women's Health Nurse Practitioner. She was very helpful and assured me that the program was working well.

Recommendations:

1. This area should be reviewed by the Medical Director as part of the QI program.

K. Therapeutic Diets

Compliance Status: This area was previously in substantial compliance.

Findings

This area was not assessed.

Recommendations:

1. This area should be reviewed by the QI program, especially with regard to the elimination of preference diets.

III. Mental Health Services

Compliance Status: Partial compliance.

Findings

We indicated earlier that the Director of Mental Health Services recently departed. There is currently an acting Director of Mental Health Services, one of the psychiatric social workers. He is a candidate for the job but it would require changing the historic requirements in order for him to be eligible for the job. We met with the new Chief Psychiatrist and certainly are impressed with her commitment to providing quality services to this population. The additional psychiatric hours are being pieced in by a variety of psychiatrists. We would like to see one psychiatrist provide the bulk of the hours. If the current Chief Psychiatrist is providing 0.80 FTEs, that means that 0.40 FTEs are available. In addition, there was and continues to be a problem with filling the psychiatric nurse practitioner positions as three out of four are vacant. One of the responsibilities of the Director of Mental Health Services is in working with the outside community and with the patient advocacy groups. We would hope that this responsibility is acquitted by the acting Director of Mental Health Services.

A. Intake and

B. Program

Findings

This electronic record apparently is incapable of providing the timeliness studies that we are used to being provided. Either this system must be altered in order to provide such data or it must be replaced with a system that is able to provide that data.

Recommendations:

1. Add two psychiatric ARNPs so that at least three of the four positions are filled.
2. Perform a manual study looking at the positive mental health histories on screening and the timeliness of social worker evaluation. Review at least 20 records of positive histories in January and February of 2017 and forward the data to me.

3. The new Director of Mental Health Services should begin professional performance reviews of the notes documented in the electronic record by the social workers for February and March with feedback where improvement is indicated.

C. Staffing

Findings

As indicated previously, there are three vacant psychiatric nurse practitioner positions and a part-time psychiatrist vacancy as well as a vacant Director of Mental Health Services.

Recommendations:

1. Fill the required mental health positions.

D. Urgent/Emergent and Emergency Psychiatric Services

Findings

This area is covered by mental health policies. We did not have the opportunity to review this with the new acting Director of Mental Health. We did not expect, given his recent ascension to this responsibility, that he would be able to comment on a factual basis.

Recommendations:

1. Develop a log to track the emergent mental health cases for both timeliness and appropriateness of services.

IV. Dental Services

Compliance Status: Partial compliance.

Findings

The problem with maximum-security inmates being denied access to dental services persisted for six months. I was encouraged by a meeting with custody leadership and they indicated that both in general and specifically for maximum custody inmates there was no reason the overwhelming majority could not be brought to the clinic. We also found that there was a paucity of restorations performed by the dental program. We would expect that the ratio of restorations to extractions be improved at both sites.

Recommendations:

1. Document the level of access in general and specifically for maximum security patients at the jail.
2. Improve the ratio of restorations to extractions at both sites.

V. Support Services

Compliance Status: Partial compliance.

A. Medical Records

Findings

In the introduction we identified four deficiencies that continue to go without remedy. The medical records software must be capable of adequately supporting the quality improvement program.

Recommendations:

1. Fix the problems identified with the electronic record software or replace the software.

B. Pharmacy

Findings

This area has improved as the services are provided by a new vendor. The QI program should begin to monitor the quality control and the timeliness of the availability of medication services as measured by the timeframe between order and receipt by the patient.

Recommendations:

1. The QI program should begin to monitor the quality control and the timeliness of the availability of medication services as measured by the timeframe between order and receipt by the patient.

VI. Miscellaneous

A. Physical Plant

Compliance Status: Substantial compliance.

Findings None.

Recommendations: None.

B. Quality Improvement Council

Compliance Status: Partial compliance.

Findings

The Quality Improvement Coordinator is about to leave her job and it may be a challenge to replace her. She did perform some excellent studies. The areas that need to continue to be reviewed on a regular basis but at a minimum once a year include:

1. Intake Services

2. Primary Care Services (sick call)
3. Urgent Care Services
4. Scheduled Offsite Services
5. Chronic Care Services
6. Dental Services
7. Communicable Diseases
8. Morbidity and Mortality Review
9. Medication Services
10. Women's Health
11. Medical Housing
12. Grievances

With regard to #7, Communicable Diseases, the communicable disease nurse appears to have left and therefore a new nurse will need to replace her. The data with regard to skin infections must include both culture-proven cases as well as presumptively treated cases.

C. Death Reviews

There have been four deaths since my last report. One of them occurred in the week before my visit; therefore, I did not request the required materials. The required materials are the Armor mortality or morbidity review, the confidential death summary report and the autopsy along with the corrective action plan. For none of the deaths have I received the corrective action plan. For the first death, Mr. T.T., I have both the mortality and morbidity review along with the confidential death summary report and the autopsy results. For the S.S. report, I have only received the confidential death summary. For the K.F. report I have only received the mortality or morbidity review. The reports, along with the corrective action plans, need to be forwarded to me as soon as possible.

Death #1

This is the only death for which I received the complete documentation. This is the death of Mr. T.T., ID#639565216, DOB 5/9/77, DOD 4/24/16, date of entry to the system 4/16/16.

This was a 38-year-old with a previous history of schizophrenia, diabetes and hypertension. He also was known to use substances such as marijuana, K2, and occasionally alcohol. Before he entered the jail he was cleared at the local hospital and brought to the jail. He was intoxicated. He was seen by the PSW supervisor who had him placed in SMT, a special unit that includes mentally ill. He was scheduled to see the psychiatric nurse practitioner the next business day but on the day he had seen the PSW supervisor he was later found to be throwing food and body fluids and no additional assessment was performed. He was not evaluated by mental health until he was seen on 4/22 by the PSW and the psych ARNP. He was uncooperative and would not speak with them. Based on his chronic diseases he should have been listed as at least a level 1 or 2 but in fact he was not given a level at the intake screening. He was only referred to sick call as needed. He was not also placed on the alcohol detox protocol. He refused most of his blood pressure monitoring and his finger stick sugar

monitoring while he was in the facility. He never had laboratory tests done and he was found dead at 1:38 a.m. on 4/24. CPR was initiated and continued for 15-17 minutes but then discontinued as he was pronounced dead. Opportunities for improvement were identified with regard to the performance of the nurse screen and with regard to the mental health team's urgency of their assessments. He was assessed as dying from dehydration, which suggests that he was not adequately taking in fluids or other means of sustenance. Given the shortage of officer staff at the jail, it leaves open to question whether more careful monitoring of him might have altered the outcome. I have talked with the medical staff regarding both the performance of the nurse at intake as well as the performance of the mental health staff. In addition, we have discussed monitoring patients' intake and insuring an assessment and offering of fluids such as Gatorade which may increase the likelihood of intake of fluids. I will await the corrective action plan, including comments by custody with regard to their monitoring of inmates in 4C.

Death #2

S.S. DOB 3/01/86, entered system 7/6/16. This death was the result of her delivering a baby unbeknownst to the staff and the baby was found dead sometime after the delivery. The suspected cause of death was fetal suffocation. The death summary report indicates this person was a 30-year-old female, G3P2, who was diagnosed with paranoid schizophrenia. She was booked on 7/6/16 after being medically cleared at Columbia St. Mary's. She was then placed in the SMU or special medical housing. Her vital signs were normal and she was seen by women's health one day later. She refused a physical exam and in fact indicated that she would not have anybody touch her. Prenatal vitamins were started, which the patient took. The patient refused an ultrasound. During SMU nursing rounds the patient accosted a nurse and therefore was moved to a disciplinary unit; however, the Medical Director was not contacted about the potential for this movement. Fetal heart tone monitoring was attempted on 7/8 but the patient refused. She was seen by psychiatry but refused the offer of psychotropic medication because she thought she would be out of jail soon. An OB visit was attempted on 7/11 by the women's health practitioner but the patient refused, saying that the baby was moving fine and she refused the physical exam. Medical rounds were attempted on 7/12, but the patient claimed she was okay and refused physical exam. PSW rounds on 7/13 documented that the patient was irritable but congruent. She was not seen by the SMU provider on 7/13 because this provider did not finish her list of patients. On 7/14, the patient apparently had her prenatal vitamins without any noted complaints. Security rounded at 5:04 a.m. and 5:35 a.m. and the patient did not appear to be distressed. At 5:55 a.m. her behavior was noted by security to be bizarre but the patient claims she was just sleepy. It was at that time that blood was noted on her sheets. At 6:04 a.m., nine minutes later, an emergency was called. Nursing supervisors responded, along with two RNs and an LPN. The patient was noted to be lying on her right side on her bed facing the wall with fresh blood noted on the bedsheets and the cell floor. She told the staff that she was fine and did not want to move. She then said that she had had the baby. Four officers came in to restrain her. The medical staff saw the baby hidden under the blankets with the umbilical cord, which was on the bed. An emergency was called immediately. The baby appeared cyanotic without chest movements. Auscultation did not show cardiac activity and CPR was started. The

umbilical cord was clamped and cut, the baby was transferred outside of the cell with CPR continued for another 10 minutes until EMS arrived. CPR was continued by EMS for another 35 minutes until the baby was pronounced deceased. The mother was transferred to Sinai to complete the delivery of the placenta.

This case raises several questions. There is a report of an inmate in the cell adjacent to her indicating that that night she had called for help. Apparently there is no custody documentation of this. Again, given the shortage of officers it is not clear how thorough the monitoring was. This patient raises a series of questions with regard to how such patients are handled. We discussed with custody leadership the fact that medical/mental health should identify complex cases which should not be moved without health care input. The custody leadership agreed to this and indicated that this could be started as soon as possible. This patient went through contractions and a delivery without seeking help. She had a history of not wanting any health care staff to touch her. It is not clear whether her housing had an impact on this negative occurrence. I would expect to see the final death summary report as well as the corrective action plan.

Death #3

K.F. #668150824, DOB 11/17/77, DOD 8/28/16, date of entry to the jail 8/24/16.

This patient was booked on 8/24/16 with a history of heroin use. She was kept on CIWA monitoring; her initial monitor was zero. She was not started on preventive detox protocol and she was not seen by a practitioner before her death. She was listed as a level 2 and she should have been seen within three days. She was, after the first CIWA monitoring, refusing subsequent CIWA monitoring and she certainly may have been going through withdrawal, which was unobserved because of her refusal. On 8/27 the patient had profuse diarrhea; however, this was never reported to medical staff. She also did not get an assessment on 8/27 because a scheduled visit was cancelled due to the fact that she had had, with a prior admission, an intake assessment by a practitioner. We discussed the fact that for new intakes who have repeated admissions in the course of a year they must have an assessment by a practitioner that includes an interval history as well as relevant physical exam. If this had been done it is possible that medications for withdrawal would have been initiated and other issues might have been addressed. We discussed the development of a policy and an encounter form that insures that all people have an assessment by a practitioner even if they have been in previously within a year. Again, that assessment must include an interval history as well as relevant physical exam. I would like to see for this case both the policy with regard to intake assessments by practitioners as well as the corrective action plan. I am told that after this case occurred all patients for whom withdrawal is identified will have their medications initiated at the time of identification.

Conclusion

The vacancy problems continue to pose a real challenge to compliance with this agreement. I was encouraged and will look forward to an email from the HSA that

indicates that the early lockdown has been eliminated as of January 1, 2017. I would like to see the corrective action plans for each case as well as the final summary for case number 3. I would also like to see the autopsies from cases 2 and 3 as well as the complete set of documents for case number 4, which occurred one week prior to my onsite review. Included in the complete set of documents should be the corrective action plan. I remain concerned about the loss of the QI Coordinator as well as the Infection Control Nurse along with the Mental Health Director. I would hope that the program is able to improve substantially its vacancy problem at least to the point where there remain only 20% vacancies at the time of my next visit. Questions certainly can be raised about the occurrence of these four recent deaths and the relationship to officer shortages (prompting the early lockdown) as well as the health care staffing vacancies and the adequacy of oversight of staff, especially at the jail. I remain committed to assisting in any way that I am requested.

Respectfully submitted,

R. Shansky, MD

RS/kh