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Review contract compliance, utilization, efficiency of contract between TCSO and medical service provider. Physical facilities review

This report is based on review of the medical records provided from:
- ICE review,
- mortality cases
- NCCHC audit
- Torts

This is the first part of the review. As additional data becomes available, supplements may be provided,

I have categorized the medical issues affecting inmates into three areas below. The inmates affected are listed below each category. Some inmates will be in multiple categories. Following the categories are clinical reviews for each inmate grouped under:
- Death Cases
- ICE
- Tort

Final section is summary of my conclusions and recommendations

Categories of medical issues

Quality of medical care

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- Damien Tucker [
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- Linda Henshaw

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- Patrick Gibson
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- Sergei Tews file 3253_ICE

Triage and Protocol compliance, protocol appropriateness

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- Frankie Thomas [file 0991]
-
- Clinton Labor
-
- Sergei Tews file 3253_ICE
- Sergey Gudashnikov_file 3234_ICE
-
- Cesar Ulloa-Bueso 3256_ICE
- Leonardo Toriio-Burnios 3257_ICE
-
- David Estrada 3259_ICE
-
- Daniel Aguilar 3261_ICE
-
- Charles Jernigen_Tort

Complex care beyond usual protocols

- Sergey Gudashnikov_file 3234_ICE
-
- Larry Carter 3252_Tort
-
- Kevin Darnold_Tort

Clinical reviews

Death cases

- Frankie Thomas [file 0991]

[05] Booked 1/1/10 at 1958 pm for public intoxication
[33-34] Triage Screen reported he drank daily and was also taking Xanax bars. His vital signs appeared in an acceptable range.
[1-2] At 0109 am he was found in his stomach, unresponsive. He went into cardiac arrest and did not respond to resuscitative efforts by Jail staff followed by EMSA.

There is a CH See 2009 Alcohol Intoxication Protocol L04. This patient appeared to meet criteria. Considering he was also taking Xanax, the possibility of benzodiazepine withdrawal was considerable along with alcohol withdrawal. Although it is unclear as to the exact cause of death without an autopsy, alcohol withdrawal seizures is a strong possibility. If this was indeed the cause, implementation of the protocol would very likely have prevented inmate's death.

- Damien Tucker

[0260 pp1-5] At 1203 pm on 3/12/10 Inmate was found to have altered level of consciousness and breathing difficulties. At 1212, medical staff arrived. Chest pain over the past week was also reported. Dr. Adusei appeared to be notified, time is unclear, and he arrived around 1225. Inmate went into cardiac arrest and EMSA was called at 1245 with apparent arrival at 1250.
[0259 p22] Medical Examiner report listed a pulmonary embolus [PE] as cause of death.

There was a 42 minute delay in calling EMSA. Patient had medical criteria at 1203 that should have prompted a 911 call. Although outcome may have not been affected based on extent of this PE, an inmate with his clinical findings at 1203 would certainly have chances for survival optimized with prompt 911 call and hospital transport.

- Linda Henshaw

[168 p25] Blood tests at Southcrest Hospital5/7/10: BUN 22, Cr 2.26, K 3.6
[NCCHC p80, 168 p1] 6/2/10 discharged from infirmary with K 5.8, BUN 59, Cr 2.29, positive urine culture. Treated with nitrofurantoin and Bactrim. 6/16 admitted to infirmary with mental status change.
[0165 p11, 16-17] 6/17/10 blood pressure [BP] of 94/60 between 7a-7p. At 1900 pm she had a blood sugar [BS] of 36, treated with glucose tablets at 2000. At 2200 her BS was 111 and she was more alert. Other than inmate asking to turn in bed at around 0300, there does not appear to be any monitoring. At around 0530 the inmate has a cardiac arrest and is eventually pronounced dead at the scene.

There are several standard of care issues in the care of this inmate. Her blood test on 6/2 shows a significant rise in her BUN and K. This is not monitored with repeat testing. There is a considerable risk of continued rise in her K which could lead to cardiac arrest. Her low blood pressure and recent urinary tract infection put her at high risk for sepsis. The antibiotics she was prescribed during 6/2 infirmary stay are not recommended for patient with renal insufficiency. Her low blood sugar is also consistent with sepsis and or worsening renal insufficiency making insulin last longer in her system. NCCHC p81 CHC Mortality Review discusses some of these issues, but does not address inadequate system protocols, and real time auditing of protocols, for treatment, monitoring, referral. Without such protocols, risk of similar episodes for other inmates, in the future, is quite high.

- Clinton Labor

[0423] On 3/28/10 patient fatally hung himself
[0425 p 15- 16] Inmate request 3/20: Need to talk. Mental Health evaluation 3/26 shows trouble sleeping anxiety, denial of suicidal ideation and concludes with referral to Dr. Harnish.

Two issues appear to be significant. First, there is a 6 day interval between inmate request and mental health visit. There does not appear to be a triage note determining acuity of this request. According to CHC policy 17.08, triage is to occur daily. If this inmate had wished to express a suicidal ideation, there is potential for it to be missed during a 6 day period. Second, the process used for suicidal risk may be too superficial in patients at higher risk such as this inmate. A more detailed assessment tool may have identified his true risk. [1]

- Patrick Gibson

[1412 p1,11,13; 1414 p16] Patient was noted on health assessment 5/27/10 to have a history of CABG and heart attacks and had been prescribed metoprolol.
[1414 pp20, 23] On 4/1/10 and 4/9/10 faxes are sent to Good Samaritan Hospital to verify his medications.
[1414, p13-14]: history and physical 8/31 by nurse reviewed 9/9 by physician. No mention of metoprolol prescription issue.
[1412 p1] On 12/14/10 inmate has a fatal cardiac arrest.

The main concern in this inmate's care relates to the lack of follow up on his metoprolol medication. Patient's with his cardiac history have improved outcomes if kept on this drug. There was never any documented attempt to pursue an outstanding medical request for records; instead it appeared to have been abandoned. If inmate had been on this medicine, his chances of having a fatal cardiac event would have been significantly decreased.

ICE

- Sergei Tews file 3253 ICE

P15- 3/1/11 intermittent abdominal pain CHC protocol [CHCP] p186 was not followed omitting detailed data collection. Purpose of a protocol is to identify life threatening issues. The further medical provider deviates from this, the more potential for missing serious illness.

P20- April 2011 urinary flow issues. CHCP I02 not followed detailed history omitted , Urinanalysis not obtained. There is a 3 days gap to see physician - his evaluation by the doctor appears to be below standard of care. There was a significant potential to miss obstructive uropathy and secondary renal failure.

- Sergey Gudashnikov file 3234 ICE

P4 March-June 2011 chronic rash. CHCP N03 does not address inmate's problem. No provider visit with prolonged care by nursing. P 18 His arthritis although addressed by doctor may have been misdiagnosed as the rash problem was not introduced as part of coordinated health care. This patient may have had a disease entity such as psoriasis,

however the process for his management lacked any physician coordination as it fell beyond the usual acute care protocols.

- Cesar Ulloa-Bueso 3256 ICE

[3256-046, P3,5] 3/25/10 inmate complains of urinary problems, seen by nurse 3/26 referred to doctor on 3/30. Urinanalysis done on 4/2. CHCP I02 is not followed by nurse. Unfortunately the protocol doesn't adequately address potential urinary retention and secondary renal failure.

- Leonardo Toriio-Burnios 3257 ICE

P 12- left ear pain 8/6/10- diagnosis wax impaction, nurse can't see the tympanic membrane. Treatment with drops for wax. CHCP E07 and patient education would lead provider to conclude that pain is not a simple ear wax issue.

- David Estrada 3259 ICE

p15- 8/16/10 Problem Oriented Record for female dysuria used on a male patient. Flank pain requires: notify provider for possible meds or transfer to hospital. Reviewed by doctor 8/18. Treatment not apparent in record until antibiotics prescribed Sept.20 [p14].

- Daniel Aguilar 3261 ICE

P30 Inmate complaint of bad heartburn 9/23/10. Triage evaluation doesn't occur until 9/27. Nurse suggests referral to provider and discontinuing Motrin. CHCP F01 186 chest pain protocol would be correct form however it was not used. . P 17 10/2, patient is given Motrin prescription despite the above concern. In addition to not utilizing existing protocols, there does not appear to be physician oversight over nursing management of medical problems.

Tort

- Larry Carter 3252 Tort

Complex back pain issue with spinal stimulator wire and surgery. He had multiple back pain medical visits without coordinated care.
It is difficult to require a protocol for each visit but inmate would benefit from comprehensive treatment plan with outline for chronic management, medication, physical therapy, etc. Triggers are needed to identify problems that require provider consultation. Usual protocols are inadequate for this type of inmate and often lead to frustration for inmate and staff.

- Charles Jernigen Tort

184 – 6: 7/28/09 [Tues] inmate request: " need to speak about problems". Not seen prior to fatal hanging on 7/30th.

According to CHC policy 17.08, triage is to occur daily. If this inmate had wished to express a suicidal ideation, there is potential for it to be missed during a 2 day period. Second, the process used for suicidal risk may be too superficial in patients [such as this with at higher risk such as this inmate [history of paranoid schizophrenia - 184 p3-4]. A more detailed assessment tool may have identified his true risk.

- Kevin Darnold Tort

Complex hand issue with surgical pins overdue for removal. Multiple visits for pain wound care.
It is difficult to require a protocol for each visit but inmate would benefit from comprehensive treatment plan with outline for chronic management, medication, physical therapy, etc. Triggers are needed to identify problems that require provider consultation. Usual protocols are inadequate for this type of inmate and often lead to frustration for inmate and staff.

Conclusions and recommendations

Quality of medical care

The CHC audits such as mortality reviews did not appear to address a significant aspect of standard of care issues. This is best done using benchmarks and incorporating real time continuous quality improvement [CQI] monitoring to avoid retrospective bad outcomes. Although there are protocols for ancillary personnel guiding them as to when to refer to provider, there were not similar guidelines in place for providers for at minimum, high risk conditions. These should be predicated on evidence based guidelines readily available in the medical literature with process triggers that avoid significant deviation by providers. Such deviations increase the potential for preventable morbidity and mortality.

Triage and Protocol compliance, protocol appropriateness

There are multiple instances of nursing not utilizing available protocols and when used, not following guidelines. Provider oversight of nursing care when acting for the provider was not consistent in several cases. This creates issues with nurses acting beyond their scope of practice and increases the potential for preventable bad medical outcomes. The system should preclude nursing from such deviations and should incorporate real time continuous quality improvement [CQI] monitoring to avoid retrospective identification of departures from protocols..

Use of telemedicine technology should be considered to allow easier access for triage and physician oversight. This may often avoid the need for multiple trips to the infirmary and more efficient process for inmate referral out of the jail.

Complex care beyond usual protocols

It is difficult to require protocols for each visit but such inmates would benefit from comprehensive treatment plans with an outline for chronic management, medication, physical therapy, etc. Triggers are needed to identify problems that require provider consultation. Usual protocols are inadequate for this type of inmate and often lead to frustration for inmate and staff. It also increases the potential for preventable negative medical outcomes.

Howard Roemer MD, FACP, FAAEM

1 Daniel AE. Preventing Suicide in Prison: A Collaborative Responsibility of Administrative, Custodial, and Clinical Staff. J Am Acad Psychiatry Law 34:2:165-175 (June 2006)