NCCHC™ Resources, Inc.

Technical Assistance Report

Focused Assessment of Health Services

James T. Vaughn Correctional Center

This report details findings from a site visit, March 7-8, 2018, to James T. Vaughn Correctional Center, Smyrna, Delaware

May 2018

FOCUSED ASSESSMENT OF HEALTH SERVICES
JAMES T. VAUGHN CORRECTIONAL CENTER

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EXECUTIVE SUMMARY

Following a security disturbance at the James T. Vaughn Correctional Center on February 1, 2017, an independent review was conducted to discover issues and make recommendations regarding improvement of various areas of operation within the compound. Recommendation 9.1 of the review states that the Delaware Department of Correction "should conduct an independent assessment of the health care and mental health care provided at the JTVCC."

Consequently, the Department of Correction engaged NCCHC Resources, Inc. (NRI), to assess the effectiveness of the daily inmate sick call process and its overall efficiency. Specific objectives were to assess and provide recommendations in the following areas:

- Evaluate the quality of health services based on compliance with the NCCHC *Standards for Health Services in Prisons* (2014 edition), with focus on health services policies and procedures pertaining to nonemergency health care requests and services (i.e., sick call)
- Review information (via charts, procedures, policies, interviews, etc.) pertaining to requests for sick call visits and care, as well as medical, behavioral and mental health, and dental care (all policies were cross-referenced with NCCHC's standards)
- Review the overall process for managing nonemergency health care services and the timing between the initial request for sick call visits, delivery of care, and referral to a higher level of care
- Review the process and frequency of sick call appointment rescheduling

Two subject matter experts conducted a two-day on-site assessment that entailed gathering information and data through observation, interviews, and review of policies, health records, reports, and other documentation.

Overview of Findings

- Inmates are aware of the sick call process, but did not report receiving any instruction on how to access health care during intake orientation or receiving a handbook.
- Waiting room space in the main clinic is limited and, due to the large volume of patients, some patients wait for hours to be seen or may be returned to their unit without being seen.
- We found no obvious trends of sick call refusal due to the co-pay program.
- Inmates reported being confronted by health staff with disrespectful or rude behavior.
- Security staff shortages and mandatory overtime are causing fatigue and poor performance, as well as tension with health staff and the inmate population.
- Security escort for off-site health services is perceived as compounding the staffing problems.

- Health staff shortages were noted, mainly with nursing staff.
- The electronic health record has many drawbacks and interferes with the effective delivery of health care.
- Patients who need to be seen (e.g., for chronic conditions) may not be seen in a timely manner because the system is geared to favor patients who present with complaints.
- Nursing staff is tasked with addressing complaints that are not related to health care.
- Health care visits for pretrial detainees are a challenge due to court schedules.
- Legal visits, which use health care privacy rooms and security staff, can interfere with the sick call process.

Recommendations

Chief recommendations are as follows. Please see the Recommendations section of this report for more details.

- Extensive revamping or replacement of the electronic health record system
- Improvement to the information technology infrastructure
- Policy that prohibits complaints unrelated to health problems as part of the sick call process
- Revision to the policy that a provider visit must occur after a patient escalates a complaint through nursing
- A process study to address the high volume of patients brought into the clinic waiting room and the lengthy waits to be seen
- An innovative approach to scheduling visits to reduce the strain during peak hours
- Coordination between health care staff and security to ensure that patients on work assignments can be seen during non-work hours
- Coordination among health care staff, security and attorneys who visit their clients to reduce interference with sick call workflow
- A plan to reduce the patient backlog over a defined period of time
- A workflow analysis and prioritization of visits to ensure access to care in a reasonable amount of time
- More patient education and information on self-care

Conclusion

A direct focus on the issues identified in this report would create a more efficient sick call process and enhance the overall delivery of patient care.

We thank the staff at the James T. Vaughn facility for their assistance and professionalism during the on-site visit. This cooperation enabled us to gather the data and conduct the review.

INTRODUCTION

Following a security disturbance at the James T. Vaughn Correctional Center on February 1, 2017, Delaware Governor John Carney issued an executive order establishing an independent review team to investigate and report on any conditions at the prison that contributed to the situation. The independent review team's final report, issued in August 2017, makes numerous recommendations for improvement at the prison.

With regard to health services, Recommendation 9.1 of the final report states that the Delaware Department of Correction "should conduct an independent assessment of the health care and mental health care provided at the JTVCC."

Consequently, the Department of Correction engaged NCCHC Resources, Inc. (NRI), to conduct an assessment and to provide recommendations based on the findings. The present study was designed primarily to assess the effectiveness of the daily inmate sick call process and its overall efficiency.

Project Objectives

- Evaluate and provide feedback on the quality of health services based on compliance with the National Commission on Correctional Health Care's *Standards for Health Services in Prisons* (2014 edition)
  - Assess health services policies and procedures pertaining to nonemergency health care requests and services (i.e., sick call)
  - Recommend policy and procedure changes that can result in improved sick call process and overall health care efficiency and effectiveness
- Review information (via charts, procedures, policies, interviews, etc.) pertaining to:
  - Requests for sick call visits and care: medical, behavioral and mental health, and dental
  - The overall process for managing nonemergency health care services
  - The timing between the initial request for sick call visits, delivery of care, and referral to a higher level of care
  - Review the process and frequency of sick call appointment rescheduling, including its effect on the timing of care
- Provide a written final report based on the observations made during the assessment

Methods

The NRI team consisted of two subject matter experts—one physician and one administrator—who conducted an on-site review on March 7-8, 2018.

The team's first step was to select the key data sources and gather information necessary to come to a comprehensive conclusion regarding the availability, effectiveness and efficiency of patient sick call. The data were obtained from direct observation of sick call; review of policies, health records and other relevant documents; and interviews with inmate, security staff, and health staff.

More specifically, as outlined in the project scope of work, activities included the following:

1. Interviews with key prison personnel to discuss patient movement and personnel availability and their effect on policies, procedures, and programs that affect health services, particularly on the sick call process

2. Interviews with key contractor medical and behavioral health personnel to assist with department-wide assessment and evaluation
3. Review of the relevant health policies and contractor site-specific procedures in comparison with NCCHC standards
4. Review of the medication administration process
5. Inspection of the pharmacy (medication room) and the medication distribution system
6. Examination of nursing sick call protocols
7. Examination of equipment and supply needs for the medical unit
8. Review of security staff training regarding signs and symptoms of medical conditions, first aid and cardiopulmonary resuscitation, and suicide prevention
9. Assessment of behavioral health sick call services through an examination of health records
10. Recommendations concerning other incidental findings that the subject matter experts may notice while evaluating the sick call process

The NRI team was assisted by facility staff who familiarized us with the clinical area; provided documents for review, both in paper and electronic formats; aided us in navigating the electronic health record (EHR) system; and gave us access to relevant policies and documentation. In addition, escorts were provided to gain access to areas on the compound where interviews were conducted.

Once the data were collected, we were able to focus on the relevant information, looking for patterns, trends, and themes regarding patient sick call, and brainstorming possible solutions to any issues that were uncovered through the review process.

We also relied on the NCCHC *Standards for Health Services in Prisons* as the basis of this review, especially with regard to effective processes relative to sick call.

Findings are reported in the following sections:

1. Interviews
2. Electronic Health Records
3. Sick Call
4. Co-Pay System
5. Patient Movement
6. Patient Backlogs

See the Recommendations section of the report for our suggestions for improvement.

SICK CALL EXPLAINED

Sick call refers to the method by which inmates initiate access to health care. It is a general term that can apply to all health care visits regardless of acuity.

See Appendix for NCCHC standard P-E-07 Nonemergency Health Care Requests and Services (essential)

The premise of the policies governing the sick call process is that prisoners cannot obtain health services on their own and must rely on corrections officials to access care. Additionally, the U.S. Supreme Court has mandated that incarcerated individuals have constitutional rights to have health care provided to them (*Estelle v. Gamble*, 1976).

The sick call process begins when an inmate has a concern regarding his/her physical, dental, or mental health. Inmates are entitled to make requests to be seen by a qualified health care professional. The sick call requests are for nonemergent problems and, according to the NCCHC standard, are collected daily. The request process can take various forms and may be through a written request. Patients, especially those in segregated housing, may also request sick call by communicating with health staff from their cells during medication passes or segregation rounds. The request is then documented by the appropriate health care professional in the patient's medical record.

"Qualified health care professionals" include physicians, physician assistants, nurses, nurse practitioners, dentists, mental health professionals, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for patients.

The next key component of the sick call process is *triage*. This is the review and prioritizing of the sick call request to be seen for medical, dental, or mental health issues. The NCCHC standard specifies that requests be triaged within 24 hours. Upon review, the patient's request may be referred to the appropriate clinician, such as a medical provider, dentist, or mental health professional.

Nursing assessment protocols are an important component of the sick call system. These are written instructions or guidelines that specify the steps to be taken in evaluating a patient's health status and providing appropriate interventions. The protocols include procedures for the identification and care of many ailments, from nonsevere to potentially urgent, as well as a sequence of steps to be taken to evaluate and stabilize the patient until the appropriate clinician is contacted and orders are received for further care. Nurses may provide only over-the-counter (OTC) medications without an order from a medical provider.

Timeliness of obtaining services is extremely important in the sick call process. When a request describes a clinical symptom, a face-to-face encounter between the patient and a qualified health care professional is to occur within 48 hours (72 hours on weekends), according to the NCCHC standard. The time that elapses between the sick call request being picked up and the face-to-face encounter is important to track and is measured most efficiently by using logs and reviewing specific health records.

The initial encounter should be accomplished in a clinical setting, with a qualified health care professional. If the patient has a condition that needs further evaluation by medical, dental, or mental health providers, then the appropriate triage occurs.

A face-to-face evaluation of a sick call request includes several steps:

1. Welcome the patient (establish therapeutic milieu)
2. Elicit and listen to the patient's description of the health concern (subjective data)
3. Examine the patient and collect data (objective data)
4. Assess the patient (synthesis and critical judgment)
5. Establish a plan of care (inform and educate the patient)
6. Evaluate plan effectiveness (ensure patient understanding)
7. Follow through on the plan (patient advocacy)

EVIDENTIARY DATA

Direct Observation of Sick Call

Sick call is held in the clinic area for the lower custody units. The waiting room space in the main clinic area is limited. Regular sick call will result in up to 40 patients waiting to be seen for medical, dental, or mental health issues. We observed a large number of patients waiting to be seen by the appropriate provider on the days of our visit.

The high volume of patients being called to sick call is a challenge for inmates, health staff, and security staff, both on the compound and in the health clinic area. Patients reported that they have waited in the clinical area for hours, only to be sent back to their units when the provider had reached the limit of patients he/she could see in a day. This is a source of contention for inmates. Security staff also mentioned this as a source of frustration, as many of these patients required a security escort to the clinic, only to later be returned to their unit.

Sick call in the Special Housing Unit (SHU) and the Maximum-High Housing Unit (MHU) is held in the exam rooms that are on each high-security housing unit. Patients are brought into the holding cells to await the clinical encounter with the nurse. Overall, the patients interviewed expressed very little frustration or contention with the process. According to these patients, sick call occurs 7 days per week and is rarely interrupted, unless there is a security emergency such as a fight. When this occurs, sick call is rescheduled in a prompt manner.

Review of Relevant Policies

The facility provided us with the manual that outlines all health care policies. We reviewed the following policies:

- Nonemergent Health Care (Sick Call)
- Fee for Services (Co-Pay)
- Medical Autonomy
- Information on Medical Services
- Security Escorts
- Medical Grievances

All relevant policies that we reviewed were cross-referenced with the appropriate standard as recommended by NCCHC.

Review of Patient Health Records

One major issue that affects daily work is that the EHR has many drawbacks and interferes with the effective delivery of health care. This will be discussed in the Electronic Health Records section of this report.

SECTION 1 – INTERVIEWS

Inmate Interviews

We interviewed a sampling of inmates from SHU, MHU, segregation, and general population. All inmates were asked the same questions, which touched on topics such as availability of health service request forms, the fee-for-service (co-pay) process, and any education from facility staff regarding access to health care. The responses revealed that sick call is occurring and that patients are able to see providers. They also revealed the following issues and concerns:

- Inmates know how to request sick call using the forms provided. However, they unanimously said that when they arrived at the facility there was no orientation or education on how to access health services, and that there is no inmate handbook describing the process. The process seems to be something that is learned from other inmates on the housing unit.
- Fee-for-service programs are common in correctional facilities, as are charges of $4 to be seen and $2 for medication. While some inmates expressed dislike for the co-pay system, we saw no trends that seemed to prevent the collective population from requesting care. One issue—reported more than once and mentioned in the February grievance log—is that inmates would be charged weeks or months before the service was rendered. In one case, an inmate said that he requested to be seen by the dentist. A co-pay was charged to his account and, at the time of our visit, he had been waiting more than 6 weeks. This creates distrust and could dissuade inmates from attempting to access the health care system.
- Several inmates said that they receive good care depending on which health staff were attending. There were reports of health staff being short tempered with patients and displaying inappropriate social skills. It was reported that some inmates would refuse pill call if certain nurses were on duty because they felt they would not be treated respectfully. Concerns about this type of treatment could hamper inmates' desire to seek medical care.
- Some patients have anxiety due to past events at the facility. One inmate said that he had a diagnosis of a cyst on his thyroid and wanted a biopsy, but was concerned. When pressed on the issue, he revealed anxiety stemming from a media-publicized misdiagnosis of one patient's medical issue. In describing his diagnosis and interaction with his provider, it appears his treatment regimen may be appropriate. However, given the general mistrust created by the media news story, health staff should take time to communicate issues to patients in order to prevent individual anxiety that can feed into the collective tensions.

Security Staff Interviews

We interviewed security staff of various ranks and who worked in different posts throughout the facility. The topics discussed included patient access to health care, interruptions of health services (e.g., for emergency facility operations), escorting of patients to the health clinic or to appointments, sharing of health-related concerns between health staff and custody staff, conflicts in policies between custody and health care, and patient privacy.

The unanimous response to questions regarding the sick call process is that sick call request forms are available and are picked up daily by nursing staff, and appointments are made based on priorities determined by health care professionals.

Our interviews with security staff revealed the following concerns:

- Security staff position control numbers are down and the staff shortage is considerable. This has created mandatory overtime of at least one to two extra shifts every 2 weeks. For some, the overtime contributes to fatigue and lack of desire to perform at their highest ability. This is reported as a factor that creates tension between security staff and health staff.
- Security staff report frustration with a perceived lack of safety practices within the main clinic area. Several staff said that they have expressed concerns to shift and facility leadership about the high volume of patients waiting to be seen in the clinical waiting area, feeling that it is a primary safety concern within the compound. At the same time, there was unanimous agreement that patients are being called to the clinic area for appropriate health care issues. That makes the issue unavoidable but is a large source of tension within security staff ranks.
- Another point of contention is the volume of escorts to off-site appointments. It was reported that at times up to 19 officers were doing off-site escorts within a single shift. We did not verify this. However, the contention is that with short staffing and high volume of staff going off-site, it creates a strain on safe numbers of security staff available on the compound. This safety issue also strains the relationship between security staff and health staff.

Health Staff Interviews

Health care staffing numbers have recovered to levels that preceded the events of 2/1/17. The staffing model is adequate, but the following staffing vacancies were noted at the time of the review. In nursing, there are vacancies in many key areas that are being covered by other nurses, which sometimes causes critical functions to be left unattended to due to lack of time.

- 1 staff physician
- 1 dental hygienist
- 1 medical records clerk
- 1 medical unit clerk
- 5 charge nurses
- 9 registered nurses
- 5 licensed practical nurses

Key findings from our interviews are as follows:

- One major issue that affects daily work is that the EHR has many drawbacks and interferes with the effective delivery of health care.
- The sick call process structure does not empower providers to have control over their own schedules.
- Patients who need to be seen (e.g., for chronic conditions) may not get seen in a timely manner because the system is geared to favor patients who present with complaints.
- Nursing staff is tasked with addressing complaints that are not related to health care.
- The grievance process is not clearly defined for health care matters. This process will be addressed by a separate work group.
- Patient wait times in the main clinic are long and increase the likelihood that a patient will refuse a visit.
- Seeing pretrial detainees is a challenge due to court schedules.
- Visits with legal professionals, which utilize privacy rooms and security staff, can interfere with the sick call process.

SECTION 2 – ELECTRONIC HEALTH RECORDS

The facility's EHR program is iCHRT, which was implemented in April 2014. As noted in Section 1, health staff reported that the system interferes with the effective delivery of health care.

- The system is slow and frequently loses data. Connectivity is clearly an issue.
- The way that the workflow is set up on iCHRT is inefficient in many cases and requires extra clicks in order to accomplish simple tasks.
- Staff universally use "work-arounds" to place documentation in the chart. For example, they enter data on Microsoft Word documents, then "copy and paste" the data into iCHRT.
- Documentation is often done after hours due to the fact that data entry is time intensive. One medical provider who sees 12-15 patients per day reported working 80-100 hours per week in order to complete documentation.
- Scheduling for mental health and psychiatry visits is done on an Excel document rather than iCHRT because a built-in process on iCHRT automatically schedules incorrect appointment types and inappropriate follow-up times.
- "Emergency" visits are automatically scheduled within 24 hours on iCHRT. This language is not consistent with a 24-hour visit; changing "emergency" to "priority" is more appropriate.
- A lab interface does not exist. Currently, labs are printed out, signed, and then scanned into the record.
- Medication renewals are inefficient and cumbersome. The pharmacy contractor faxes a list to the facility. The provider must then order medications one by one into iCHRT.
- Late entries in iCHRT are a common occurrence due to slow or poor connectivity and the risk of losing documentation.
- Some forms require that a nurse enter an ICD-10 code for a diagnosis. Since nurses are not supposed to diagnose conditions, this step should be reconsidered. Furthermore, searching for an ICD-10 diagnosis in order to complete a note slows the workflow for nursing staff.
- Providers are not using the chronic care module consistently due to system slowness and the risk of losing documentation. The physical exam section is used by some providers.
- All progress notes get saved into the same section of the chart, making it difficult to quickly access information
- There is no search function (by provider name or specialty) to find prior documentation.
- Follow-up visits may be deleted by staff members incorrectly, but there is no effective way to track this process to recover visits.
- Scheduling of visits: if a patient isn't seen one day, the appointment does not automatically "roll over." Rather, health staff must manually reschedule the visit. This creates the risk of a patient visit being missed completely.

SECTION 3 – SICK CALL

Nursing staff pick up and triage the sick call forms. In the SHU and MHU, the forms are picked up twice daily during medication pass, and in the other housing units, they are picked up at the designated drop box once daily. Nursing staff triage the sick call forms consistently in accordance with the written policy and see the patients in a timely manner. The NRI team does not have concerns about the timeliness of form pick-up or triage.

However, we observed the following concerns related to sick call documentation in iCHRT:

- SOAPE (subjective, objective, assessment, plan, education) notes are documented, usually using the "copy and paste" method from Microsoft Word into the iCHRT templates. This method of data entry is used out of necessity, due to the time-consuming nature of documenting in iCHRT and the risk that data will be lost while writing a note in iCHRT. This work-around adds extra steps to the documentation process but has been found to be more time efficient than documenting directly in iCHRT.
- Sick call forms are scanned into the record but are not attached to the iCHRT note.
- Nurses are triaging many complaints that are not related to medical issues, which is not good use of medical staff time. For example, they receive requests for pencils and lotion.

SECTION 4 – CO-PAY SYSTEM

According to JTVCC policy, inmates receive a written explanation of the co-pay program at the time of admission. Charges for health care are $4 for sick call and $2 for medications. Health staff do not collect fees.

Services excluded from the co-pay program include the following:

- Admission health screening
- Health assessments required by policy
- Emergency care
- Infirmary care
- Ordered laboratory and diagnostic service
- Diagnosis and treatment of contagious/communicable disease
- Any chronic care clinic, including any mental health service, which also includes ordered medications to maintain health

Charges are not assessed when seen by one or more providers for the same problem three times in a 7-day period. Furthermore, health care is not denied because of inability to pay.

Inmates may use the grievance process to lodge complaints about the co-pay program. Grievance and other relevant data are reviewed to verify that the co-pay program does not impede access to care.

In our judgment, the copay system is not punitive and does not impede access to health services.

SECTION 5 – PATIENT MOVEMENT

We identified the following concerns regarding patient movement for health services:

- Mandatory overtime hours for security staff reportedly results in an assignment at the clinic.
- Identification by security staff of patients who need urgent or emergent care may be impeded by excessive fatigue.
- Patients on work assignments have difficulty getting seen in the clinic due to their work schedules.
- Unsentenced inmates also have difficulty getting seen in the clinic. At times, court schedules may interfere with clinic visits.
- Legal visits can interfere with sick call workflow, as privacy rooms are used by attorneys visiting their clients.

SECTION 6 – PATIENT BACKLOGS

Backlogs on schedules exist for certain disciplines, physical therapy in particular. This can lead to obstacles in access to care.

Some patients may find other ways to access to care, for example, by claiming an emergency for nonurgent conditions. This was stated by more than one inmate during the interviews.

RECOMMENDATIONS

Sick Call

- Overall, sick call for all disciplines is greatly hampered by an inadequate electronic health record system. Extensive revamping or replacement of iCHRT and overall improvement of information technology infrastructure are necessary. Without these changes, staff productivity will continue to be severely limited.
- Complaints that are not related to health problems should not be part of the sick call process. A separate process should be developed to address requests for extra items.
- The sick call process should be restructured so that a provider visit is not mandated after a patient escalates a complaint through nursing.
  - A chart review by a provider will usually suffice. A provider can then determine the next course of action.

Health Records

- Issues surrounding the EHR need to be remedied in order for health staff to deliver effective health care and to limit liability concerns.
  - This includes addressing issues with connectivity and slowness.
  - Major workflow restructuring within the program is also needed.
  - Being able to document visits in real time at the site of the patient visit (e.g., at the clinic in the SHU) allows for delivery of optimal patient care. This is rarely done due to issues of connectivity and slowness.
- Health services should develop a standard to ensure that all staff indicate when they have documented a late entry.
- Sick call forms should be attached to the sick call documentation

Patient Movement

- Health services should conduct a process study to address the high volume of patients that are brought into the clinic waiting room, sometimes for hours, to be seen for sick call or by a provider.
- A comprehensive look at patient movement is needed.
- Close coordination between medical, dental, mental health, and security is needed to optimize movement of patients.
- An innovative approach to scheduling of visits should be considered to have patients seen during times when staff are usually not present in the building.
  - For example, rotating staff during evening hours or weekends to aid in patient movement and staying caught up with sick call can reduce the strain that happens during peak hours. The staff hours can then be “flexed” in order to minimize overtime.
- For patients who are on work assignments, health care staff and security should coordinate to ensure that they are seen outside of work hours.
- For unsentenced inmates, coordinating visits with security in advance can help reduce obstacles to delivering prompt health care.

- Coordination between health care staff, security, and attorneys who visit clients is needed to reduce interference with sick call workflow.

Patient Backlogs

- Backlogs on schedules should be addressed and a plan implemented to reduce the backlog over a defined period of time (e.g., 60 days).
- Prioritization of visits and workflow analysis should be done to ensure access to care in a reasonable amount of time for a wide array of patients. Focus on identifying follow-up visits that may provide little patient benefit and cancelling these visits.
- Patients should receive more materials on self-care.

Patient Education

- Use patient education forms and postings on bulletin boards to increase health literacy and reinforce health care policies. This has the potential to improve the efficiency of the sick call process through reduced complaints.
- Regular use of patient information sheets also can help to increase health literacy. These sheets can be handed out during nursing/provider visits and posted on bulletin boards in the housing units. Examples of topics include the following:
  - Latent tuberculosis
  - Hepatitis B and C
  - Dental problems
  - Substance misuse
  - Sprains/strains
  - Upper respiratory infections
  - Constipation/diarrhea
  - Acid reflux
  - Extra items
- The focus should be on self-care and over-the-counter remedies.

Communication

- Provide training that focuses on communication between custody staff and health staff, as well as between health staff and inmates. Reinforce to staff that it is unacceptable to have rude or demeaning conversations during patient encounters.
- Employ a more empathic form of daily communication to ease the inmate populations' collective anxiety and tensions that arise after a major disturbance.

Staffing

- Work to improve nursing staffing.
- Conduct a study that addresses recruitment of nurses and other health staff.

DISCLAIMER

Technical assistance by NCCHC Resources, Inc., is a professional activity that is completely separate from accreditation by the National Commission on Correctional Health Care and in no way guarantees accreditation, reaccreditation, or any other outcome of a survey.

ABOUT NCCHC RESOURCES, INC.

A nonprofit organization, NRI works to strengthen NCCHC's mission: to improve the quality of health care in prisons, jails and juvenile detention and confinement facilities. NRI leverages NCCHC's expertise in correctional health care to provide customized education and training, preparation for accreditation and professional certification, performance improvement initiatives, and technical assistance to correctional facilities interested in health care quality improvement.

For more information, contact us at info@ncchcresources.org or call (773) 880-1460.

APPENDIX: NCCHC STANDARD P-E-07

P-E-07
essential

NONEMERGENCY HEALTH CARE REQUESTS AND SERVICES

Standard

All inmates have the opportunity *daily* to request health care. Their *requests* are documented and reviewed for immediacy of need and the intervention required. Qualified health care professionals *respond to health services requests* and conduct *clinicians' clinics* on a timely basis and in a *clinical setting*.

Compliance Indicators

1. Oral or written requests for health care are picked up daily by qualified health care professionals and *triaged* within 24 hours. When a request describes a clinical symptom, a face-to-face encounter between the patient and qualified health care professional occurs within 48 hours (72 hours on weekends).
2. When responding to health services requests, qualified health care professionals make timely assessments in a clinical setting. Qualified health care professionals according to clinical priorities or, when indicated, schedule patients as clinically appropriate.
3. All inmates, regardless of housing assignment, have access to regularly scheduled times for nonemergency health services (i.e., sick call).
4. The frequency and duration of response to health services requests is sufficient to meet the health needs of the inmate population.
5. All aspects of the standard are addressed by written policy and defined procedures.

Definitions

Daily means 7 days per week including holidays.

Request for health care refers to oral or written petitions for medical, dental, or mental health services. These requests are to be documented.

Responding to health services requests is the medical, dental, and mental health evaluation and treatment of an ambulatory patient in a clinical setting by a qualified health care professional.

Clinician's clinic is a designated time and place for physicians, nurse practitioners, physician assistants, dentists, or mental health clinicians to respond to health services requests.

Clinical setting refers to an examination or treatment room appropriately supplied and equipped to address the patient's health care needs (see D-03 Clinic Space, Equipment, and Supplies).

Triage is the sorting and classifying of inmates' medical, dental, and mental health requests to determine priority of need and the proper place for health care to be rendered.

Discussion

This standard intends that inmates' routine health care needs are met. There are many ways to satisfy this standard. Inmates can access the health care system by walking into a clinic and making an appointment, writing their requests on slips that are dropped into a locked box (these are picked up by health staff who go to all housing areas), telephoning a nurse in the clinic, or using sign-up sheets in the dining hall or housing area. In all cases, care should be taken to protect the confidentiality of inmates' health concerns (see A-09 Privacy of Care and H-02 Confidentiality of Health Records).

A disposition is made and noted on the patient's health request form or in a log or appointment book (e.g., patient requested to appear at the next regularly scheduled period for nonemergent care, dental appointment made, referred to psychologist). Not every nonemergency health services request requires an appointment; however, when a medical, dental, or mental health request describes a clinical symptom, a face-to-face encounter between the patient and a health professional is required.

The frequency and duration of providing nonemergency health services may vary according to facility size. Correctional institutions with a high proportion of segregated inmates or special needs patients may require more frequent opportunities for nonemergency health services or extended hours to accommodate all requests and needs.

When indicated, referral to the clinician's clinic is made for the inmate to see a physician or midlevel practitioner. In general, when a patient presents for nonemergency health services more than two times with the same complaint and has not seen a physician, he or she receives an appointment to do so.

When qualified health care professionals are not on duty within a 24-hour period, health-trained correctional staff, using facility protocols established by the legal and health authorities, review and respond to inmates' health care requests (see C-08 Health Care Liaison).

Because better disposition decisions are likely to result, it is recommended that qualified health care professionals with the most experience triage and assess inmate health care requests.