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Mellie Nelson, Esq.
U.S. Department of Justice
Civil Rights Division, Section of Disability Rights
1425 New York Avenue, NW
Washington, DC 20005

Re: Women's Huron Valley Correctional Facility

Dear Ms. Nelson:

This is a report on the nursing care provided to inmates, with a focus on those with disabilities, at the Women's Huron Valley Correctional Facility (WHV) in Ypsilanti, Michigan. I was asked by the U.S. Department of Justice to evaluate the nursing care at WHV, focusing especially on those inmates who were long-term Infirmary inmates and those inmates in the Segregation Unit. My opinions are based on my visit to the facility on August 11 – 12, 2015, interviews with staff, interviews with patients, review of documents, and review of medical records. I previously visited the facility on January 12-13, 2015. All of my nursing record review was done in conjunction with WHV's health unit manager (HUM), and other nursing staff to assure reliability and validity of my findings.

My opinions are expressed to a reasonable degree of nursing certainty. If I receive any additional materials, I may choose to supplement or modify my report. In this report, inmate identifiers are contained in confidential endnotes.

FINDINGS AND RECOMMENDATIONS

A. Medications/Medication Room

1. Pre-Pouring Medication

During my visit to the Infirmary area, I observed the nursing staff pre-pouring medications into envelopes. I asked if this was a normal and usual practice and I was told that it occurs when the Infirmary area is busy to assure timely medication delivery. This practice is highly problematic due to the potential that an envelope could be given to the wrong inmate, that an envelope could be lost or misplaced, or that someone passing by could take one of the envelopes. Indeed, I observed nursing staff entering and leaving the Infirmary medication area, leaving the envelopes of medication sitting on top of the medication cart.

Recommendation

Pre-pouring of medications is not a good or standard nursing practice. There can be errors in dosage, medication can be lost, and the potential for providing the medication to the wrong patient increases with this practice. In addition, it takes as much time to pre-pour medication into an envelope as it does to give the

medication from the cart at the appropriate time. WHV must provide training to all nursing staff on the proper procedures for medication delivery and stress the necessity to follow standard operating procedures.

2. Narcotics and Sharps Count

I observed the change-of-shift narcotics and sharps count done by the outgoing and incoming nursing staff. During count in the Infirmary area I observed needles that had been signed out, not used, and placed on top of the medication cart. The explanation given for this practice was that the nurse on duty had signed out the needles to give injections to patients, but the patients were not available at the time the nurse came around. Rather than return the needles, they were simply placed on the medication cart and the instruction by the outgoing nurse to the nurse coming on duty was to use those needles when the patients returned.

I also observed lancets sitting on top of the medication cart that were not on the sharps count. While lancets may not pose the same risks as other sharps, they still should not be left out where they could be easily taken. They should be under lock and key.

Recommendation

An accurate narcotics and sharps count is critical in a correctional environment. Because the door to the medication room is not always closed or locked, there is always the potential for someone to enter and take narcotics or needles, which could be extremely dangerous, so they must all be accounted for at all times. As noted above, needles and lancets should be under lock and key. WHV should provide training to the nursing staff on the proper procedures for medication and sharps count. The importance of following standard operating procedures and nursing protocols must also be stressed to all nursing staff.

3. Medication Lines

While at the facility, I observed inmates waiting in extremely long medication lines. Some of the inmates were extremely feeble and I observed that they had difficulty walking to and standing in the lines. Having long medication lines is inconsistent with practices for medication delivery. I identified this issue as problematic during my previous visit in January.

Recommendation

During this visit, WHV informed us that it had performed a staffing analysis and as a result, WHV will be adding five more nursing positions to its staff. If the additional staff members are placed in the medication area to speed the process of delivering medication, this may help to alleviate the long medications lines. However, WHV should also analyze the potential harm to those with disabilities caused by having to wait in line to receive medications. WHV should also take other steps to reduce the lines, such as directly delivering medications in the housing areas, and make exceptions for those who are infirm and feeble.

4. Medication Orders

The medication re-ordering process appears to work smoothly when the chief technician is in the pharmacy. However, when she is on vacation or out of the pharmacy, the process breaks down. I noted that on multiple occasions there were significant lapses in the re-ordering of medications, and they principally occurred when the chief technician was out. (Dr. Griefinger also notes this in his report). In addition, the pharmacy technician noted that due to a serious shortcoming in the Maxor system, there is only a very narrow

window of time that she can submit a medication refill order. If submitted outside the window, the profile is merely put in a "tickler system" to timely reorder medication, an unwieldy process which increases the chances of error.

Recommendation

WHV must train the pharmacy technicians to ensure that they all have knowledge of the process (and the flaws) in the WHV's medication re-order system. WHV or MDOC should discuss the problem with the patient profiles with Maxor Correctional Pharmaceutical Services to ensure that orders for patients are not held up or refused based on the lack of the Maxor system's ability to distinguish between a new order and a renewal.

5. Inmate Movement

WHV routinely moves inmates to other housing units without notifying medical. The NextGen medical record system and the correctional locator system are not able to communicate with each other. This causes problems for the nursing staff in terms of medication delivery, medication re-ordering, missed doses of medications, and continuity of care for inmates.

Recommendation

As suggested by WHV staff during our exit briefing, a daily sheet detailing the movements of inmates should be provided to the nursing staff. This will allow the nursing staff to transfer needed medication and treatment protocols to the inmate's new housing area. The exchange of information will assist both the nursing and medical staff to provide better continuity of care for the inmate population. Once the daily sheet procedure is put in place, WHV should evaluate if the process works as expected, or if a different approach is required.

B. Infirmary

1. Chart Reviews/Charting consistency

I reviewed 10 charts of patients in the infirmary area with two different supervisory staff. I observed that the location of the nursing notes is inconsistent among patient records. Some notes are contained in the nurse master area of NextGen, while some are in the nurse protocol area. The lack of uniformity in the location of nursing notes causes confusion for supervisory and line staff. If one nurse places a note in the nurse protocol area and another in the nurse master area, a subsequent reviewer may not obtain all the information needed to provide continuity of care to the patient. Indeed, during my review, the amount of information that I was able to obtain from the patients' records varied by which of the two supervisory staff was working with me. The first supervisor provided me information only from the nurse protocol area of the chart, while the second provided information from the nurse protocol, the nurse master, and other areas of the system. Thus, the knowledge of where to obtain chart information was inconsistent even between the two supervisory staff.

Recommendation:

WHV should develop a process to ensure that required charting is completed in one consistent area of the NextGen system. It is difficult to provide continuity of care for those with serious medical and disabling conditions if the charting is done in such an inconsistent manner.

2. Chart Reviews/Charting timeliness

All 10 charts I reviewed had nursing notes. This was an improvement from my first visit in January, but charting timeliness was inconsistent. Some notes were added every shift; others were charted daily. Still others were completed every other day. There appears to be no requirement of the time frames within which nursing notes are to be recorded. Further, in looking at the charts, there appears to be no criteria as to what information should be placed on the chart. For example, there may be a patient who has recently had surgery. There needs to be clear direction from nursing leadership as to the time frame and requirements for nursing notes post surgery. Does each shift have to write a note on the current condition of the patient. And, depending on how the inmate may progress, a determination when a note each shift may not be needed and only a daily note. Then maybe only a note every couple of days, unless there is a change in the condition of the patient. Additionally, I reviewed the log book at the nurses' station. However, it was unclear for what the log book was used. Each of the nurses with whom I spoke had a different interpretation as to the uses of the log book. Some felt it was to be used for critical issues that needed to be noted from one shift to another, while others thought it was for treatments.

Recommendation:

WHV must provide training on the importance of timely charting on all patients. WHV should establish specific criteria for the timeframes for charting as well as the information to be recorded. WHV should also establish a Continuous Quality Improvement (CQI) process for charting within the facility. It should develop a system to identify the critical needs of each patient, develop a stratification of those needs, and assign a score to assist the nursing staff in providing the needed care for the patient and charting the care in the medical record. In addition, the log book should have a defined purpose, of which the nurses are informed.

3. Chart Review/Wound Care

During my visit, I noted that there were a number of inmates who were receiving wound care. Upon inquiry of the staff, including the HUM, as to where those treatments were placed in the chart, I was told that the wound care module was not working properly so charting was being done in one of the nursing areas. This created difficulty for the nursing staff to determine if and when a treatment was completed, as there was no consistent place to look in the chart for the performance of wound care.

Recommendation:

WHV should develop a plan and process to identify where to consistently chart wound care. If the wound care module is not available, a uniform policy or procedure needs to be implemented until the module is functioning.

4. Staffing Levels

The HUM advised that, shortly after our January visit, she had submitted a revised staffing matrix to the central MDOC. As previously noted, the central MDOC granted her request for five additional RNs. She anticipates that they will be hired in the next quarter. The HUM also advised that nursing aide staff had been added to the schedule since the previous visit. This additional staff seemed to alleviate the challenge noted in the last report with toileting for those inmates who were in a "dry cell". The HUM finally advised that this

summer had been challenging due to call offs. In order to assure adequate staff coverage she had to ask nurses to work overtime, and that, at times, there were gaps in coverage.

Recommendation:

WHV should continue to review the staffing analysis submitted to the MDOC to determine the appropriate staffing levels for the level of care needed in the Infirmary and Clinic areas. The level of care indicated by the patients may impact the demand on the nursing staff at any time and WHV must ensure that at all times the patients' needs are being met. And, as previously noted in my last report, the name and level of licensure should be visible on staff members at all times.

Programming

At the time of my visit, long-term residents in the Infirmary had limited, if any, access to activities and programs. When I asked a staff nurse and a Correctional Officer on the floor of the Infirmary if the patients had access to programs, I was told no, that these inmates are sick and are here for treatment. In a discussion with the WHV Deputy Warden for Programs, she described what programs were available to the inmates in the Infirmary, and the options that inmates in the Infirmary had to participate in programming required for parole. She also noted that she would initiate additional programming to those in the Infirmary. Programming such as choir, reading, crocheting may be available. She advised that Infirmary inmates also have access to the Salvation Army Toy Project, access to Chapel, a post-partum group, and general population groups such as healing trauma, Catholic Social Services, and the library self-help books. It was noted, however, that none of this information was easily available for staff or inmates to know how to participate in programs or the eligibility requirements for any of the activities.

Recommendation:

An important part of the Americans with Disabilities Act is that those who may be classified as having a disability should have the same, or similar, access to programming as those in the general population. The Deputy Warden for Programs should continue to explore and initiate programs for inmates in the Infirmary, as well as post a notice in the Infirmary of the programs available to Infirmary inmates. The Deputy Warden for Programs should also be advised by staff of any infirmary patient being recommended to attend programming. This could be done at the weekly Case Management meeting with the Warden, or via e-mail. If an Infirmary inmate is unavailable to participate in a program due to a medical condition, program staff should document it. WHV should follow-up with both inmates and staff to determine whether Infirmary inmates who wish to do so are engaged in programming activities.

B. Sick Call Referral

During our interviews, a number of inmates indicated that in order to be seen by a physician they first have to be seen by a nurse three (3) times. They complained that because the inmates are charged for these nurse sick calls, inmates effectively have to pay for four (4) visits in order to be seen by a physician. Although the HUM indicated that this rule is supposed to increase, not decrease, the chances that inmates are seen by a physician, she did indicate that if an inmate is not seen three (3) times in a 30-day period for the same medical issue, the time for referral to a physician starts over. Thus, this practice may cause a delay in care and the

potential for negative sequela. According to a nurse we spoke with, if a patient is seen by the nurse and needs to be referred directly to the provider, the nurse will do so. However, there is a definite impression by inmates that there is a systemic impediment to getting to see a physician and my review of grievances shows that there is a delay for inmates to be seen. I do not know if the delay is solely attributable to the "three visit" issue, but this appears to be a continuing problem.

Recommendation:

WHV should review the specific policy on sick call referrals to see if this may be a cause of the number of grievances relating to delays in medical care. If medically indicated, nurses must refer inmates to a physician. There should not be an arbitrary requirement of three-visits-within-thirty-days-for-the-same-issue in order to see a physician. WHV should use the admission process to clarify the procedure to see a physician.

C. Prisoner Observation Aides (POAs)

During the visit, Dr. Griefinger and I spoke with Prisoner Observation Aides (POAs) observing patients. On the previous visit, I had noted that the POAs were not encouraged to communicate with the inmates for whom they were observing. This was not the case on this trip. Each of the POAs I spoke with talked about the encouragement they received from custody to speak with those inmates whom they were observing.

Since my first visit, the form for the POAs to record their notes has been revised. It now contains a checklist with spaces for both custody and mental health staff to sign-off that they had reviewed the information documented by the POA on the form. This was a positive change from the previous visit.

I did note that the POA notes and information are not provided to medical staff. When asked, the nursing staff felt this was a custody and mental health issue and that they did not have responsibility for those patients.

Recommendation:

WHV should establish a clear and identified process to ensure that health information and concerns about the observed inmates documented in the POA notes are reported to appropriate nursing and medical staff — in addition to custody and mental health staff. WHV should also ensure that nursing and medical staff have access to the POA reports as a source of medical information. To segregate this information from medical personnel is problematic because some behaviors that an inmate may exhibit may be interpreted as a mental health issue, while in fact the behaviors may be caused by a physical or medical condition. This is consistent with the current process used at WHV with those inmates who are placed in segregation: medical and nursing staff evaluate the inmate as they enter segregation, provide notes on the patient chart during the time in segregation, and provide updates as needed to the appropriate medical or mental health staff.

D. Grievances

During this visit Susan DeClercq, Mellie Nelson, and I reviewed twenty one (21) of the medical grievances submitted in August 2015. We only reviewed those grievances that had been resolved prior to our visit. There were three grievances concerning medication lapses. As discussed previously, the dates of the medical lapses were consistent with when the pharmacy technician was on vacation. There were four

grievances indicating a lack of treatment. All four indicated a time frame from late June through late July and all four grievants indicated that they had placed a sick call slip and had been seen by a nurse, but no action had been taken. In fact, one was diagnosed with a urinary tract infection on the 23rd day after the first sick call slip was sent to medical. It took 23 days to diagnose the infection. The first nurse sick call visit was 20 days earlier The other three indicated similar time frames. Thus, all of the issues were eventually resolved, but there were unnecessary delays in treatment.

Again, whether this delay is part of the "three nurse" visits issue I cannot say. However, it is important to review grievances for patterns. Delays in care, such as these, could result in serious medical issues going unaddressed.

Recommendation:

WHV should conduct an assessment of the grievances submitted to detect any patterns, as it may help to alleviate the number of grievances submitted. Similarly, WHV should conduct an analysis of the reasons behind missing, delayed, or incomplete-refills for medications as noted above. Both areas should be part of a continuing CQI process. I understand that Dr. Griefinger had previously requested information on the CQI process, but was not provided the information. WHV should initiate a CQI process in all of these areas.

Sincerely,

James C Welch, RN, HNB-BC

Confidential patient names:

[redacted]

Nursing Staff present during visit:

HUM: Price; RNs: Jones, Rose, Jackson, Iott, Hammons; LPNs: Manning, Thomas, Daily; RCA: Ware; Pharm Tech: Stewart