James C. Welch, RN, HNB-BC

14914 Deer Forest Road• Georgetown, DE 19947
Phone: 302 864 5499 • Fax: 302 855 9422 • E-Mail: jameswelch@seeliecourt.net

Date: March 24, 2015

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 to evaluate the nursing care of 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 January 12 – 13, 2015, interviews with staff, interviews with patients, review of documents, and review of medical records. 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.

All of my nursing record review was done in conjunction with WHV's health unit manager (HUM) to assure reliability and validity of my findings.

Medical and nursing care at WHV is provided through a combination of Michigan Department of Correction (MDOC) employees, and contracted physician and mid-level practitioners through Corizon, Inc.

Findings and Recommendations

A. <u>Medication Delivery</u>

During my visit, I observed the delivery of medications in the Segregation Unit only. The Registered Nurse (RN) identified the medication from the Electronic Health Record/Medication Administration Record (EHR/MAR), reviewed the patient name and identifier, and checked for the right dose and route. During the process of delivery of the medications to the patient she confirmed the name of the patient and reviewed the medications that were in the container. She also was diligent regarding the need to assure that each patient received each medication as ordered. When there was a question from the patient — for example one of the patients stated that she was to get three pills rather than two — the nurse went back to the MAR, checked on the correct dosage and returned to the patient with all the medications assuring that none were being given inappropriately. She also took note when a patient asked for any as-needed (PRN) medications. The RN noted the request and returned to the patient and delivered the PRN medication. Missing medications were noted and she checked the MAR to assure that the medication was ordered. The RN also accepted sick call slips, "kites," and took them back to the medication room, placing them in the inbox for triage and review. If there was a kite she was able to answer while in front of the patient, such as a PRN medication issue, she immediately answered the question posed on the kite request. There was also one patient who had refused her

psychiatric medications three times. The RN noticed this prior to pouring the medications and e-mailed the proscribing physician to notify him or her of the refusals. I noted that upon the RN's return from her rounds, the provider had already acknowledged the e-mail and was going to schedule to see the patient. I also noted that the facility had inhalers located on the outside of relevant cells for quick use should the patients require their use quickly. The Correctional Officer was present and asked each patient to open their mouth to assure that none of the pills taken were "checked".

While walking from one area of the facility to another, I observed long medication lines. Some of the inmates were extremely feeble and I observed they had difficulty walking to the lines and were shivering in their coats. The temperature that day was in the single digits.

Recommendation:

The medication delivery process as observed in the Segregation Unit was consistent with processes in major correctional institutions. The nurse was thorough and consistent during the entire process and she appropriately informed the proscribing provider of refused dosages.

However, the length of the medication lines, coupled with the severe weather that those who have to wait in line must endure, is a significant concern. This is inconsistent with practices for medication delivery. WHV should review the policy to see if there is anything that they are able to do to reduce the lines, deliver the medications in the housing areas, and make exceptions for those who are infirm/feeble.

B. Management Plans

There were seven (7) inmates under one-on-one observation in the Kent observation area. Four (4) had individual management plans, three (3) did not. One of the patients with no management plan had arrived on Saturday and another had arrived on Friday. My tour of the facility was on a Monday afternoon. The absence of a management plan is a critical deficiency as it is important for staff to be able to follow a plan for each patient. I also noted that the management plans themselves were generic in nature and were not specifically tailored to the particular needs of the individual patient. It is clear that they were formatted for ease of completion and were not targeted towards the particular patient.

Recommendation:

WHV should ensure that there is a process to establish and audit individualized management plans so that each patient on one-on-one observation has a current plan. WHV should provide training opportunities for the mental health staff to assure that the management plans are targeted towards the needs of that particular client, not simply a generic recitation that mirror one another.

C. Infirmary Observations

1. Chart Review Renal Patient

In reviewing charts with the HUM, I noted that a renal patient who was on dialysis had been refusing medications and dialysis on an intermittent basis. The patient would refuse dialysis for one or two days, then accept dialysis and medications, and then go back to refusing. On three occasions, her blood pressure was high (160/85, 173/92, 187/96, respectively) and there was no documentation in the chart as to a referral to the staff physician. This all occurred from December 1-13, 2013.

Recommendation:

Develop a process, either in the NextGen system or through a verbal report, for the RN to notify the physician of significant changes in vital signs for review and action if deemed appropriate by the staff physician. (NextGen is the electronic health record (EHR) used by the MDOC.)

2. Post-Surgical Care

A patient who had a mastectomy[ii] was returned to WHV on January 23, 2014 with 2 drains. From January 23, 2014 to February 03, 2014, there were inconsistent notations regarding when the drains were emptied, the condition of the dressings, if a dressing change was performed, and when the drains were removed. Some notes of the above were excellent, identifying the condition of the dressing, quality, consistency and amount of drainage, but they were inconsistent. For example, there was a clear notation of when the first drain was removed, but we were unable to find a notation of when the second drain was removed. We could only assume that it occurred sometime between February 03, 2014 and February 04, 2014 as a C/T of the chest was performed and there was no mention of the drain on the report.

Recommendation:

WHV must provide training on the importance of charting treatments of all patients. WHV should establish a Continuous Quality Improvement (CQI) process for treatments within the facility.

3. Patients with Foley Catheters

During my site-visit I noted that there were a number of inmates who either currently or previously had Foley catheters. In reviewing the electronic charts in NextGen with the HUM, I found no documentation in the chart as to when or if routine Foley care was given, or when the catheter was changed. When I asked one of the patients if Foley care had been given, she was unable to remember if or when it was given, and only responded that they "empty the bag when it is full." Foley catheters are a direct route to the bladder, and are a potential conduit for infection. Indeed, on this particular patient,[iii] review of the NextGen chart indicated that on December 18, 2014, Bactrim was prescribed for a urinary track infection. It is critical that routine Foley care be provided, and documented in the chart on an ongoing basis. It should be noted in the EHR and on the Foley catheter when it was changed and also on the plastic urine receptacle when that bag was changed. There was also no documentation of intake and output (I and O) in the NextGen system. In discussions with the HUM she suggested there was a way within the EHR to ensure the documentation of Foley catheter care that was provided, including the notation of I and O.

Recommendation:

WHV should develop a plan and process to assure Foley catheter care and routine cleaning, as well as ensure that it is documented in the EHR. WHV should further ensure that it is documented in the EHR when a catheter is placed. WHV must ensure that the process is followed to avoid potential urinary track infection for those patients who have an indwelling catheter and document insertion and care of the Foley catheter. WHV should also ensure that I and O is routinely recorded for all patients who have an indwelling catheter.

4. Staff

Staffing documents were sent to me for review. However, the staffing matrix was unclear as to the specific level of staffing. It was very difficult to actually identify which of the staff were assigned to the Infirmary area and which of the staff were assigned to other areas, such as the "pill line," etc. When I questioned the HUM, she indicated that the level of staff depended on the needs of the institution at the time and the "call outs" of nursing staff. That is appropriate. However, interviews with inmates who were in the Infirmary area indicated that they often have to wait a long while to be taken to the toilet as some of the cells are "dry cells" and do not have toilets in the cell. (See physical plant section below.) This is not appropriate. Furthermore, it was difficult for me to identify either the name or position (i.e., physician, a registered nurse, etc.) of staff members because their identification was not clearly visible.

Recommendation:

WHV should conduct a staffing analysis to determine the appropriate staffing levels for the level of care needed in the Infirmary and Segregation Unit. The level of care indicated by the patients may impact the demand on the nursing staff at any time and WHV must ensure that the patients' needs are being met. The name and level of licensure should be visible on the staff members at all times.

5. Programming

Long-term residents in the Infirmary have no access to activities and programs even though some are capable of participating in activities and programs. For example, one inmate[iv] is a talented artist and expressed a desire to teach an art class or participate in an art show. However, she said that she was not allowed to do so while she was in the Infirmary. An important part of the Americans With Disabilities Act is that those who may be classified as having a disability have the same, or similar access to programming as those in the general population.

Recommendation:

WHV must review the potential opportunities for those inmates in the Infirmary area for prison programming. Some accommodation may need to be made for the infirmity of the inmate, but some form of programming must be made available to the inmates housed in this area.

D. 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 times. 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. The HUM also indicated that if the 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. This may cause a delay in care and the potential for negative sequela.

Recommendation:

WHV should review the specific policy on sick call referrals to see if this may be a cause of the number of grievances which cite the "kite" process as a problem for inmates. If medically indicated, nurses must refer inmates to a physician.

E. Prisoner Observation Aides (POAs)

Along with the DOJ attorneys, I interviewed five (5) former Prisoner Observation Aides (POAs)[v]. Each of them identified situations where medical issues arose relating to the inmate they were observing and where nursing intervention may have assisted with the identified problem. For example, the POAs identified observing issues including inmates urinating or defecating in dry cell, defecating without cleaning self, having severely chapped and bleeding lips, not eating food, etc. However, there is no clear method or process by which the POAs can inform nursing/medical staff of health issues that may arise. This lack of a process creates a challenge for both the POA and the nursing staff who are charged with the wellbeing of the patients in the WHV facility. If the POA observes a situation that could require a nurse, there needs to be a mechanism for that to be reported to the nursing staff.

During the nursing change of shift report that I observed, there was no mention or coordination of a report from the POAs who were on the floor and observing patients, to convey information to the oncoming shift. The shift report only identified the number of patients who were in the hallway on POA status. Also, there is no nurse on the late shift (11:30 PM – 8:30 AM) at all, so there is no exchange of information as to what occurred overnight.

We were advised that the POAs create written reports while observing inmates. However, each of the POAs interviewed stated that they were specifically directed not to write anything in their report about medical issues. We were also advised that the POA reports are kept for three years, but only for the purpose of job performance reviews, not as a source of health information on the inmate being observed.

Recommendation:

WHV should establish a clear and identified process to ensure that health information and concerns about the observed inmates from POAs is reported to appropriate nursing/medical staff – both verbally and through written reports. WHV should also ensure that nursing and medical staff have access to the POA reports as a source of medical information. This is a golden opportunity for the WHV to obtain information on the wellbeing of patients that should not be wasted.

F. Physical Plant

In the Segregation Unit there are two types of cells: "wet" cells, meaning that they have a toilet in the cell itself which allows inmates to urinate and defecate as needed, and "dry" cells where there is not a toilet available to the inmate. The POAs interviewed indicated that there was no process or schedule in place for the inmates in dry cells to use the toilet facilities in the general area. They reported that this caused a problem for some of the inmates who then urinated and defecated in their cell. The POAs indicated that they had to ask security for the inmate to be taken to a toilet and at times, nursing also had to be present, depending on the infirmity of the inmate. This is also the case in the Infirmary area. Interviews with the patients in the Infirmary indicated that at times, it is difficult to get nurses to assist them for toileting. This was especially apparent in one of the four-bed cells where there was one patient who was incontinent and the other inmates who were in the cell expressed concerns that the inmate urinated in the room.

There was no documentation in either the nursing or the security documents that I reviewed for a set schedule for inmates housed in a dry cell for toilet or shower access. There was documentation in the EHR for some for the inmates indicating instances of toileting or showering, but this was not consistent.

Recommendation:

WHV should establish a clear process and procedure for those patients who are in a dry cell to get routine toilet and shower access. WHV should also require nurses to consistently note toileting and showering in the inmates' EHRs.

G. Grievances

I reviewed 77 (seventy seven) of the medical grievances submitted in December 2014. At the time of my review, over half (57%) of the grievances that had been submitted still had not been acted upon. A number of the grievances (16%) involved allegations that medication was either delayed, missing, or where refills were not completed. Although it was noted on some of the resolutions that the issue had been addressed, there is no explanation for the delay in the refill of the medication. Several of the grievances (8) complained of a delay in medical care or intake assessment.

I also noted that in some of the grievance responses, not all of the issues that were raised in the grievance were addressed. For example, in grievance WHV 2014 09 4052 12F the complaint about medications that had "run out" was not addressed.

Recommendation:

WHV should conduct an assessment of the reasons why there were so many grievances submitted, and not acted upon, 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. In addition, it is important that all issues in a grievance are addressed. Even though the patient is supposed to address only one area, WHV's response should still address all areas noted in the grievance. WHV should initiate a CQI process in all of these areas.

Sincerely,

James C Welch, RN, HNB-BC