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Our Independence Matters

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NCCHC Teams Up With National Partners to Improve Mental Health Care

Caring for mentally ill inmates has become a central challenge for correctional institutions. A 2014 study by the National Sheriffs’ Association and the Treatment Advocacy Center found there are currently 10 times as many people with mental illness in the nation’s jails and prisons as in state mental institutions. At Cook County Jail in Chicago, which Sheriff Thomas Dart refers to as the largest mental institution in the country, as many as one-third of the inmates are mentally ill, leading Dart to appoint a psychologist as the jail’s new warden and executive director earlier this year. “No longer can we view jails and prisons as places that happen to house mentally ill inmates,” he said. “Incarceration and mental health treatment have been infused; they are one and the same.”

Recognizing NCCHC’s expertise in mental health care, the National Institute of Corrections selected NCCHC to take the lead in developing a training curriculum to help jails improve their mental health care services and prepare correctional leaders to manage the influx of mentally ill inmates in and out of their jails.

“The National Institute of Corrections, through its collaboration with NCCHC, has developed a model for implementing mental health services that is specifically tailored to regional, county and local jails,” said Oscar Aviles, CJM, CCHP, recently retired director of the Hudson County (NJ) Correctional Center, who participated in a recent pilot class at the NIC Academy in Aurora, CO. “Based on the standards of care required by NCCHC, the NIC’s theoretical orientation is informed by the fundamental principle that good treatment results in good security,” he said.

Aviles serves as the American Jail Association liaison to the NCCHC board of directors.

NCCHC is also a key partner in the Major County Sheriffs’ Association project designed to divert individuals with serious mental health issues from incarceration in their jails to professional mental health providers and networks in the community. The project team surveyed MCCA members to help identify programs and processes that are working and represent the best opportunity for replication and ongoing success.

The project is made possible by a grant from the Department of Justice’s Community Oriented Policing Services (COPS), whose mission is to advance public safety through community policing, a law enforcement philosophy that focuses on community partnerships, problem-solving and organizational transformation.

New Edition of Juvenile Standards Now Available

NCCHC’s juvenile standards task force has finished updating the Standards for Health Services in Juvenile Detention and Confinement Facilities and the manual is being introduced at the National Conference on Correctional Health Care, where it will be featured in a preconference seminar on Oct. 17.

Led by longtime board member Robert Morris, MD, CCHP-P, who serves as liaison of the Society for Adolescent Health and Medicine, the task force was guided by the extensive updates in the 2014 Standards for Health Services for jails and prisons, with additional revisions reflecting contemporary practices in juvenile health care.

One significant addition is in standard Y-A-03 Medical Autonomy. A new compliance indicator requires that health staff are not to write disciplinary reports, and the Discussion section elaborates on this requirement. Another notable change is in Y-I-03 Forensic Information. Health staff are still prohibited from participating in the collection of such information, but the revised standard no longer allows for exceptions.

The Juvenile Standards may be purchased at www.ncchc.org/ncchc-store.
Recently, a friend who works in health care thanked her supervisor for allowing her to grow in her job with educational opportunities, mentoring and a minimum of micromanagement. We marveled that she felt the need to express her appreciation because she had routinely experienced the opposite throughout a long career. That led us to discuss what makes people love or hate their jobs, what makes them feel valued and respected. This is especially important in health care because a healthy work environment is most effective in caring for patients.

In the literature I have seen much about employees who quit their jobs. This can be detrimental to an organization’s cost-effectiveness due to the need to hire and train new employees. My observation as an employee, employer and surveyor is that many, perhaps most, people who are unhappy tend to stay where they are but become disengaged. Disengagement can take many forms: taking extra time to answer calls, “filing” sick slips in the trash, refusal to stay up to date on knowledge needed to do the job, routinely coming late to work and refusal to communicate with coworkers. Occasionally there is an incident of sabotage, as in the manager who stopped filing records after his supervisor refused to give him a new file cabinet. In most cases their resistance is not blatant enough for personnel action. The effect is an erosion of morale that can destroy an organization’s culture and undermine its reason for existence—in this case, the delivery of excellent health care.

When employees are disengaged it is most important to look for reasons. Many employees will talk about feeling undervalued. They say that they have approached supervisors with requests but have been ignored, or have not received a reasonable explanation for why the request cannot be granted. Some say that they are not given the educational opportunities that they feel they need. Some perceive that they are not paid equally for equal work. Some feel overburdened or are given more work than their coworkers. Some are unable to achieve a work–life balance. Some say that they have not been acknowledged for great work.

**Sense of Purpose**

Correctional health care organizations exist within the framework of much larger organizations and many personnel policies can make it seem impossible to properly supervise employees. However, the most satisfying job I ever had was in Virginia’s Department of Youth and Family Services, where I was included as a member of a team that had a purpose. I was given a position to play to achieve that purpose, but was allowed to create many of my own expecta-

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I have represented inmate plaintiffs and advised correctional systems about health care cases for over 35 years. I write to share some thoughts about CorrectCare’s cover story on peer review and litigation, Hindsight Is Bittersweet: Quality Improvement Studies as Evidence in Inmate Litigation (Summer 2015).

There is no federal privilege for peer review. This is the unanimous holding of numerous federal appellate courts that have addressed the issue (not just isolated district courts with “inconsistent” rulings, as the article suggests). Perhaps the leading case is Agster v. Maricopa County, 406 F.3d 1091 (9th Cir.), cert. denied, 546 U.S. 958 (2005). In Agster, an inmate who died experienced decreased respiration and irregular heartbeat after placement in a jail “restraint chair.” The court noted the need for transparency in corrections when it ordered disclosure of the mortality review conducted by the jail’s contractual provider:

Whereas in the ordinary hospital it may be that the first object of all involved in patient care is the welfare of the patient, in the prison context, the safety and efficiency of the prison may operate as goals affecting the care offered. In these circumstances it is peculiarly important that the public have access to the assessment by peers of the care provided. — Id. at 1094.

That corrections is different, calling for public review, can be traced to such early statutes as the English Coroner’s Acts of 1887 and 1926 (widely replicated in the United States), which required inquests of all prison deaths, whether “natural or not.” Thurston, “The Coroner’s Limitations,” 30 MED-LEGAL J 110, 111 (1962).

When a patient sues a physician for medical malpractice, the case looks at the accepted community standards of medical practice and whether the physician departed from them. The doctor’s subjective intent is largely irrelevant to this objective analysis. By contrast, “deliberate indifference” cases in federal court under Estelle v. Gamble, 429 U.S. 97 (1976), have a strong “subjective” component, in which the plaintiff must show that the defendant knew of a substantial risk to the patient and disregarded that known or obvious risk. Farmer v. Brennan, 511 U.S. 825 (1994).

Federal courts are concerned not with medical mistakes but with outright denial of care, extreme or abusive behavior, failure to exercise medical judgment or refusal to act on medical orders. They also examine systemic lack of resources and failures of supervision where they result in deliberate indifference to serious medical needs. Lack of quality assurance mechanisms, previously ordered by a three-judge court as a remedy for constitutional violations, was one of the bases for a receivership and later an inmate population reduction in California in Coleman v. Schwarzenegger, 922 F.Supp.2d 882, 891-96 (E.D. and N. D. Calif., 2009), aff’d sub nom. Brown v. Plata, 563 U.S. ___, 131 S.Ct. 1910 (2011).

Having watched this area, I can say that, in most of the cases in which inmates prevail in federal court, the safeguards that have prevented the problem from escalating to a civil rights matter had all broken down: the grievance system, the quality assurance program, peer review and employee discipline. In egregious cases, there is an effort to cover up such failures, sometimes by the people in charge or conducting the peer review. In one case, a prison dentist with an alcohol problem caused over 30 cases of patient emergency room visits due to drill slips when the dentist worked while impaired. The supervising dentist testified that he found no deficient care, even as the dentist failed a blood alcohol test in the warden’s office. In another case, an inmate hung himself on a ceiling fixture that was installed backwards so that sheets could be attached to it.

Disclosure of peer review documents (psychiatric autopsies) revealed that the subject death was the third such incident without corrective action.

For NCCHC accreditation, Continuous Quality Improvement is an “essential” standard. As important, and consistent with the above, NCCHC standards require a “corrective action plan” to remedy the deficiencies identified through quality assurance. See P-A-06; J-A-06 (2014). Completing this informational loop (from identifying the problem to providing a remedy) is a better inoculation from litigation than attempting to obfuscate responsibility or removing identifiers.

Health professionals (like lawyers) will admit if they are candid that they sometimes audit others better than they practice themselves, but knowing that they are writing for the federal record should not engender fear that their candor will come back to bite them. In the long run, courts are more impressed with good faith efforts to resolve problems than with attempts to conceal them.

William J. Rold, JD, CCHP-A
Rold is a former civil rights attorney and judge in New York City. He represented the American Bar Association on the NCCHC’s board of directors for six years.

The Authors Reply
Thank you for your letter and comments. We certainly agree that quality improvement benefits everyone as relates to the provision of correctional care. Our article advises providers that not every jurisdiction protects information obtained for quality improvement or review from becoming evidence in a federal or state court claim. We agree that improvement can only occur when those involved can be candid with what is working well and what is not. If there is incentive not to be candid, the review process cannot be as effective.

continued on page 20
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AMA Adopts Policy on HCV Treatment and Payment
The American Medical Association’s board of delegates has approved a resolution that supports HCV prevention, screening and treatment programs that target patients who would benefit most and that aim at maximum public health benefit. Of note, the policy supports adequate funding by governments, insurance companies and other third-party payers, including negotiation for more reasonable pricing of HCV antivirals. It also recognizes correctional and other public health physicians as key stakeholders in the development of HCV treatment guidelines.

Mortality in Local Jails and State Prisons
A total of 4,446 inmates died in 2013, an increase of 131 deaths from 2012, according to a recent Bureau of Justice Statistics report. This marks the third consecutive year of increase and the highest number of deaths reported to the BJS Deaths in Custody Reporting Program since 2007. While the number of illness-related deaths (such as heart disease, liver disease and cancer) in local jails declined, the decrease was offset by an increase in unnatural causes of death, such as suicide, drug or alcohol intoxication, accident and homicide. In state prisons, about 90% of deaths were related to an illness, 6% were suicides and 3% were homicides.

• Report: www.bjs.gov/index.cfm?ty=pbdetail&iid=5341

Study Promises Effective New Alzheimer’s Treatment
A noninvasive ultrasound technology has proven effective in restoring the memories of 75% of the mice treated with the technology, with no damage to surrounding brain tissue, according to a study in Science Translational Medicine, published by the American Association for the Advancement of Science. The “focused therapeutic ultrasound” activates brain cells that are responsible for clearing out the toxic amyloid plaques that cause cognitive decline and memory loss. The researchers plan to conduct trials with higher animal models, followed by human trials in 2017.

• Article: www.sciencealert.com/new-alzheimer-s-treatment-fully-restores-memory-function

Steven Spencer, MD, CCHP-A: 1929-2015
Longtime correctional health care veteran Steven Spencer, MD, CCHP-A, passed away on July 11 after a brief battle with cancer. Spencer was a lifelong champion of care for underserved people and, among his many accomplishments domestically and abroad, served as medical director of the New Mexico Corrections Department for eight years. He later worked as an independent correctional health consultant for many years. He had long ties with NCCHC, serving as a physician accreditation surveyor since 1992 and maintaining his Certified Correctional Health Professional credential since 1993. He also was a member of the Society of Correctional Physicians since 1993.

• Obituary: www.berardinellifuneralhome.com/obituaries/Steven-Spencer-4342497219
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As nurses, we are very concerned about being sued. We hear quite a bit about large monetary judgments against health care professionals on television and radio news, in professional journals and from each other. In reality, however, lawsuits and large monetary judgments are not as frequent against health care professionals, especially nurses, as one may perceive (see box on page 9).

Registered nurses and licensed practical or vocational nurses are far more likely to face disciplinary actions by their state boards of nursing than to be named in medical malpractice lawsuits. Compounding this situation is that nurses may have more than one disciplinary action brought against their nursing licenses if they are repeatedly reported to a state board of nursing or have a nursing license in more than one state. A little known fact is that if a nurse has more than one state nursing license and is disciplined by one state board of nursing, the nurse is subject to discipline in every state in which the nurse is licensed. Some state boards of nursing will discipline even if the nursing license is not current.

The underlying issue for nurses is whether or not they have practiced within their scope of practice by adhering to nursing practice standards. The depth and breadth in which individual nurses engage in the total scope of nursing practice depend on their education, experience, role and the population served. Education, knowledge and nursing skills form the basis for determining whether a nurse is practicing within scope. A six-step decision-making model (available through states boards of nursing) can help nurses determine whether they are being asked to accept an assignment that is commensurate with their scope of practice. The nurse must truthfully answer “yes” to each of the six questions before accepting the assignment. (See the model on page 10.)

Nurses who understand and adhere to standards of nursing care within their scope of practice generally deliver safe, quality patient care. A standard is an authoritative statement by which the quality of practice, service or education of the nurse can be evaluated. Standards include decision making and critical thinking in the execution of independent nursing strategies, provision of care as ordered or prescribed by authorized health care providers, evaluation of interventions, development of teaching plans, delegation of nursing intervention and advocacy for the patient. A necessary management tool in correctional nursing scope of practice is the collection, measurement and analysis of data to more efficiently manage the systems and processes used to deliver health care.

State Boards of Nursing
State boards of nursing use educational and clinical practice measures from professional nursing organizations to define and determine standards of practice. The role of a state board is to monitor nurses’ practice, including the use of nursing standards, in order to protect public safety. This role

By practicing within their scope and adhering to standards of practice, nurses protect not only their patients’ safety but also their licenses.
is contrary to many nurses' belief that state boards of nursing exist to protect them. However, this belief is not entirely untrue. State boards of nursing do provide some specific guidance to nurses on standards of care that they have developed. This guidance is generally called "rules" and is found under the heading of "rules and regulations."

Rules are often more specific than the nurse practice act established by law in each state. The NPA may require safe practice, whereas the rules may specify a plan for safe practice, such as requiring orientation and training for competence when encountering new or unfamiliar care situations. State boards expect nurses to know how to access standards, refer to them frequently and use them daily in their practices.

Standards are general to address overarching themes of practice, such as medication administration. An example is that "all nurses shall know the rationale for and the effects of medications and treatments and correctly administer the same." In administering medication, generally nurses must know the eight "rights": (1) patient, (2) drug, (3) dose, (4) route, (5) time, (6) reason, (7) response and (8) documentation. Depending on the setting, medication administration could be very different. For example, in a correctional health care setting "medication call" may be conducted differently than medication administration in an infirmary. What doesn't change is the underlying general theory of medication administration.

Nurses must adhere to rules developed and disseminated by boards of nursing because the rules are based on the law—the state nursing practice act. Nonadherence that is reported to the state board of nursing can be cause enough to investigate whether or not the nurse is a safe practitioner. Nonadherence to nursing standards can lead to employment issues and state board of nursing investigation. Investigations for potential nonadherence to nursing standards are assessed in terms of incompetence or unprofessional conduct.

State boards of nursing are legally required to determine whether an investigation of a nurse's practice is warranted. Common reasons for an investigation are being named in a malpractice lawsuit, termination from a nursing position, complaints to a state board of nursing that a nurse has violated a nursing standard, a criminal conviction and driving under the influence. In a state that requires fingerprints of all nurses, a criminal report that the person is an LPN/LVN or RN who is duly licensed in the state. If the person is not an LPN/LVN or RN, the board sends a report to the district attorney's office in the jurisdiction where the person is alleged to be practicing as a nurse. That is a criminal report that the person has committed an act of fraud on the public.

Second, if the person is indeed a nurse, an investigatory timeline is established. Generally, the more harmful the act, the shorter the time line. For example, if the complaint states that the actions of the nurse caused serious injury or death, the investigation may be accelerated. It is important to the board to remove, as soon as possible, nurses from practice when they present a risk of harm to the public. If the complaint is that the nurse gave a medication that was not ordered but no serious injury or death occurred, the time line may be longer.

The third step in this process involves two activities that may occur at the same time: (a) an investigatory letter is sent to the nurse and (b) the board starts to collect evidence.

The investigatory letter explains that the board has received information that the nurse may have violated the state's nursing practice act, and that an investigation has been initiated. The board investigator outlines what the alleged conduct or facts are, and asks the nurse to respond to the allegations. The complainant's name is not disclosed. The nurse is given the investigator's name and telephone number to call if the nurse has questions. Upon receiving the letter, the nurse has a limited time to respond to the board's inquiry, usually 30 days or less.

The second activity of this third step involves the board investigator requesting information from all reasonable sources, such as the nurse's employer and coworkers. Some of these sources may require a subpoena to obtain the necessary information.

The fourth step in the process starts when the board investigator has gathered all evidence from both the nurse and other relevant sources for review and offers a recommendation on how to dispose of the case. In most cases, the decision is to close the case because of lack of sufficient evidence.
Six-Step Decision-Making Model for Determining Nursing Scope of Practice

This decision-making flowchart was developed by Texas Board of Nursing staff to assist nurses in making good professional judgments about the nursing tasks or procedures they choose to undertake. For each question, if the answer is “yes,” the nurse may proceed to the next question. If any answer is “no,” the activity is not within the nurse’s scope of practice.

1. Is the activity consistent with the Nursing Practice Act, board rules and board position statements and/or guidelines?
2. Is the activity appropriately authorized by valid order/protocol and in accordance with established policies and procedures?
3. Is the act supported by either research reported in nursing and health-related literature or in scope of practice statements by national nursing organizations?
4. Do you possess the required knowledge and have you demonstrated the competency required to carry out this activity safely?
5. Would a reasonable and prudent nurse perform this activity in this setting?
6. Are you prepared to assume accountability for the provision of safe care and the outcome of the care rendered?

Source: Texas Board of Nursing, available at www.bon.texas.gov/pdfs/publication_decrreek.pdf

V

evidence to impose sanctions. Some cases are closed with prejudice—which means that the board won’t use the facts from the current investigation in any future allegations against the nurse—or without prejudice (the board may use the facts at hand in future allegations).

However, if the investigator found enough evidence to support sanctions against the nurse’s license, a proposed agreed order is given to the supervisor. The proposed sanctions can range from remedial educational courses to revocation of the nurse’s license. If the evidence reveals that the nurse may be impaired by drugs, alcohol or a mental health condition, the board may order an alternative to discipline. The nurse may be admitted into a board-approved nursing peer assistance program or a program that the board must approve that addresses the drugs, alcohol or mental health condition of the nurse.

If sanctions are brought against a nurse’s license, the nurse must sign the sanction agreement. The agreement, sometimes called an “agreed order,” becomes effective on the date that the executive director of the state board of nursing signs it. The agreed order enumerates the stipulations with which the nurse must comply and the length of time the nurse has to comply. It may have a stipulation of a fine, remedial education, limited nursing practice, suspended license for a period of time or revocation. After the nurse has received the signed agreed order, close monitoring by the board of nursing will start for the length of time indicated in the agreed order.

The state board of nursing investigatory and disciplinary process is important for many reasons. First and foremost, it indicates that the board is actively engaged in monitoring nursing practice to protect the public from incompetent and unsafe practitioners. Second, the board projects to the public that nurses who continue to practice are safe practitioners who adhere to all relevant federal, state and local laws as well as rules and regulations affecting the nurse’s current area of nursing practice.

Strategies for Safe Nursing Practice

Although correctional health care can be challenging, nurses who practice in these settings must at all times adhere to the standards of practice while practicing within their scope of practice. By doing so, nurses protect not only their patients’ safety but also their nursing licenses. And while doing so may not prevent a lawsuit, it is a powerful affirmative defense to it. In a board of nursing investigation, being able to articulate how one practices as a nurse will help to achieve a positive outcome. Articulation of one’s practice should be based firmly on the nursing process, nursing standards and ethical principles found in the American Nurses Association’s Code of Ethics for Nurses (2015).

Resources available to nurses practicing in correctional health care settings include those developed for nurses in community settings, the ANA’s Correctional Nursing: Scope and Standards of Practice (2nd ed.) and NCCHC’s Standards for Health Services as well as its position statements.

Should a nurse receive a state board investigatory letter, it must be read carefully, noting the letter’s date and deadline for responding. Failure to respond on time will cause the nurse to suffer a default judgment. If the nurse has questions or concerns about the letter, seeking advice from a professional nursing organization, such as the state nursing association, is a good first step. These organizations generally have staff who are knowledgeable about these types of situations. However, the nurse’s best first step is to contact an attorney, such as a nurse attorney, who is knowledgeable about nursing law in that state. Nurse attorneys were practicing nurses prior to becoming attorneys. Their understanding of nursing law is based on personal experience and formal nursing and legal education. The decision that the nurse needs to make is whether keeping the nursing license is worth retaining legal counsel.

Response to the investigatory letter should be in writing. Verbal response to the investigator is not sufficient. Additionally, writing the response enables the nurse to review what was said and allows for revisions without risking additional allegations. The response should incorporate the education, knowledge and skills that the nurse uses on a regular basis in practice. It should also reflect that appropriate standards and scope of practice employed are aligned with the nursing process.

Patricia Blair, JD, MSN, CCHP, is the principle of The Blair Firm, Houston, TX, a law firm specializing in health law, including nursing and guardianship law. She serves on the NCCHC board of directors as liaison of the American Bar Association. She is presenting on this topic at the National Conference on Correctional Health Care, Oct. 17-21 in Dallas. Contact her at pblair@pblairlawfirm.com.

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Effective Communication With Your Legal Counsel
How to Both Make a Difference in Your Defense and Get the Information You Expect

by Deana Johnson, JD

One complaint lawyers often hear from medical provider clients is they are not satisfied with the level of communication received from counsel during the pendency of the lawsuit. Unfortunately, this feedback usually comes when it is too late: after the case has ended. Effective communication with your lawyer throughout the inevitably stressful litigation process is as much your responsibility as it is your lawyer’s.

At the beginning of a suit, there is a flurry of activity. You receive suit papers, you contact your employer, counsel is assigned to represent you and an insurance representative is designated to follow the case on behalf of the carrier. Normally, your lawyer quickly arranges to meet with you either in person or via phone to discuss the allegations, your memory, etc. Hopefully, you participate in the drafting of your answer to the lawsuit.

What usually happens next is a lull in activity before fact discovery begins. This respite is the perfect time to express your expectations to your lawyer so that everyone is clear how involved you want to be and how much information you expect as the case progresses for the next few years.

If You Speak Up, You Largely Control Your Level of Involvement in the Discovery Process

Opportunities During Fact Discovery

You have little choice but to be involved as your lawyer drafts your written discovery responses. Not only will counsel need you to provide much of the information needed to compose the answers, you also must certify that the responses are true and accurate. If your deposition is requested, you will participate in its preparation, be the center of attention during the proceeding and review the transcript after it is completed to ensure accuracy.

However, there are myriad other discovery activities that take place, and your level of involvement is largely up to you. Some providers want to review all parties’ written discovery responses. Some find it very enlightening to sit in on fact witness depositions, especially if the defendant is new to the litigation process or if the case involves significant factual disputes about relevant events.

For example, if a malpractice case centers around interaction between you and the plaintiff that was allegedly not recorded in the medical chart, the plaintiff’s deposition is going to largely focus on this supposed exchange of information. Since you and the plaintiff are likely the only ones who were present during your patient-provider interaction, you are in the best position to refute the plaintiff’s testimony if it is not truthful. Think how helpful it would be for your lawyer to having you sitting right there, able to pass notes and provide information during breaks to further the cross-examination and prove any untruthful testimony.

Unfortunately, it is not only the opposing party who may give less-than-truthful testimony in deposition. If your case involves codefendant medical providers, they may testify in deposition about factual events involving you. They can also give harmful opinions about your actions if they think it will further their own defense. All of these things are less likely to be successful if you are present, looking them in the eye as they testify.

Opportunities During Expert Discovery

Next, when discovery shifts to experts, I strongly recommend that the provider defendant stay actively involved. If you have contacts for potential defense experts, share those with your counsel. Medical providers are busy professionals, and you have a far better chance of getting a well-known, respected colleague to take on the project of serving as the defense expert than your lawyer will.

If there are peers that you know will be biased against you for whatever reason, notify your lawyer. When you get the identities of the other side’s experts, see what you can find out about them from colleagues.

Consider attending the deposition of the main opposing expert, if feasible. As a party to the case, you have an absolute right to attend all depositions. Sometimes these take place out of town at odd hours, so that may not be a viable option, but you can participate via phone.

Your attendance serves several purposes. Some experts may feel constrained to be too negative in their opinions with the subject provider present. You can also give your lawyer important input to use in the cross-examination of the expert.

Whether you were able to attend or not, you should definitely review the transcript of the expert’s deposition after the fact and talk to your counsel about points of disagreement or important concessions the expert made. This exchange may lead counsel to add further defense experts to support you or change the focus of the defense of the case. While your lawyer is the expert on the law, you remain the expert on the medicine and, as your case develops, theories of the case and defense strategies will evolve, as well. Staying involved throughout the expert witness stage will not only give you peace of mind, it also will serve as an invaluable resource for your defense team.

After Expert Discovery Ends, You Need to Be Clear How Often You Expect Updates and What Information You Want to Receive

The discovery period is usually a fairly work-intensive time of anywhere from four months to several years, depending...
on the venue where your case is pending. After that period
ends, however, the real waiting game begins. Now, your case
is at the mercy of the judge’s calendar. During this time, it
is natural to have less contact with and correspondence from
your defense counsel.

That does not mean nothing is happening. The insur-
cance companies require periodic evaluations and updates,
the court may require your counsel to attend status and
scheduling conferences, the parties may discuss settlement,
lawyers assigned to your case may change, etc. Unless you
specify differently, your lawyer is probably only going to cor-
respond with you on matters that require your direct input,
such as the scheduling of a settlement conference where
all parties are required to attend. Otherwise, most of this
communication is between the lawyers and the insurance
company representative.

If you want to be copied on all that correspondence, you
have that right. You just need to express that desire to your
lawyer. If you want monthly updates, regardless of whether
an important event occurred during the past 30 days, your
lawyer will abide by your wishes if they make them known.
If you change your mind about how much information you
want during the case, your lawyer can accommodate that
shift if you communicate it.

**Communication Is a Two-Way Street:** Your Lawyer Needs to Know All of This Important Information, As Well
One of the hardest things to experience as a lawyer is sit-
ing in your client’s deposition (or live testimony at trial) and
watching them get hammered on cross-examination with information you do not have. Not only is this situa-
tion completely avoidable if the client is simply honest and
communicative, it also is devastating to a carefully crafted
malpractice defense.

As a medical professional, one of the strongest advantages
you have in defending a malpractice case is the public’s,
hence the jury’s, innate belief that you would not conscious-
ly do harm to your patient. If the other side is successful at
portraying you as less-than-honest, that advantage is lost.

Here is a list of the top things you need to tell your
lawyer both when you are first asked and throughout the
remainder of the case whether you are asked again or not:

**Your Social Media Habits and Content**
It is just amazing what information people post on the
Internet with a false sense of security and anonymity. Regard-
less of how private you think you have made your
Facebook page, the other side likely has a lot more informa-
tion about you from your social media than you think. You
need to give your lawyer a list (and access) to your posts,
tweets, web pages, etc. Assume that anything you have
posted in the past will be brought up if it helps paint you in
an unflattering light. Consider discontinuing using this type
of social media during the pendency of the case.

**Changes in Employment, Privileges or Licensure**
Not only does your lawyer need to know how to get in

**Other Lawsuits or Licensure Complaints**
While these may not seem at all relevant to your case, your
defense counsel needs to know about them. One very dan-
gerous path is to decide to answer a licensure complaint on
your own without the advice of counsel. Your good stand-
ing as a practitioner is key to your successful defense.

**Correspondence You Receive Related to the Case**
Do not assume that your counsel is copied with everything
you receive. For instance, the insurance company may send
you a letter outlining the case and any reservation of rights
it will assert. Another example is correspondence from your
licensing board. Even if your lawyer is representing you on a
board matter related to the litigation, the licensing boards
are notorious for communicating directly with the licensee
and not the lawyer. Inquiries from the media should be
forwarded to your lawyer. If there is a parallel criminal case
involving any of the parties or issues in your civil malprac-
tice case, notify your lawyer of any calls or correspondence
you receive.

**Additional Responsive Information or Documents**
Fact discovery may be long over, but it is your affirmative
obligation to supplement your responses with updated
information. If you were asked to provide all emails between
you and any other party to the case, and months after your
responses are filed you get an email from a codefendant, you
must give that to your lawyer so it can be produced in dis-
covery. Instead of trying to guess whether subsequent informa-
tion is relevant or discoverable, give it all to your lawyer
and let them earn their money by performing that analysis.

**Problems With Witnesses or Records**
When the case is first filed, lawyers spend a lot of time
comparing copies of medical records to originals, combing

continued on page 20
Mental Health Considerations for Segregated Inmates

By Jeffrey L. Metzner, MD, CCHP-A

The scientific literature remains problematic, due to methodological issues, concerning the impact of locking an inmate in an isolated cell for an average of 23 hours per day with limited human interaction and minimal or no programming in an environment designed to exert maximum control over the individual. However, mental health clinicians working in correctional facilities frequently report that it is not uncommon for inmates who have no preexisting serious mental disorders to develop irritability, anxiety and other dysphoric symptoms when housed in segregation units for long periods of time. Kaba and colleagues found self-harm to be associated significantly with being in solitary confinement at least once, serious mental illness, being aged 18 years or younger and being Latino or White, regardless of gender.

Zinger and Wichmann provide a very useful literature review relevant to the psychological effects of 60 days in segregation. They point out that the literature in this area is conflicting, filled with speculations and often based on far-fetched extrapolations and generalizations. Methodological shortcomings apparent from reviewing the literature include reliance on anecdotal evidence, response bias, nonexistent or poor comparison groups, wide variation regarding the conditions of confinement in different prisons, cross-sectional design in contrast to a longitudinal design study and an overreliance on field and laboratory experiments pertinent to sensory deprivation.

Zubek, Bayer and Shephard conceptualized segregation units as having three main characteristics: social isolation, sensory deprivation and confinement. Each of these elements can vary significantly, as will different inmates’ responses to the segregation experience. In general, the decreased or altered social interactions appear to be more of a problem from a mental health perspective compared to sensory deprivation. In fact, many of the milieus in such units are characterized by sensory overstimulation (e.g., inmates yelling for communication purposes or for other reasons). Radios and television sets, which may be available in these housing units, can decrease or eliminate sensory deprivation, although the severe disruption in normal social interactions remains a problem.

Barriers to Care

The difficulties of providing appropriate and adequate access to mental health care and treatment are especially problematic in a segregation environment. Logistical barriers frequently include inadequate office space and limited access to inmates because of security concerns. In correctional settings with inadequate mental health services, it usually is not difficult to find inmates with serious mental illnesses in segregation housing units because their untreated or inadequately treated mental illnesses often result in significant behavioral problems. Subsequent segregation placement often occurs due to the lack of available appropriate mental health housing and programming.

Gendreau and Labrecque describe the two dominant schools of thought regarding the impact of segregation housing on an inmate’s mental health. One school equates the segregation environment with torture since it is perceived to be psychologically very harmful to inmates. Another school’s position is that segregation results in far fewer negative effects and only for some inmates in prisons that meet basic standards of humane care.

Clinicians generally agree that placement of inmates with serious mental illnesses in settings with extreme isolation is contraindicated because many of these inmates’ psychiatric conditions will clinically deteriorate or not improve. In other words, many inmates with serious mental illnesses are harmed when placed in such settings. In addition to potential litigation, this is a main reason that an increasing number of the so-called supermax facilities will not admit inmates with serious mental illnesses.

Evolving Views

Consistent with the above, the Society of Correctional Physicians adopted a position statement in July 2013 that stated the following:

The Society of Correctional Physicians acknowledges that prolonged segregation of inmates with serious mental illness, with rare exceptions, violates basic tenets of mental health treatment. Inmates who are seriously mentally ill should be either excluded from prolonged segregation status (i.e., beyond 4 weeks) or the conditions of their confinement should be modified in a manner that allows for adequate out-of-cell structured therapeutic activities and adequate time in an appropriately designed outdoor exercise area.

SCP further recommends that correctional systems provide mental health input into the disciplinary process in order to appropriately shunt some of these inmates into active mental health housing and programming rather than disciplinary segregation when the mental condition is a mitigating factor in the commission of the infraction.

The American Psychiatric Association developed a similar position statement in 2012. There is a growing movement by health care staff and national organizations within the United States to exclude...
inmates from long-term segregation housing. These efforts at exclusion have been much more successful for inmates with serious mental illness. Improvement in the dismal conditions of confinement, however, should be extended to all inmates in segregation settings. This may require long-term advocacy and perseverance before such changes occur. Until then, the processes described below can at least minimize the harm caused by segregation housing units.

For many years, international treaty bodies and human rights experts, including the United Nations Human Rights Committee, the United Nations Committee Against Torture and the U.N. Special Rapporteur on Torture, have concluded that solitary confinement may amount to cruel, inhuman or degrading treatment in violation of the International Covenant on Civil and Political Rights and the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. Many correctional health care clinicians are unaware of these international views.

**Recommendations**

A mental health screening process, which should include screening assessments at the sending facility and the receiving facility with the segregation housing units, is a recommended mechanism to identify inmates with serious mental illnesses in a timely fashion. Inmates with serious mental illnesses and developmentally delayed inmates are usually excluded from admission to extreme isolation housing unless a specialized mental health program exists within the institution similar to residential treatment programs for general population inmates with serious mental illnesses.

Regardless of the admission policies relevant to inmates with serious mental illnesses, in a supermax facility, mental health staff should regularly perform rounds in all housing units as an additional mental health screening procedure. This screening is necessary as it is frequently not possible to predict an individual inmate’s reaction to confinement in a segregation unit characterized by extreme isolation. Use of a mental health liaison consultation model with the correctional and health care staffs, along with the rounds process, will facilitate the timely identification of inmates exhibiting acute symptoms of mental illness and the provision of appropriate clinical interventions.

Similar rounds should be performed on a regular basis by health care staff, preferably mental health staff, in other segregation housing units as outlined in the National Commission on Correctional Health Care’s Standards for Mental Health Services in Correctional Facilities. The Standards specify the required monitoring based on the inmate’s degree of isolation. If the monitoring is not provided by mental health staff, health care staff who do the monitoring should be trained on pertinent mental health issues.

While important for screening and triage, mental health rounds at the cell front do not substitute for clinically indicated assessment or treatment sessions. Such clinical interventions should occur out-of-cell in a safe setting that allows for adequate sound privacy.

A task force of the APA (2015) recommended that provision of essential mental health services in segregation housing should observe the following principles:

1. No inmate should be placed in segregation housing solely because he or she exhibits the symptoms of mental illness, unless there is an immediate and serious danger for which there is no other reasonable alternative. (This principle does not refer to medical or psychiatric seclusion, which should follow state mental health law and professional practice.)

2. Inmates with a serious mental illness who are a high suicide risk or have active psychotic symptoms should not be placed in segregation housing.

3. When an inmate is placed in segregated housing for appropriate correctional reasons, the facility remains responsible for meeting all of the serious medical and psychiatric needs of that inmate. Thus, such inmates must receive any mental health services that are deemed essential, their segregation status notwithstanding.

4. Inmates who are in severe psychiatric crisis, including but not limited to acute psychosis and suicidal depression, should be removed from segregation.

5. Inmates known to have serious mental health needs, especially those with a known history of serious and persistent mental illness, when housed in segregation must be assessed on at least a weekly basis by qualified mental health practitioners to identify and respond to emerging crises at the earliest possible moment.

6. Institutions should provide for regular rounds by a qualified mental health clinician in all segregation housing units. During these rounds, each inmate should be visited briefly so that any emerging problem can be assessed. The clinician should also communicate with segregation security staff to identify any inmate who appears to be showing signs of mental deterioration or psychological problems.

7. A policy and procedure should be developed and implemented relevant to the provision of mental health input into the disciplinary process with a focus on assessing potential mitigating factors that contributed to the inmate’s alleged disciplinary infraction.

8. Alternatives to prolonged segregation for inmates should be developed by correctional systems.

**Note:**

Jeffrey L. Metzner, MD, CCHP-A, is a clinical professor of psychiatry, University of Colorado School of Medicine, Department of Psychiatry, Denver, CO. This article is a reprint of a white paper that Metzner updated in August 2015. It has been edited to CorrectCare style, and it omits some citations and the reference list. These can be found in the version posted at www.ncchc.org/other-resources. The original paper appeared as an appendix in the 2008 edition of the NCCHC Standards for Mental Health Services in Correctional Facilities.
What Causes Clinical Errors?

by Lorry Schoenly, PhD, RN, CCHP-RN

This article is the fourth in a series on patient safety.

How easy it is to seek out “bad apple” employees as the cause of a clinical error. After all, most errors come down to a specific staff member missing an important assessment finding or miscalculating a medication dose. Unfortunately, clinical events are rarely that simple and, when investigated, are more often the result of a combination of system, process and individual factors. Applying models of error causation can provide a framework for getting to the true causes of error events so that lasting improvement can be made. Here are four models of error causation that can help organize information when investigating an adverse event.

Active and Latent Failures
Clinical errors usually have many attributing causes, which are categorized as either active or latent failures. Active failures are those readily apparent causes that can be seen at the point of care. These are most often the actions taken by a care provider, such as the example of a nurse giving a patient the wrong dose of a medication due to a mathematical error. Latent failures, on the other hand, are less obvious system design flaws. These are embedded in the system, often invisible at the point of care. In the wrong dose example, the error may have also been caused by a lack of unit dosing in the pharmaceutical operations and short-staffing that led to this nurse working a double shift.

Blunt End and Sharp End of Clinical Error
Viewing a clinical error from the “blunt end” and “sharp end” of care delivery can also be helpful (Figure 1). The blunt end, upstream from the clinical error, involves the many complexities of the structure and process in health care delivery that influence the point of care but are removed from it. This corresponds to latent system failures. Examples might be staffing patterns, a culture of silence or poor training resources for off-shift staff. The sharp end of clinical error is the point of patient contact; it corresponds with active system failures. Examples might be the inattention to the potential for infection, the failure to take adequate precautions or improper medication administration. In the prior wrong dose example, the sharp end of the clinical error involved the nurse’s dose miscalculation and the administration of the medication.

Swiss Cheese Model of Clinical Error
The image of the many and varied holes in Swiss cheese provides an analogy for the safety gaps in error protection that are incorporated into health care processes (Figure 2). This model proposes that a clinical error happens when multiple “holes” line up in the layers of system protection to allow penetration of the safety system and result in harm. Layers in the system may include various components of both the blunt end and the sharp end of the patient care system, and involve both active and latent failures.

Analyzing the wrong dose medication error using this model might identify causation through inappropriate pharmacy ordering practices, incomplete staff orientation and inadequate staffing to initiate a double-check process for the high-alert medication list. In the correctional setting, issues with security interface, the geography of care settings in the facility and characteristics of the patient population can add additional layers to further complicate the process.

All modern models of error causation take a systems approach—rather than a person approach—to clinical error. A person approach focuses solely on the sharp end of the process and assumes that primary responsibility rests on the individual provider at the point of care. In the person approach, error is the result of forgetfulness, inattention, carelessness or negligence. Research on error reduction has shown that, although the provider needs to be a part of the equation, a majority of the causes of error are inherent within the health care system. Changes to the system that reduce error achieve the greatest results.

Normalization of Deviance
In a complex system involving many staff members, various equipment failures and communication challenges, deviation from protocol can become normalized. The term “normalization of deviance” was coined during the investigation of the fatal Space Shuttle Challenger disaster in 1986. Inquiry revealed cases of overlooked warnings such as inclement weather forecasts and prior O-ring (a mechanical gasket) concerns. Since previous instances of these deviations did not result in injury, they were treated as normal and were not fully included in the launch decision. By cutting corners, ignoring protocol, repeatedly silencing equipment alarms and disregarding standard safety checks, deviation is normalized and becomes standard protocol.

Secondary to normalization of deviance is the establishment of a “culture of low expectation.” This culture develops in a setting where team members begin to anticipate faulty behavior and incomplete communication. Instead of demanding safe procedure, participants grow accustomed to the mediocre culture and participate in it. A culture of low expectation combined with normalization of deviance further increases the risk of clinical error and patient injury.

Lasting Change
By considering these models of error causation, you can supercharge your evaluation of clinical errors and develop lasting change through an effective improvement plan. Try them with your next error evaluation.

Lorry Schoenly, PhD, RN, CCHP-RN, is a nurse author and educator specializing in correctional health care. She provides consultation to jails and prisons on projects to improve professional practice and patient safety. This is an excerpt from the Correctional Health Care Patient Safety Handbook, available from amazon.com in print and Kindle versions. Contact her at lorry@correctionalnurse.net.
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Jail Menu Study Finds Nutritional Gaps

This may come as no surprise, but jail diets may not be optimal for good health. However, researchers say that small changes to the menu could improve the nutritional content of food being served and, potentially, improve inmates' health. That conclusion comes from a new study published in the October issue of the Journal of Correctional Health Care. Authors Emma Cook, MS, and colleagues are in the Department of Nutrition, Dietetics and Hospitality Management at Auburn (Alabama) University.

The team examined a 28-day cycle menu used in a county jail in Georgia, comparing the daily energy and nutrient content with the Dietary Reference Intakes published by the Institute of Medicine. The menu is strictly followed, except on major holidays, and is used for both male and female inmates. Inmates also may purchase food twice a week from the commissary.

The nutrients examined include energy (calories), protein, fat, carbohydrate and fiber, as well as 10 vitamins (thiamin, riboflavin, niacin, folate, B6, B12, A, D, E and C) and seven minerals (calcium, iron, zinc, phosphorus, magnesium, sodium and potassium). Fat, protein and carbohydrates were calculated as their percentage contribution to total energy.

To determine how these nutrients compared with recommendations, the researchers used the standard reference male (69.3”, 195.5 lbs., sedentary) and female (63.8”, 166.2 lbs., sedentary) and a reference age of 35 years.

The menu was also compared with the U.S. Department of Agriculture's MyPlate food group recommendations for grains, protein foods, dairy, vegetables and fruits, based on 2,600 calories for males and 2,000 calories for females.

Strengths and Weaknesses

The investigation found that the jail's menu provided adequate amounts of several vitamins and minerals, including thiamin, riboflavin, niacin, B6, B12, folate, C, phosphorus and iron. However, vitamins A, D and E, as well as magnesium and potassium, were provided in quantities of less than two-thirds of recommendations. Calcium and zinc were at less than 80% of recommendations.

The menu also met recommended percentages of energy from the three macronutrients (fat, protein and carbohydrates). But the menu provided high calories for females, and for all inmates, high levels of cholesterol, saturated fat and sodium, and less than recommended amounts of fiber and some vitamins and minerals. The menu did not meet MyPlate guidelines for grains (overrepresented) and fruits, vegetables and dairy products (underrepresented). The study did not factor in commissary foods items, typically high in fat and sodium.

The authors make several recommendations for menu improvement, including reducing portion sizes for female inmates. To increase dietary fiber, whole grain products could be substituted for some refined grains, and legumes, beans and peas could be provided in “southern comfort” dishes. Adding fruits and vegetables would add fiber as well as several vitamins and minerals.

To reduce saturated fat and cholesterol, the menu could limit the provision or portion sizes of sauces, gravies, eggs, sausage and lunch meats, and consider adding meatless options such as bean dishes. Serving fortified low-fat or nonfat milk and/or yogurt instead of eggs a few times a week could add more calcium and vitamins A and D. Sodium content could be reduced by decreasing use of packaged foods and processed sandwich meats and by offering lower-sodium options in the commissary.
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through EMRs to make sure everything printed in order to produce a “complete” copy of the record, interviewing witnesses about any memories that are not recorded in the chart, etc. However, as time passes, things can easily change. A nurse who was completely on your side when the suit was filed may have moved on to another job and now believes you failed to communicate an important fact about the patient’s condition to him. Records that you had never seen before may appear in the chart, obviously added after the fact by someone who thinks they are helping. Your lawyer needs to know about these changes as soon as you discover them. That being said, it is not your role to assess coworkers to determine whether they will make good witnesses for you. Your lawyer will interview them and find out, as long as you provide a list of those important witnesses to your counsel.

Deana Johnson, JD, is vice president and general counsel for MHM Services, Inc., Atlanta, GA. She presented on this topic at NCCHC’s 2015 Spring Conference on Correctional Health Care in New Orleans. This article is reprinted with permission from the Spring 2013 issue of CorrDocs, the newsletter of the Society of Correctional Physicians / American College of Correctional Physicians. It has been slightly abridged for CorrectCare.

In order to encourage candor without incriminating any particular person, it may be best to document that a medication error occurred because the bottles for TB shots and tetanus shots are too similar and are stored next to each other in the medical refrigerator. Solution: Keep medications in different areas; add colored labels to these medications to clearly identify. This would seem better than saying Nurses Jane and Sally gave inmates Brown, Smith, Washington and Thomson tetanus shots when they should have received TB shots. Certainly, patients should be told about errors as soon as possible, but making quality review information easily obtainable may encourage litigation and discourage candid reporting and documentation of issues that certainly need to be addressed.

As attorneys who represent medical providers in the correctional system, impressing the Court has little value when defending claims. Evidence regarding this type of information may be confusing and influential with a jury in inappropriate ways. Comments made by coworkers or unqualified staff about another individual’s care and treatment may be based upon bias or dislike for that person, rather than having a basis in fact. These comments are often hearsay or lack foundation, but can make their way into a court record as notice of an issue. While I often would agree that notice has been provided, the context presented to the trier of fact may inappropriately taint the jury, ultimately leaving the health care providers with a disincentive to participate openly in the improvement process.

It is undeniable and unfortunate that egregious cases exist as you have described. Those scenarios can and have occurred both within and outside of the correctional setting. In no instance should they occur. Eliminating and/or significantly reducing medical errors should be the goal of any medical facility regardless of where and to whom the services are provided. Our article was meant to provide accurate information regarding the law of privileges in the various jurisdictions in order to make correctional care workers both aware so that they may tailor their quality review process accordingly and/or to encourage them to lobby for more legal protections for medical providers regardless of the settings in which they practice.

Theresa Powell, JD
Powell is the managing partner of the Heyl Royster office in Springfield, IL, and coauthored the original article with Jana Brady, JD, and Keith Hill, JD.

We welcome your comments about this issue of CorrectCare. Send an email to editor@ncchc.org, or write to Editor, c/o NCCHC, 1145 W. Diversey Pkwy., Chicago, IL 60614. Please include your full name and a phone number. Letters may be edited for clarity or length.
CCHP-P Task Force Member Devoted to Caring for Vulnerable Populations

by Barbara S. Granner

For Ilse Levin, DO, MPH, CCHP-P, it’s all about the patients. “When inmate-patients finally begin to feel better, begin to understand their health needs and to feel that someone cares what happens to them, it is very rewarding,” she says.

Levin serves as the liaison of the American Medical Association on the NCCHC board of directors, which she joined in 2011. She has a strong interest in international public health and her work has taken her around the world: She has conducted research on tropical medicine in Australia, Myanmar, India and Papua New Guinea, as well as donating her time and talent as a volunteer physician in Uganda and Papua New Guinea.

An internist, Levin has been involved in correctional health care since medical school, when one of her first rotations was at Patton State Hospital, a forensic psychiatric facility in San Bernardino, CA, that houses offenders who are mentally disordered, incompetent to stand trial and not guilty by reason of insanity. “The patients were in such need of care and were generally much sicker than the average patient I would see in the general community,” she recalls.

With her interest piqued, in 2009 she began working for Unity Health Care, a Washington, DC, nonprofit that offers a continuum of medical care and human services to underserved populations including homeless, indigent and individuals incarcerated in the DC jails. For five years, she was a staff attending physician at the DC Department of Corrections, working closely with the psychiatry department to provide integrated care for patients, and she continues to work at the jail on an as-needed basis.

At the same time, she worked at Unity’s reentry clinic, which provides primary care and social services to people returning to their communities. According to the Bureau of Justice Statistics, nearly 650,000 people are released from prison each year. Most of them have few resources for navigating reintegration into society—including finding work, securing housing and accessing health care and substance abuse services that are crucial to successful reentry. “Much of success in our society is based on access to resources,” Levin points out. “Reentry programs can offer that access.”

Unity’s program provides care to more than 8,000 people annually. “Patients may not know how to take their medications, such as insulin, or how to obtain their medicines. They may need help applying for insurance,” Levin says. “We often have patients who have been incarcerated for 20 or more years. For those individuals, reentering society can be particularly difficult.”

Advocate for the Incarcerated

Levin recently earned her CCHP certification, and was a member of the task force that developed NCCHC’s new CCHP-Physician specialty certification program. “I think it’s important for all physicians who work in correctional health care to get this certification,” she says. “The knowledge a physician needs to work with incarcerated populations goes beyond what we learn in residency training.”

“This is a population that truly needs the support of the medical community,” she adds. “They are some of the most vulnerable patients, and they are easily forgotten. But now the medical community has become advocates for the incarcerated. I hope to see more and more physicians taking the CCHP-P exam and continued support for quality care for incarcerated populations.”

Barbara S. Granner is NCCHC’s manager of marketing and communications.

The CCHP Program Thanks YOU!

As another year draws to a close, the CCHP board of trustees would like to express its gratitude to all of the Certified Correctional Health Professionals who continue to make this program a great success.

For those of you who are not yet certified, make it your New Year’s resolution to commit to increased knowledge and professionalism in 2016. The calendar at right is only a snapshot of the testing opportunities available. We encourage you to talk with your employer about setting up an exam at your facility.

CCHP Exam Dates

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<thead>
<tr>
<th>Date</th>
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<tr>
<td>February 20</td>
<td>Regional sites</td>
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<td>April 10</td>
<td>Nashville, TN</td>
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<td>June 4</td>
<td>Regional sites</td>
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<td>July 16</td>
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<td>October 23</td>
<td>Las Vegas, NV</td>
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Nurse/nurse practitioner 39%
Physician/physician assistant 28%
Administrator 10%
Psychiatrist/psychologist 8%
Social worker, therapist, counselor 7%

Decision Makers With Authority
State/facility medical director, director of nursing, other directors 17%
Health services administrator 8%
Department manager/supervisor 15%
Health services, dental or mental health staff 20%

Who Do Attendees Represent?
Jail facility 50%
Prison facility 17%
State DOC/agency 9%
Private corporation 9%
Juvenile detention or confinement facility 4%
Federal agency 3%

Categories Attendees Recommend or Buy
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EMPLOYMENT

Infectious Disease Medical Director - SC Department of Corrections/USC Internal Medicine

USC School of Medicine seeks an Infectious Disease physician to serve as ID Medical Director for the SC Department of Corrections (SCDC) Broad River Correctional Institution/Kirkland facility with a clinical faculty appointment as Assistant/Associate Professor of Medicine. This is a clinical position based at SCDC and is predominately responsible for directing inmate infectious disease health care delivery services and coordinating the infectious disease training of all medical providers serving in the SCDC facilities around the state of South Carolina. This position reports to the SCDC Medical Director and the Asst. Deputy Director of Health Services for the SCDC. As a USC Department of Medicine faculty member, this position joins our innovative educational, clinical, and research programs in the infectious disease division.

SC Department of Corrections:

Infectious Disease Medical Director – SCDC Broad River/Kirkland complex

- Provides the coordination of health care, medical treatment, and services for HIV-infected inmates.
- Supervises mid-level providers and clinical staff at SCDC.
- Provides ID/HIV education and training of SCDC personnel and medical providers serving in the SCDC facilities across South Carolina.
- Provides inpatient infectious disease consultation at the Broad River/Kirkland facility.
- Develop and implement infectious disease programs such as Antimicrobial Stewardship, Infection Control, Epidemiology, Telemedicine, and infectious disease treatment protocols.

USC School of Medicine:

Assistant/Associate Professor of Clinical Internal Medicine - Division of Infectious Disease

- Provide ID patient care including attending on inpatient teaching services at Palmetto Health Richland and outpatient clinic at USC Immunology Center, focusing on released inmates.
- Participate in research projects impacting quality and delivery of inmate care, such as infection control, antimicrobial stewardship, HIV, and Hepatitis C.
- Supervises medical students, residents and infectious disease fellows.

Qualified applicants must have a MD/DO degree, successful completion of accredited Internal Medicine Residency program and Infectious Disease Fellowship program, Board Certification in Internal Medicine and Board Certification or Board Eligibility in Infectious Disease, and be eligible for licensure in South Carolina.

Salary commensurate with experience. Interested applicants should submit a letter of interest and CV to: Shawn Chillag, MD, Professor and Chair, USC Department of Medicine, 2 Medical Park, Suite 502, Columbia, SC 29203 or email at shawn.chillag@uscmed.sc.edu. The University of South Carolina is an AA/EOE employer. Women and minorities are encouraged to apply.

Registered Nurses $65,000 Annually

The Michigan Department of Corrections offers great opportunities for Registered Nurses to practice in locations throughout the beautiful state of Michigan. We are looking for motivated individuals to provide professional nursing care to patients in our correctional facilities. Benefits include:

- Health, vision, and dental insurance!
- 401K retirement account!
- 12 paid holidays annually!
- Accumulation of Vacation and Sick hours!

Candidates must possess a Michigan Registered Nurse license in good standing. Registered Nurses $65,000 annually. Plus overtime availability. RNs working second and third shift also receive an additional 5% shift premium.

To apply for this position visit the web site: http://agency.governmentjobs.com/michigan/default.cfm

A Drug Free and Equal Opportunity Employer

Jail Health Director

Northwest Regional Council (NWRC) seeks experienced individual to serve on executive team and manage jail health nursing services contract within Whatcom County jail in Bellingham, WA. With Puget Sound and the San Juan Islands to the west, snow capped Mt. Baker and the Cascade Mountains to the east, and the surrounding area dotted with lakes, Bellingham is a breathtakingly beautiful place to live and work. For full job description and application packet, go to http://www.nwrcwca.org/employment/. Open until filled. EOE.

About CorrectCare®

CorrectCare is the quarterly magazine of the National Commission on Correctional Health Care. Its mission is to publish news, articles and commentary of relevance to professionals in the field of correctional health care.

Subscriptions: CorrectCare is mailed free of charge to members of the Academy of Correctional Health Professionals, key personnel at accredited facilities and other recipients at our discretion. To see if you qualify for a subscription, create an account online at www.ncchc.org or email us at info@ncchc.org. The magazine is also posted at www.ncchc.org.

Change of Address: Send notification four weeks in advance, including both old and new addresses and, if possible, the mailing label from the most recent issue. See page 1 for contact information.

Editorial Submissions: Submitted articles may be published at our discretion. Manuscripts must be original and unpublished elsewhere. For guidelines, email editor@ncchc.org or call 773-880-1460. We also invite letters or correction of facts, which will be printed as space allows.

Advertising: Contact Carmela Barbany, sales manager, at sales@ncchc.org or 773-880-1460, ext. 298.

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Q: In our state, the law requires that the sheriff’s office house people who are intoxicated but not under arrest. We conduct a brief screening, but are we required to do a full receiving screening?

A: For jails, the Receiving Screening standard (E-02) requires a receiving screening as soon as possible. This includes anyone being detained, arrested or housed for any reason in the facility. If the brief screening mentioned does not include all of the inquiries required by this standard, then staff would need to conduct a receiving screening on these individuals, as well.

Q: Is a clinical performance enhancement review required for part-time and per-diem nurses and subcontracted nurses?

A: The Clinical Performance Enhancement standard (C-02) requires that the clinical performance of the facility’s direct patient care clinicians and RNs and LPNs is reviewed at least annually. The intent of the standard is to enhance patient care through peer review of the individuals’ practice, and therefore it applies to all nurses regardless of the number of hours worked per week.

Q: We have an infirmary in our jail and custody staff is always stationed outside of the infirmary, in full view through a very large window. Since standard G-03 Infirmary Care requires that patients are always within sight or hearing of a qualified health care professional, would we meet the “within hearing” requirement if we, on occasion, had the infirmary nurse, who carries a radio, work in another section of the infirmary away from any patients? The nurse could be readily be reached by radio by the custody staff who are at the infirmary post and able to fully view the patients.

A: The Infirmary Care standard requires that patients are always within sight or hearing of a qualified health care professional. The use of an officer to notify health staff of an infirmary patient’s needs does not meet the intent of the standard. Please keep in mind, though, that this applies only to patients admitted to the infirmary and not those in the infirmary area for sheltered housing.

Tracey Titus, RN, CCHP-RN, is NCCHC’s manager of accreditation services. If you have a question about the NCCHC standards, write to accreditation@ncchc.org or call 773-880-1460. For an archive of past Standards Q&A questions, visit the Standards and Guidelines section at www.ncchc.org.
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