GRIEVANCES
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Best Practices for Patient Safety in Corrections

A valuable new white paper provides a thorough overview of the concept of patient safety, as well as specific steps for making patients safer in the correctional environment. Commissioned by NCCHC, the white paper was written by correctional health care expert Marc Stern, MD, MPH.

Stern briefly recounts the background of the patient safety movement and gives several definitions, but says it is more useful to focus on the goals, tools and typology of patient safety. “To achieve safe care, we try to eliminate errors in the provision of that care,” he says, outlining several ways to classify errors, such as errors of planning and errors of execution.

The majority of the document provides steps for making patients safer, relying on the best evidence available. These steps are grouped into four categories: how to avoid preventable adverse effects, how to increase patient safety after preventable adverse effects have occurred, what individuals can do to bring patient safety to their facility and what organized correctional medicine can do to increase patient safety in the field.

The paper is augmented by a recommended reading list and four appendices: the recruitment/retention plan of a state department of corrections, the Rand patient safety standards, the John Jay standards for patient safety in prisons and examples of how the John Jay standards can be used to enhance a health care operation that follows the NCCHC standards for health services.

Find the paper at www.ncchc.org/other-resources, along with nearly two dozen guidelines, management tools and white papers on important correctional health care topics.

Gunshot Wounds in Youthful Offenders: Webinar Recording

Presented by three leading experts on juvenile gunshot wounds and corrections, this webinar addresses the incidence of gunshot wounds in the Cook County (IL) Juvenile Temporary Detention Center. The largest single-site juvenile detention facility in the country, CCJTDC counts gunshot wounds among the top seven health conditions in its population. The program covers the attendant injuries incurred, PTSD responses, CCJTDC’s approach to treatment and management, and community care models for follow-up.

The webinar was hosted by NCCHC’s juvenile health committee and presented by Ngozi Ezike, MD, CCHP, medical director, Cermak Health Services at CCJTDC, and assistant professor of pediatrics, Rush University; Faran Bokhari, MD, chairman, Cook County Trauma & Burn Unit; John H. Stroger, Jr. Hospital; and J. Brian Conant, PsyD, CCHP, mental health program director, The Isaac Ray Center at CCJTDC.

The one-hour program was recorded Sept. 7, 2016. The recording and PowerPoint are available free of charge at the NCCHC University page at www.ncchc.org/NCCHC-University, along with several other webinars.

Give Back to the Field—And Earn CCHP Credit!

The continued growth and success of NCCHC’s Journal of Correctional Health Care depends on individuals who volunteer to review manuscripts. With our move to an online manuscript management system, the number of submissions has increased greatly, along with the need for qualified peer reviewers to provide timely feedback to authors. Authors have taken the time to develop their manuscripts and to share what they have learned. Likewise, doing peer review is a service to other correctional health professionals. And—did you know?—Certified Correctional Health Professionals earn credit for recertification when they review manuscripts.

All professional specialties/disciplines in medicine, nursing, legal and operations/administration are needed. Guidelines for reviewing are included with each manuscript assigned. We invite you to join our team to help strengthen the content published. If interested, write to JCHC editor John Miles, MPA, at journal@ncchc.org.

Finally, we are very grateful to the cadre of reviewers who have supported and continue to support the Journal.

Congratulations to Our Early-Bird Registrant!

Heidi Abbott, LPN, CCHP, is the winner of a drawing among all who registered for the National Conference on Correctional Health Care by the early-bird deadline. She won a two-night stay at the Paris Hotel in Las Vegas. Abbott is assistant director of nursing at the Montana State Prison.
The Objectified Inmate Converted to Consumer: Everyone Gains

by Fred Cohen, LLM

Persons held in penal captivity tend to be objectified, to be dealt with as objects who are acted upon as part of the lopsided power relationship between keeper and kept. As “objects”—or, more kindly, recipients who legally must receive specified, basic items necessary for physical survival—there is now no room for what I will call a consumer perspective whereby inmates may voice complaints linked to satisfaction with a product or service. Failure to receive something related to survival is, of course, a matter of legitimate concern, even litigation. Satisfaction with the condition, commodity or service is quite another matter.

Inmates remain within the boundaries of their role as recipients when they complain about food, shelter, clothing, health and the safety of physical conditions, but those complaints cannot successfully rest on anything resembling what we think of as consumer satisfaction. By consumer satisfaction I simply mean a belief, or concern, that the item or service fulfills the recipient’s needs or wants; that it was or service is quite another matter.

Inmates may file a federal lawsuit after exhausting internal grievance procedures, but that which is complained about must focus on deficits that exist at the “outer fringes of civilized decency”: deliberate indifference to necessary health care; the malicious and sadistic use of force; food and water unfit for human consumption. The “minimal conditions for human survival” is a popular overarching legal test for measuring inmates’ claims of constitutional deprivation.

For example, inmates are constitutionally entitled to clothing minimally adequate to meet the conditions of their confinement. A complaint that the clothing provided was ill-fitted (or—gasp—not stylish) is a consumer-oriented complaint and will not be successful.

Creating a Better Environment

If custodians viewed those in their custody as people, not merely the objectified detainee, convicted or condemned, and came to view their satisfaction with various aspects of institutional life as a decisional factor in running a jail or prison, there could be an enhancement in security along with the creation of an environment more receptive to treatment, rehabilitation and mutual respect.

I will quickly concede that the consumer perspective in the competitive world of commerce is closely linked to the supplier obtaining and retaining business. Inmates do not get to choose their vendors or service providers. They must accept what is proffered if the minimal attributes of training, competence or fitness for the purpose provided are present.

I am not here addressing consumer satisfaction in the traditional sense as an aspect of commercial intercourse. I am speaking to a penal facility management style that includes the inmates’ perspectives, evaluations and even ideas on how to enhance inmate-consumer satisfaction.

In the world of commerce, consumer satisfaction quite often is linked to customer expectations. Here, the reference must include the provision of basic needs along with how those needs are met.

In my work as a federal court monitor or in performing a pretitigation study of a facility (or system), I view the inmates as consumers whose narrative may provide extremely valuable input. I put together inmate focus groups, to be discussed shortly, and for an hour or so I ask questions and listen. You might be surprised, even amazed, at how even-handed so many inmates are. For every Correctional Officer Jones who brutalizes them, I will hear about a CO Smith who listens, takes them to recreation, doesn’t call them names and treats them like people, even if they screwed up.

For every doctor, nurse or dentist who is pilloried for providing poor care and treating the inmate as though every complaint is malingering, there are others who are extolled, praised and valued.

Pay Attention to Dissatisfaction

Where a validated consumer complaint pitches the level of care or services below constitutional minima (“I never see a doctor!”), then a mandatory official reaction is required. Where the pitch is more like dissatisfaction (“My food was cold and tasteless; the shoes don’t fit just right; CO Jones calls me a fag”), then a mandatory official reaction is required. Where a validated consumer complaint pitches the level of care or services below constitutional minima (“I never see a doctor!”), then a mandatory official reaction is required. Where the pitch is more like dissatisfaction (“My food was cold and tasteless; the shoes don’t fit just right; CO Jones calls me a fag”), then a mandatory official reaction is required. Where the pitch is more like dissatisfaction (“My food was cold and tasteless; the shoes don’t fit just right; CO Jones calls me a fag”), then a mandatory official reaction is required.

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offered and adequacy may be importantly grasped by talking with inmates who are the consumers of mental health care. Timeliness of screening, availability of staff and programs, the state of health care records, even accreditation by the National Commission on Correctional Health Care all matter. They are the ingredients of spreadsheets.

What the consumers report, what’s right and wrong and what would it take to improve are just as important. Indeed, more important in my mind.

My proposal seeks input from the inmate-consumer as one way to assess the human rights barometer in a facility (or system) and to help determine the availability and quality of required services and commodities. I must emphasize that the information obtained from inmates need not be viewed as the unvarnished truth; that accounts of improper behavior by staff typically cannot be viewed as anything more than sufficient cause for further investigation; that complaints about the amount of food served or that bugs often are in the food, again, are a basis for investigation.

The inmates in a focus group often fear retaliation. Staff will know who was in the group, even if they do not know who said what. The person conducting the group is morally, if not legally, obligated to shield the group from retaliation.

**Focus Groups and the Consumer Perspective**

What follows is an outgrowth of my own experience with focus groups in three state prison systems. My roles were a federal court monitor overseeing health care, the head of an investigation team working under a federal court order or a consultant to a state system seeking relief from a long-standing consent decree focused on mental health. The important ingredient: I was an outsider but one with rather open access to inmates. My experience included adult prisoners and juveniles adjudicated delinquent.

Whether investigative or oversight in nature, the process and outcomes from the groups did not seem to vary. Juveniles could be a bit more difficult, particularly all-male groups where, for example, I might have inadvertently selected opposing gang members to be in the same room. In that case, resistance prevailed and only afterward did I learn of the unfortunate selection.

**Selection**

Who is selected for the focus group is vital and the selection process can be delicate. As an outsider, I had to rely on some officials’ input and cooperation. If the focus group is conducted by a staff member, then the problems of selection are different.

Let’s focus on mental health care as an example. If my interest was in the functioning of a mental health unit, I would ask for six to eight inmates for the group and that two be among the most recent arrivals, two or three the longest in residence and the others (depending on my mood) should include one who has filed multiple grievances about care or another who staff find cooperative and uncomplaining, as well as the inmate who is thought to be “the sickest” and so on.

My effort is to get some variety and to pursue randomness. If I am doing multiple groups from the same unit, I might try to be consistent on selection criteria but it is not a vital concern. Why?

Invariably, a theme related to care will emerge early and then tends to be confirmed as the focus-group day progresses. If the unit is a segregation unit, exactly the same type of selection process is useful and the confirmation of consistent themes also generally is the same: “We never get recreation; we don’t get our required showers; second-shift officers call us names, stir us up.”

There is no pretense here of scientific selection or randomness in the unvarnished sense. You are looking for themes, names when possible and a response to “... and what can be done to change this?”

**The Session**

Obviously, the topic or the place of interest will drive the questions and discussion. This time using a group of inmates in the segregation unit as an example, I will first ask how long they have been locked down and what got them there. I will next ask what is the worst thing about doing time in this segregation unit and follow-up questions will take their course.

I initially insist that they talk about what they have experienced directly, not what fellow inmates complain about. I will ask the same “softball” questions of each inmate, but as I get to inmate #4 or #5 a pattern will emerge, such as “We never get the out-of-cell exercise we are supposed to get,” and I will shift.

“Do you agree with what everyone has said about that?” “Yes, I do.” “OK, let’s talk in detail about that. How does staff deny you the right? Weather? Too busy? What else?”

I do not have a checklist of questions. I find the sessions flow when they are softly structured—inmates speak only in order—and the discussion is fluid. It is vital to show the inmates that you care about them and value what they say. Don’t be afraid to probe or even express disbelief: “Come on, CO Smith did not expose himself to you?” If every other inmate chimed in: “No, man, that’s what he does,” you can record “probable cause” to believe it.

The person conducting the session is not looking for truth in some abstract fashion; you are looking for credible accounts of misconduct and appropriate conduct. You want the consumer perspective on recreation, showers, a safe environment, heat, ventilation and so on.

Where a particular issue is widely reported (e.g., “We never see the psych down here”), you have probable cause to go further (when allowed to) and check records or even interview the “psychs.” You certainly have enough to say to the warden, “You have a real problem with XYZ and I urge you to investigate this.”

Again, perhaps surprisingly, there often are glowing accounts about a service or a particular staff member. That, too, needs recording and transmission to the executive staff.

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In this column, we will examine a standard that is sometimes misinterpreted, leading to compliance issues. An initial health assessment in a correctional setting is an essential component of a health care system and the standard has many requirements that must be met to achieve compliance.

**Options for Facilities**

Standard E-04 is unique in that it gives a jail or prison two options for demonstrating compliance with the standard: Option One, Full Population Assessment, and Option Two, Individual Assessment When Clinically Indicated. The two choices cannot be combined, so once an option is chosen, the compliance indicators for that option must be followed. The standard for juvenile facilities does not offer different options for compliance. The differences for juveniles will be discussed throughout the article.

**Option One: Full Population Assessment**

This option involves performing an initial health assessment on 100% of inmates as soon as possible but no later than seven days (prisons and juvenile facilities) or 14 days (jails). Facilities should base their decision for scheduling the health assessment on factors such as length of stay, allocation of staff and disease prevalence in the facility or community. For example, in a jail, performing an initial health assessment within two or three days may assist in identifying patients with chronic diseases or those who may be undergoing drug or alcohol withdrawal. In a prison, performing an initial health assessment upon admission may assist in getting patients identified and enrolled in a chronic disease program earlier in their stay.

The components of an initial health assessment on the full population include a review of the receiving screening results; however, we find that this is often omitted and leads to compliance issues. The responsible health authority should ensure that the process for health assessments includes this documented review. A history, vital signs, height and weight may be collected by a qualified health care professional. The history should also include follow-up from positive findings from the receiving screening and subsequent health encounters leading up to the health assessment.

The hands-on evaluation of the patient involves inspection, palpation, auscultation and percussion of the patient’s body to determine the presence or absence of physical signs of illness. The RHA should ensure that this part of the health assessment is truly a hands-on approach, rather than simply collecting a current health history. The physical exam can be done only by a physician, physician assistant, nurse practitioner or a registered nurse. The RN may perform the health assessment only after receiving documented training approved or provided by the responsible physician.

Another component that often poses compliance issues is the requirement for laboratory and/or diagnostic testing for communicable diseases. Testing for sexually transmitted diseases is required in all cases, with one exception: A facility may work with its local health department to determine whether local prevalence rates warrant routine testing. If not, current documentation from the health department should be kept on file to support the testing practices of the facility. For jails and juvenile facilities, testing for tuberculosis is required before or during the initial health assessment. Unique to the prison standards is the requirement for a Pap test during the initial health assessment. Immunizations, as needed, are required in all facilities.

Upon completion of the health assessment by an RN, all positive findings must be reviewed by the treating clinician (physician, physician assistant or nurse practitioner). If a physician, physician assistant or nurse practitioner performs the initial health assessment, then further review may not be required. However, the treating clinician must update the problem list and develop diagnostic and therapeutic plans for each problem as clinically indicated.

**Option Two: Individual Assessment When Clinically Indicated (Jails and Prisons Only)**

The individual assessment when clinically indicated has many more requirements than Option One. However, it focuses staff energy and time only on those patients with chronic or acute health care needs. When using this option, it is imperative that the RHA and/or responsible physician clearly define conditions that qualify as clinically significant findings.

To qualify for this option, the facility must have on-site health staff coverage 24 hours per day, seven days per week. This option also requires that all inmates receive a comprehensive receiving screening, which must be done only by licensed health care personnel. In addition to meeting the requirements of standard E-02 Receiving Screening, the screening must also inquire into past history and symptoms of chronic diseases, as well as medications, including dosages. A finger-stick blood glucose reading must be obtained on individuals with diabetes during the receiving screening. Finally, vital signs must be obtained during receiving screening then again during the initial health assessment.

Next, within two days of admission, the initial health assessment must be performed by a physician, physician assistant or nurse practitioner. A registered nurse may not perform the physical examination in Option Two. The components of the health assessment are the same as in Option One except that laboratory and/or diagnostic tests for disease, such as a peak flow for asthma patients or blood work for diabetes patients, must be performed.

**Juvenile Standard Requirements**

The first noticeable difference in the juvenile standards is in the title “Health Assessments.” Whereas jails and prisons...
require an initial health assessment only, juveniles must receive initial and periodic assessments. The components of the health assessment for juveniles are very similar to Option One for jails and prisons. However, for juveniles, the physical exam should include breast, rectal and genito-urinary exams as indicated by gender, age and risk factors. Females should also receive a gynecological assessment when indicated. The responsible physician should determine which laboratory and diagnostic tests should be performed.

**Repeating the Health Assessment**

In all facilities, once the initial health assessment is completed, the responsible physician must determine the frequency and content of periodic health assessments based on protocols promulgated by nationally recognized professional organizations (E-12 Continuity and Coordination of Care During Incarceration). Certain elements should be repeated at an appropriate frequency as determined by the responsible physician, in consideration of age, gender and health needs (Y-E-04 Health Assessment).

Finally, for all facility types, when a patient is released and readmitted and a health assessment has been performed within the last 12 months, it is not necessary to repeat the health assessment under certain conditions. The new receiving screening must be reviewed to determine whether there has been any change in health status. If there are no changes, the review and the decision to not repeat the assessment must be documented in the health record. Otherwise, when appropriate, histories, physical examinations and tests should be updated on readmitted inmates.

A word of caution for facilities that include the mental health screening and oral screening in the initial health assessment: If the health assessment is deferred when an inmate is readmitted and has no changes in health status, the mental health screening and oral screening still must be completed with each admission. Failure to perform those screenings may result in compliance issues in other standards.

**An Integral Component of Health Care**

The intent of the health assessment standard is that qualified health care professionals identify a patient’s health needs and establish a plan for meeting those needs. Having a process to effectively and efficiently complete health assessments is an integral component of a correctional health care system.

Tracey Titus, RN, CCHP-RN, is NCCHC’s vice president of accreditation. If you have a question about the standards, write to accreditation@ncchc.org. Find the complete Spotlight series online at www.ncchc.org/standards-explained.
You provide quality care to a large, complicated and often thankless patient population. An inmate grievance is then lodged against you—the content of which may have no basis in fact or medicine. This is annoying. You feel confident that you provided all medically necessary care and your charting is accurate, so you brush off the grievance knowing it to be unfounded. This is where you go wrong. While responding to grievances is time consuming, if it’s done properly, you might avoid a lawsuit or you can lay the foundation for getting the inevitable lawsuit dismissed early on.

This article discusses the Prison Litigation Reform Act grievance requirement and instances where poor response to grievances enabled inmates to overcome grievance challenges and proceed to full-blown litigation. The article will conclude with practice tips and recommendations.

An Inmate Must Comply With the Grievance Procedure Before Litigating a Claim

The PLRA provides that “[n]o action shall be brought with respect to prison conditions” under federal law by “a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted.” The plain language of the PLRA contains only one exception: The grievance procedure must be “available.” This caveat has been interpreted to excuse compliance with the grievance procedure in instances such as the following three examples: a grievance was not responded to (or was insufficiently responded to) by prison officials, prison officials interfered with the prisoner’s attempt to submit a grievance and the inmate lacked the mental capacity to utilize the grievance procedure.

The grievance requirement gives inmates an incentive to make full use of the facility’s grievance process and provides the administration with an opportunity to correct any errors. It also reduces the number of inmate suits and improves the quality of suits that are filed because proper exhaustion is believed to result in the creation of an administrative record helpful to the court. The PLRA has been interpreted to require strict compliance with the facility’s grievance procedure—use of appeals, compliance with deadlines, submitting grievances to the appropriate person and so forth.

If an inmate files a Section 1983 claim against you, one of the first issues your defense attorney will address is whether the inmate exhausted the facility’s grievance procedure.
before filing suit. If not, your attorney will file a motion with the court asking the judge to dismiss the case on that basis. Discovery on the merits of the claims asserted against you will be stayed pending the court’s ruling on this threshold issue.

If there is an issue of fact as to whether the inmate exhausted the grievance procedure, the judge may hold an evidentiary hearing where testimony and evidence will be elicited and submitted on the grievance issue. If there are no issues of fact, the case may be dismissed based on written submissions filed by the parties.

If the judge concludes that the inmate exhausted the grievance procedure or that the grievance procedure was not available to the inmate—i.e., because the inmate did not receive a sufficient response to the grievance—the parties will proceed to full-blown litigation that addresses the merits of the claims asserted against you. More often than not, litigation will go on for years and will require you to assist in responding to written discovery, execute an affidavit, sit for a deposition and/or testify at trial. Time spent properly responding to a grievance is well worth your time when viewed in this light.

The Courts Often Find That Exhaustion Is Unnecessary Under Certain Circumstances

The Seventh, Third and Eighth Circuits have held that administrative remedies are not available, and therefore exhaustion is not required, where prison officials refuse to give a prisoner the forms necessary to file an administrative grievance. Similarly, the Seventh Circuit has held that where prison officials invite noncompliance with a procedure, the prisoner is not required to follow it. In one case, prison officials told the inmate not to file a grievance because the problem would be resolved without the need for the formal grievance procedure.

The Seventh Circuit has also held that prison officials’ failure to respond to a properly filed grievance makes remedies unavailable and therefore excuses a failure to exhaust. The Third Circuit has held that exhaustion was excused where guards erroneously informed an inmate that he had to wait until an investigation was complete before filing a grievance. The Ninth Circuit has excused exhaustion where the prisoner was prevented from doing so by a prison official’s mistake. And several circuits have held that prison officials’ threats of retaliation can render administrative remedies effectively unavailable such that a prisoner need not exhaust them.

Finally, courts have found a prison grievance process to be unavailable because of an inmate’s physical infirmity. In one of these cases, the prisoner had a stroke leaving him totally incapacitated; in another, the prisoner had advanced multiple sclerosis and moved in and out of lucidity. Even a broken hand sufficed in yet another case.

The Grievance Process Should Be Used as a Way to Improve Health Care and Communication

Correctional facilities may or may not have formal grievance procedures. To the extent they exist, there should be a written grievance procedure advising the incarcerated person of

Is this grievance actually related to the provision of medical services?

Inmate grievances may contain any number of issues. Typically, a facility will have a person designated to respond to grievances. In such cases, the official grievance examiner will conduct some fact investigation that may require information from medical staff in order to properly respond. If the issue is not medically related, there is likely no need to become involved. Your response or input may be limited to stating that the matter is not medical but relates to a security issue, for example.

What should or can be my role in answering grievances?

If you are asked to give medical information to the grievance examiner, ask to review the grievance personally. The examiner may simply ask you, “How is Mr. Jones doing?” You might read an assessment from the physician that states the patient is stable and respond with “stable.”

However, if you knew that the grievance was actually related to an issue concerning medication, or an issue relating to whether or not the patient should be weight bearing, you would tailor your response to address the issue raised in the grievance. You don’t want to inadvertently provide information that may make the matter worse—for example, a vague response may be incorrectly interpreted by the person who actually writes the response. If you are not sure how your comments or input are being conveyed to the grievant, keep a personal record or, better yet, document in the patient’s chart what was asked and your response.

Consider contacting a supervisor if you are asked to prepare a written report of a patient’s care and treatment if it is to be sent for reasons not related to treating a patient. Statements regarding medical treatment for a patient may or may not be shared with others under the law (HIPAA). If information is needed to answer a grievance, you will want to know the nature of the complaint so it can be addressed specifically.

Are you the person being complained about in the grievance? This is important because if you are named as a party in a case, any written or oral statements by you could be used against you as evidence.

Also, the manner in which your response is documented may be very important later. Sometimes the grievance staff may be asking for your input when you are already represented by counsel in a pending matter. In such cases, you
should relay that communication to your attorney before answering.

In smaller facilities, medical staff may be asked to directly respond to a grievance in writing. Again, you want to address the specific issue referenced and to do so within the guidelines of the policies at your facility. Be familiar with the terms of those policies. If the policy requires a response from you in 30 days, there may be no time for delay.

If the grievance suggests that a person did not receive a certain medication, be sure to address the issue raised after confirming the facts.

1. Was there an order for that medication in the chart?
2. Does the patient’s chart reflect whether the medication was given?
3. Does the chart reflect that the medication was refused?
4. What are the circumstances in which medical staff will write “refused”?
5. Find out what the circumstances were in this instance.
6. Respond accordingly.

What else can or should I do about the complaints made in grievances regarding medical care and treatment?

If the grievance makes reference to an ongoing issue, be sure to take steps to document the complaint and address the issue in the patient’s medical records if necessary. If you determine that a medication error did occur and would continue to occur without a corrected order, note that you are now aware of the issue and that you have taken steps to address it. It is not enough to just respond to the grievance. You need to follow through to correct any issue that is discovered through the grievance process.

However, if you determine that the patient’s complaint is not founded, you will want to document that, as well, to show that you have reviewed the record, discussed the issue with the physician and resolved the issue using your best professional judgment. For example, if a patient believed that he was not getting his medication and the medication administration record also showed that the medicine was not being given, you would document the reason for withholding the medication. Maybe the patient was on a hunger strike at the time and the medication is one that must be taken with food or on a full stomach, maybe the patient refused the medication (list the witnesses and/or circumstances for the refusal) or maybe the patient is scheduled for an upcoming procedure and the medication needed to be discontinued for a short time.

It is helpful to document such information to remind yourself about the circumstances of any modification in a patient’s care and treatment. Correctional health care poses many challenges for the practitioner. Inmates are often transferred from one facility to another without any notice to the medical staff at either facility. Documentation of complaints in the patient’s medical records may prove vital to addressing pressing concerns and changes in a patient’s care.

Work Together to Address the Issues

Addressing medical grievances is a process that requires coordination between medical and correctional staff in most instances. Work together to address the issues raised in a way that provides appropriate resolution for the patient, and document your efforts and level of involvement in addressing the situation. The goal should be to not only address the issues raised in the grievance for the inmate, but also improve the provision of medical services and communication to avoid such grievances and complaints in the future.

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Brady is a partner in the Rockford office and defends correctional health care professionals, sheriffs, correctional officers and police officers who are sued by inmates.

Powell is the managing partner of the Springfield office and defends civil rights claims filed by inmates in the Illinois Department of Corrections and the clinical psychology facilitators at the State of Illinois sex offender treatment facility.

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Correctional staff and health staff differ in their primary areas of focus: Security and safety are foremost for correctional staff, while patient care is the mission for health staff. Yet all must work in harmony. That also is true in the realm of documentation.

In the NCCHC Standards for Health Services, standard H-01 Health Record Format and Contents intends that a health record is properly created and maintained. This article will discuss common concerns with correctional and health staff documentation, and explain why it is critical that documentation be accurate and reflect what is actually happening and when.

**Forms: Useful, but Watch for Pitfalls**

In the world of documentation, checklists, flow sheets and log entries (which I will refer to collectively as “forms”) are becoming popular because they reduce the amount of repetitive documentation. They also enable health professionals to concisely communicate information to each other and to correctional staff.

There are forms to track notification and communication between correctional and health staff. These could include a change in housing unit assignment based on a medical or mental health issue, a special diet for medical reasons, recreation restrictions and segregation or kitchen clearances, to name a few.

Today, many facilities are moving to electronic health records systems because they reduce the need for storage space, can be programmed to meet a facility’s specific needs and make records easily accessible.

However, there are pitfalls that can become obvious when these documents are reviewed, especially in litigation. For example, some programs have preset answers, which, if not changed, will retain the preset answer. In some programs, space is not always provided for write-in comments such as, “The patient stated, ‘I cannot live like this anymore.’” EHRs also document events in real time when they are entered, not necessarily when they actually took place.

Many forms have “keys” to eliminate the need to write words in small boxes. Examples of these words might be “sleeping,” “talking,” “restless” and “diaphoretic.” But there is a big difference between someone talking to others around them versus talking to an imaginary person or object. So if the finding is abnormal, then the patient must be evaluated further.

Abnormal findings must lead to an intervention. That may be the correctional staff notifying the health staff of the abnormality, or sending the patient out for services not available at the facility, or making a change in housing. Regardless of the intervention taken, there must be a follow-up observation or evaluation to determine whether the intervention has achieved the desired goal.

**Be Careful With Dates and Times**

Another pitfall with forms is that many have time slots written on them. This can be useful, but remember that the related entry must be for that exact time, otherwise it can be deemed a falsified document.

Dates and times can also come into question when the facility has stationary or portable cameras that record events in that area. The date and time on documented information must match these recordings.

If your facility’s policies or procedures specify time frames for documentation (e.g., “every 15 minutes,” “once a day,” “once a week”), then make sure that the documentation is completed in that time frame. It is, of course, acceptable to document more often than the policy requires.

There have been cases where a person was on a particular observation status, such as “every 15 minute watch,” yet the camera recording shows no one near the area for an hour at a time. This conflict would discredit the written or computer documentation.

**Basic Rules**

Here are a few basic rules for correctional and health staff to keep in mind when documenting.

1. Date, time and sign each entry. “Sign” can be a badge or staff ID number. If initials are used, a full signature must also be on that document somewhere.
2. Document in real time and in chronological order. If the documentation takes place at a different time than the encounter or event, document both times.
3. Do not skip lines or leave open spaces.
4. Document only the things you did, observed or reported. Do not document for others nor have others document for you.
5. Never erase or use Write-Out correction fluid.
6. Be objective, specific and factual.
7. Complete all areas on a checklist, flow sheet or log.
8. Document any conversations with other disciplines (e.g., physicians, nurses, mental health staff, correctional staff) regarding questions or concerns for the well-being of a patient. This documentation should include the person to whom you spoke, the patient’s name, what the conversation was about and any decisions or plans that were initiated.

Bottom line, most documentation never gets a second look. Yet when there is a poor outcome or legal dispute, that documentation will be scrutinized intensely by many people—including lawyers and expert witnesses—who are looking for a clear picture of what happened. It’s everybody’s job to make sure that the documentation is accurate and complete.

Susan Laffan, RN, CCHP-RN, CCHP-A, is a critical care transport nurse and correctional health care consultant. She may be reached at njjailnurse@aol.com.
Competent and appropriately credentialed care providers are the backbone of a safe health care delivery system. An essential element of risk management programs is the confirmation of credentials at the start of employment followed by an initial evaluation of competence, and an ongoing program to develop competencies of all staff in the organization. It is not uncommon for incompetent providers to seek employment in the correctional system on the mistaken belief that standards are lower when dealing with inmate-patients than with the general public. Safeguards must be in place to prevent these individuals from entering the correctional health care field.

**Credentialing**

Credentialing to evaluate the licensure and certification status of a potential staff member should be accomplished prior to hire. Licensing acts as a safety net for the consumer. Because it is government regulated, licensing is a legal requirement for many health care positions. Systems must be in place to ensure that practitioners have a free and unencumbered license to practice in the position and in the geographic location of the facility (usually the state).

Professional boundaries of licensure differ among states but not among health care settings within jurisdictions; therefore, a physician unable to practice in a traditional setting would also be unqualified to practice in a correctional setting. Indeed, the NCCHC standard on credentials (C-01 in the manuals for jails and prisons) requires that “The credential verification process includes inquiry regarding sanctions or disciplinary actions of state boards, employers, and the National Practitioner Data Bank (NPDB).”

Variability of licensure boundaries is most apparent for the LPN/LVN licensure. The types of responsibilities and functions allowable for practical nurses can be wildly different from one state to the next. This is an area of great concern in the correctional environment, where limited budgets and oversight can lead to risky practices. Thus, careful review of state practice acts for all licensed staff is warranted.

**Initial Competency**

Employers have a responsibility to ensure that new staff members are competent to practice; therefore, employee orientation practices are a part of risk reduction efforts.

An organized orientation process addressing the knowledge, skill and attitude necessary for successful job performance ensures consistency and increases safety in care delivery.

The orientation program should incorporate major risk concerns in correctional health care as well as those particular to the facility or program. For example, personal safety is a significant concern in the correctional setting. New employees must understand how to activate the facility safety mechanisms and how to be mindful about personal safety.

**Ongoing Competency**

The changing nature of correctional health care requires a process for ongoing competence development and evaluation, including peer review. This can be challenging in a small setting, where there may be only one physician or nurse providing care. In this situation, an outside peer review process is necessary. County jails may be able to partner with the state prison system to attain a pool of peer professionals to review clinical situations and documentation to determine competency.

Ongoing competence development is needed when any clinical system is changed. Staff members must understand the reason for the change, the components of the new process and their role in accomplishing the intended outcome.

**Reduce Errors and Improve Patient Health**

By mindfully attending to the credentialing and the initial and ongoing competency of health care staff, correctional health systems reduce the risk of major medical errors while safeguarding their patients’ health. Staff ability to legally and practically perform their job functions is an important component of a correctional health care patient safety program.

Lorry Schoenly, PhD, RN, CCHP-RN, is a nurse author and educator specializing in correctional health care. She provides consultation on projects to improve professional practice and patient safety. Her latest book, the Correctional Health Care Patient Safety Handbook, is available from amazon.com. Contact her at lorry@correctionalnurse.net.
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Chest Radiography Remains an Effective Way to Prevent TB Exposure in Jails

In NCCHC’s Standards for Health Services, the initial health assessment standard calls for testing all inmates for communicable diseases, including tuberculosis, unless the responsible physician and local public health authority find that this is not necessary.

But how to do this efficiently and effectively, especially in settings that have a high volume of intakes and often short lengths of stay? According to research published in the October issue of the Journal of Correctional Health Care, digital chest radiography remains an effective way to reduce the number of exposures to active TB in a jail. As explained by lead author Nicholas Degner and his colleagues, traditionally, new inmates were screened for TB based on symptoms and a purified protein derivative test. During the 48 to 72 hours before the PPD result is available, an inmate with active TB could expose many others to the disease, resulting in immense effort and cost to follow up.

In the 1990s, studies found that chest radiography detects more cases, reduces time to isolation and costs less per case detected compared to the PPD test. Importantly, results from CXR are known within an hour or two. But TB rates in the United States have decreased from 7.9 cases to 3.0 cases per 100,000 persons between 1996 and 2014, creating the need for a new study to confirm the utility of CXR as a screening tool for active TB in jails.

Factors Associated With Receiving Rapid HIV Testing Among Individuals on Probation or Parole — Michael S. Gordon, DPA; Steven B. Carswell, PhD; Monique Wilson, DrPH; Timothy W. Kinlock, PhD; Lauren Restivo, MS; Michelle McKenzie, MPH

Challenges and Opportunities in Correctional Health Care Quality: A Descriptive Analysis of Compliance With NCCHC Standards — Brent R. Gibson, MD, MPH; CCHP-P, Gary Phillips, MAS

The researchers performed a limited cost analysis comparing the screening methods. Summing the cost for PPD tests, repeat chest radiographs and treatment for latent TB, total costs for the eight cases of active TB during the PPD screening period were $46,807, or $5,851 per case. In comparison, costs associated with the 37 cases identified during the CXR screening period were $14,767, or $399 per case. The authors conclude that their data show that CXR screening results in decreased exposure to active TB for jail inmates. Although CXR screening costs more per test ($21.35 per screen compared to $2.56 for PPD), significant savings are realized through more effective screening.

Another benefit of CXR screening is that it reduces the burden on health care staff, who no longer have to perform and interpret PPD tests, and reduces the work required for follow-up and testing of active TB case exposures.
Lieutenant Sees Corrections as ‘People Business,’ CCHP as Way to Bring Staff Together

by Katie Przychodzen, MA

Lenny O'Keefe believes in returning incarcerated individuals to society in better shape than when they arrive at his facility. Key to this undertaking, according to O'Keefe, is making sure they receive quality health care from the start. “A proactive approach to inmate health care is the smart approach,” he says.

A correctional officer at the Merrimack County Department of Corrections in Boscawen, NH, since 1997, O'Keefe decided to pursue CCHP certification last year. Along with the professional recognition and validation that comes with the credential, he believes being a CCHP serves to reduce what he calls the “we/they syndrome” that exists between medical and security staff in some facilities. For him, earning his CCHP was a step toward a better understanding of correctional health care operations and a way to reinforce the shared mission of security and health care staff: to keep the public, staff and those in custody safe.

O'Keefe also has earned the credentials of Certified Jail Manager, Certified Jail Officer and Certified Correctional Trainer. Throughout his 19 year career in corrections, he has won several awards including the Superintendent’s Award, his facility’s highest honor.

Well-Rounded Trainer

O'Keefe has served as the Merrimack County DOC’s training coordinator for the past seven years. It was taking on this role, in which he oversees correctional staff hiring, orientation and training, that really got him thinking about becoming a CCHP. As training coordinator for the 247-bed facility, which houses both pretrial and sentenced male and female inmates, O'Keefe must be familiar with all aspects of jail operations in order to impart this knowledge to his staff.

In addition to educating his own employees, O'Keefe often acts as a liaison between the DOC and the public, giving facility tours and speaking to local nonprofits about health care in corrections. A central focus of these discussions is the expanded role of correctional health care workers in treating inmate mental health and addiction issues. This increased scope of service, O'Keefe explains, underscores the importance of taking an active approach to providing health care in a correctional setting.

With the CCHP program celebrating its 25th year in 2016, O'Keefe reflects on how the relationship between corrections and health care has evolved throughout his years at the Merrimack County DOC. He concludes that the biggest difference is the change in the quality of health care that inmates receive.

“When I began, medical was a small portion of our facility and [staff] were basically placed in a reactive role,” he says. “Now medical deals in a proactive manner, providing preventive care and … helping the individual lead a healthier life once they are out of our care.” He believes quality health care is essential to rehabilitation.

Katie Przychodzen, MA, is NCCHC’s marketing assistant.

2015 STANDARDS for Mental Health Services in Correctional Facilities

Newly revised, the 2015 Standards present NCCHC’s latest recommendations for managing mental health services delivery in adult correctional facilities.

This second edition represents the culmination of hundreds of hours of careful review by a large group of experts, including specialists in psychiatry, psychology, social work and professional counseling, to ensure that NCCHC standards remain the most authoritative resource for correctional mental health care services.

Notable updated topics include continuous quality improvement, patient safety, clinical performance enhancement, medication services, inpatient psychiatric care, mental health assessment and evaluation, continuity and coordination of care, emergency psychotropic medication and women’s health. This edition supports facilities in achieving and maintaining compliance with NCCHC accreditation and constitutionally required care.

To order or to see a list of all NCCHC publications, visit www.ncchc.org.
The Report and Follow-Up

Findings from the focus groups can vary with the individual conducting the group. Some will summarize what they heard, others will not. I summarize. I tell the inmates I cannot promise to change X or Y but I will report X and Y to those who can and urge them to investigate and make changes accordingly.

With the private correctional facility operators, I would urge a trial run at a couple of “hotbed” facilities using an outsider operating under confidentiality and who prepares a quality assurance-type report for designated executives. As for private providers, I think the mere doing of this will give the company heightened credibility and, if done properly, will likely help them avoid some major issues (and litigation) down the road.

In the public arena, if the warden or a deputy warden regularly conducted focus groups, I suspect the gains would be rather quickly forthcoming, particularly if the inmates came to trust the process as authentic—that they were listened to and then some changes resulted.

Never promise a change that cannot be delivered. Always promise to investigate further, at the least, and do what seems needed and is possible.

The issues presented will sort themselves out into the “class action” variety or the highly individual and personal. It is the class action variety that is most compelling. For example, suppose every inmate you speak with housed on the mental health unit states that if you tell a clinical staff member you feel suicidal you will be immediately taken from your cell, stripped and left naked in an observation cell with no counseling until you tell someone, “No problem, I’m over it.”

There is a collective credibility to this unanimous report and a significant danger that lives are needlessly at risk. This must be quickly verified and just as quickly changed. As a monitor, I could insist on change; as an investigator, I would take this to the highest authority available to me and plead for verification and change; as a warden—you would know what to do.

Summing Up

The core idea presented here is quite simple despite my effort to dress it up. Persons in charge of correctional facilities should consider a technique whereby inmate focus groups are regularly convened. These randomly selected groups should be asked about the delivery and quality of a particular service or commodity and they should be approached as consumers whose satisfaction matters. Try it. You will be surprised.

Fred Cohen, LLM, is executive editor of the Correctional Law Reporter. This article is reprinted in slightly abridged form with permission of the publisher. All rights reserved.

For subscription information, contact Civic Research Institute, 4478 U.S. Route 27, P.O. Box 585, Kingston, NJ 08528; 609-683-4450; www.civicresearchinstitute.com.
STDs at Unprecedented High
The total combined cases of chlamydia, gonorrhea and syphilis reported in 2015 reached the highest number ever, according to the CDC’s latest annual Sexually Transmitted Disease Surveillance Report. The largest increase in cases reported from 2014 to 2015 occurred in primary and secondary syphilis (19%), followed by gonorrhea (12.8%) and chlamydia (5.9%). In recent years more than half of state and local STD programs have experienced budget cuts, resulting in more than 20 health department STD clinic closures in one year alone, according to a CDC news release. “We must mobilize, rebuild and expand services—or the human and economic burden will continue to grow,” said Jonathan Mermin, director of CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

Few HCV Patients Receive Care With Costly Meds
Less than 1% of inmates with hepatitis C in state prisons are receiving treatment, according to a study in the October issue of Health Affairs. The study was conducted by the Association of State Correctional Administrators and the Yale Global Health Justice Partnership. The main barriers to increasing access to care were reported to be the high price of the medications, the lack of policy options for reducing drug costs for state prisons and the lack of funding for correctional health services to meet patients’ needs.

The researchers say that to reduce the hepatitis C epidemic, state governments should increase funding to treat infected inmates. They recommend that state DOCs collaborate with other government agencies to negotiate discounts with pharmaceutical companies and with qualified health care facilities to provide medications through the federal 340B Drug Discount Program.

‘Artificial Pancreas’ Approved by FDA
The Food and Drug Administration has approved the first device intended to automatically monitor glucose and provide appropriate basal insulin doses in people age 14 and older with type 1 diabetes. The MiniMed 670G hybrid closed looped system is made by Medtronic.

TM Reduces Stress in Inmates
A Transcendental Meditation stress-reduction program was found to have significantly reduced trauma symptoms in a population of male prisoners in Oregon. Published in The Permanente Journal, the study is said to be the first to examine TM in prison inmates. The authors describe TM as “a simple, natural, effortless technique that allows the mind to experience finer levels of the thinking process until the mind transcends and experiences the least excited state of human awareness.” In the four-month study, 181 inmates with a moderate- to high-risk criminal profile were randomly assigned to either the TM program or a usual care control group. Results were measured using the Trauma Symptom Checklist and the Perceived Stress Scale. Data analysis found significant reductions in total trauma symptoms, anxiety, depression, dissociation, sleep disturbance and perceived stress in the TM group compared with controls.

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Physician/physician assistant 21%
Administrator 12%
Psychiatrist/psychologist 9%
Social worker, therapist, counselor 6%

Decision Makers With Authority
State/facility medical director or director of nursing 17%
Health services administrator 11%
Department manager/supervisor 13%
Health services, dental or mental health staff 20%

Who Do Attendees Represent?
Jail facility 42%
Prison facility 15%
State DOC/agency 13%
Private corporation 12%
Federal agency 6%
Juvenile detention or confinement facility 5%

Categories Attendees Recommend or Buy
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Expert Advice on NCCHC Standards

by Tracey Titus, RN, CCHP-RN

Policy on Electronic Cigarettes

Q Our jail’s policy is that tobacco products are not allowed in the building, and smoking outside of the building is allowed only in designated areas. There has been a proposal to allow electronic cigarettes. Our chief of corrections is against the idea for multiple reasons. Does NCCHC have a policy on vaping?

A NCCHC does not have a policy on e-cigarettes. We do have accredited facilities that allow them, and the accreditation committee has determined that they do not violate our standard F-03 Use of Tobacco.

Defining Levels of Segregation

Q Standard J-E-09 Segregated Inmates defines the level of monitoring based on three degrees of isolation. We believe our segregated population fits into the category described in compliance indicator #2c: “Inmates who are allowed periods of recreation or other routine social contact among themselves while being segregated from the general population are checked weekly by medical or mental health staff.”

For example, our segregated inmates have daily access to the dayroom for social contact, exercise and showers. Inmates in administrative segregation are authorized access to fresh-air recreation a minimum of three individual hours per week, and some receive four or five hours per week. Segregated inmates generally aren’t allowed to attend programming in groups as programming is provided on an individualized basis. However, they are granted one-to-one religious access with approved clergy and are able to attend group worship services.

Can you confirm that we are categorizing our segregated inmates correctly?

A It seems as if there are varying degrees of isolation in the facility. For example, some inmates have daily access to the dayroom. You don’t specify if these inmates are allowed out in groups or individually, but if they are in groups this may fall into category c. However, recreation for ad-seg inmates is described as “individual hours,” and it seems as if these inmates may fall into category b (limited contact with staff or other inmates) or even category a (little or no contact with other individuals).

It isn’t uncommon for large facilities to have varying degrees of segregation that span all of the categories described in the standard. Ultimately, it is up to facility staff to determine the degree of isolation, then develop a system to monitor the inmates based on the standard’s requirements for each category.

Clinical Performance Review for Optometrists

Q Our facility has an optometrist that comes on-site on a regular basis for patient care. Does standard C-02 Clinical Performance Enhancement require that the optometrist receive a clinical performance review?

A Although it is good practice to have a clinical performance review for all providers with direct patient care, the standard does not require that an optometrist be part of this review.

Tracey Titus, RN, CCHP-RN, is NCCHC’s vice president of accreditation. If you have a question about the standards, write to accreditation@ncchc.org or call 773-880-1460.

For an archive of past Standards Q&A columns, visit the Standards and Resources section at www.ncchc.org.

For more in-depth information about the standards, attend one of the preconference seminars at NCCHC’s Spring Conference on Correctional Health Care, being held April 29 - May 2 in Atlanta.
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“I am convinced that the decision to ... reach out to you for technical assistance is undoubtedly one of the best that I have made since my arrival.”

—Medical Director, Department of Youth Rehabilitation Services, Washington, DC

For more information on how NRI can help your facility improve the quality of health care delivery, contact info@ncchcresources.org or 773-880-1460.