

Protect Yourself and Your Facility Against Litigation



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Disclosure and Disclaimer

- Dr. Ofogh owns a correctional healthcare company, Mediko, and Ms. Brewer represents Mediko and other correctional healthcare companies.
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Educational Objectives

- Learning Objective 1: Identify medical issues that lead to risk and liability and appropriately triage those issues using nursing guidelines.
- Learning Objective 2: Implement safe and practical preventive quality control initiatives.
- Learning Objective 3: Understand current trends in litigation around correctional medicine, to include seven serious and acute clinical conditions.

Best Practice Standards

- Nurses should have clearly written guidelines and protocols reviewed, approved and signed by the site Medical Director for the following high risk medical conditions:
 - Chest Pain
 - Abdominal Pain
 - Shortness of breath
 - Seizures
 - Headaches
 - Nausea/Vomiting
 - Medications upon Arrival
 - Fever
 - Sudden Change of Mental Status
 - Withdrawals (Alcohol, Opiate, Benzos)
 - Suicides

Best Practice Standards

- A Healthcare Provider (MD/NP/PA) should be available 24/7 for the nurse to call and provide relevant information for potential serious medical presentation or complaints.



12 Steps for Nurses Calling the Provider

- Step 1: Start with the patient's age, gender and length of time in the facility.
- Step 2: Report the signs and symptoms and when they began. Include vital signs.
- Step 3: Has the patient been seen previously for these problems by medical? If yes, what treatment was provided? (medications or other means)
- Step 4: Identify medications that the patient is currently prescribed with the dosage, frequency and compliance.

12 Steps for Nurses Calling the Provider

- Step 5: Open your **nursing guidelines** and use to interact with the patient during your sick call and BEFORE you call the provider
- Step 6: Using the nursing guidelines will allow you to give relevant information to the Provider and eliminate unnecessary reporting. **But when in doubt, call.**
- Step 7: Once you receive verbal orders from the Provider, **schedule a task** in the EMR so the Provider may approve the orders when at the facility.
- Step 8: **Read the orders back** to the Provider to ensure you understood them correctly.

12 Steps for Nurses Calling the Provider

- Step 9: Do NOT “guesstimate” or assume. **Ask questions** for clarity.
- Step 10: Typically, the provider will ask you to **schedule the patient for follow-up** with the MD/PA/NP at a certain time or next business day.
- Step 11: **Culture then cover** open wounds/ulcers and **isolate** the patient until the Provider authorizes release from isolation.
- Step 12: The more you use your **Nursing Guidelines** and document based on guidelines, the more you will **Protect Your License, Improve Patient Care, Feel Confident and ENJOY Your Job!!!**

Withdrawal Syndrome

- A Group of Signs and Symptoms that typically develop after discontinuation or a rapid decrease of a substance upon which an individual is dependent.
- Minor Withdrawal: Three of the following
 - Temperature >38.3 C (101 F)
 - Systolic B/P >140 mmHg
 - Diastolic B/P >90 mmHg
 - Pulse >110
 - Nausea & vomiting
 - Tremors
 - Diaphoresis
- Major Withdrawal = minor plus delirium or seizures



Withdrawal Syndrome

Presentation and treatment depends on the following factors:

- Nature of substance
- Duration of action
- Length of abuse
- Amount and frequency
- Simultaneous use of other drugs
- Presence of co-morbid conditions

Co-Morbid Conditions include:

Brain Injury

Seizure Disorder

Cardiac Disease

Liver and Kidney Disease

Elderly Inmates

Pregnancy

Psychiatric Disorders

Withdrawal Syndrome

Dangerous/Life Threatening: Intervention Needed

- Alcohol
- **Opiates:** Heroin, Methadone, Codeine, Morphine, Oxycontin, Dilaudid, Suboxone, Fentanyl, Carfentanyl
- **Benzodiazepines:** Xanax, Valium, Ativan, Klonopin
- **Barbiturates:** Phenobarbital

Not Dangerous/Life Threatening: Symptomatic Treatment Is Enough

- Cocaine
- **Amphetamines** including Methamphetamines
- **Cannabis:** Marijuana
- **Hallucinogens:** LSD, PCP, Bath salts
- **Inhalants:** Paint Thinners, Glue

Alcohol Withdrawal

Alcohol: One of the leading causes of death and litigation

A. Quantity, duration, last time used

- Minor symptoms: (6 – 8 hours after last drink)
 - Temp ≥ 100 , Pulse > 110
 - Systolic BP ≥ 140 ; Diastolic BP ≥ 90
 - Nausea, vomiting, tremulousness

B. Generally, no treatment is needed unless there are pre-existing conditions; cardiac, previous DT's, history of mental illness, seizures, liver disease,...

- Reassess every 6 – 8 hours

C. Major symptoms: Two of the above plus total disorientation (delirium tremens)

- 911: Do not waste your time

D. CIWA is the most practical and comprehensive form that can be used in detention centers.

E. Ativant oral or IM shots are the gold standard treatment versus Librium.



Alcohol Withdrawal: Management

1. Early signs and symptoms usually start 6-8 hours after last drink and peaks in 24-36 hours
 - Tremors
 - Mild BP, Temp, Pulse Rate
 - Anxious, Agitated
 - Nausea, Vomiting
 - Difficulty Sleeping
 - Sensitive To Light Or Sound
 - Headaches
2. Later signs and symptoms usually start 48-72 hours after last drink
 - Hallucinations, usually visual
 - Seizures, usually generalized

Alcohol Withdrawal: Delirium Tremens

- DT's do not always follow the classic pattern of symptoms but may happen 3-4 days after the last drink, especially in people who take medications that may mask initial signs and symptoms.
- Reasons Patients go to DT's:
 - Late Detection of withdrawal in booking
 - Late start of treatment/protocol
 - Severe Dehydration
 - Not knowing/ignoring history of previous DT's
 - Existence of co-morbid conditions
 - Relying only on use of Dilantin, Haldol
- Once DT's happen:
 - Do not waste time calling each other.
 - Nurse or Officer should call 911 and patient should go to the hospital for admission to an intensive care unit.
- Yet, even if this is done:
 - 1% to 2% of patients who go into DT's will die, even in the hospital.
 - Imagine what percentage would die, if they are not sent to the hospital.



Opioid Epidemic: What are Opioids?

- A group of medications that act on opioid receptors in spinal cord and brain to reduce the intensity of pain-signal perception
- Prescription opioids are:
 - Hydrocodone (ex. Vicodin)
 - Oxycodone (ex. Oxycotin, Percocet)
 - Oxymorphone (ex. Opana)
 - Morphine
 - Codeine
 - Synthetics
 - Fentanyl
 - Carfentanil



Opioid Epidemic: What are Opioids?

- For whatever reason opiates are prescribed, should be for a limited time and in many cases the goal to use opiates is to reduce the pain 20%-30% for chronic pain management
- If used chronically, some people may experience worsening of the pain or they may even become more sensitive to the pain
- The most frequently abused non-prescribed opioid: Heroin
- Taking opiates along with alcohol or another group of drugs called benzodiazepines, such as Xanax, will increase the risk of toxicity and overdose

Opiate Withdrawal

A. Early signs and symptoms: (8 – 12 hours after last use)

- Sweating, goose bumps, anxiety and irritability, tearing, yawning or runny nose, dilated pupils

B. Advanced: (2 – 3 days after last use)

- Diarrhea, HTN $\geq 140/90$ and/or pulse > 110 , insomnia
- Need to be screened by mental health for suicide risk



Medications are used to reduce symptoms of discomfort (i.e., nausea, diarrhea, aches and pains)

Opiate Withdrawal

Early Symptoms (8-12 hrs)

- Anxiety
- Irritability
- Increased Respirations
- Sweating
- Tearing or Crying
- Yawning or Runny nose
- Goosebumps
- Anorexia
- Dilated pupils

Advanced Symptoms (2-3 days)

- Insomnia
- Nausea & Vomiting
- Diarrhea
- Weakness
- Abdominal cramps
- Tachycardia
- Hypertension
- Muscle Spasms
- Muscle & bone pain
- Seizures
- Death

REMEMBER

- The standard of care is universal.
- There is no such thing as two standards (one for incarcerated population and one for general public).



The “Why?”

- Health care in custody is constitutionally required. Estelle v. Gamble (1976)
- Government has a duty to provide humane conditions to incarcerated people.
- Running a substandard facility can be very costly.



**JUST IN: Family of deceased inmate
sues Arlington sheriff, jail healthcare
provider**

Jo DeVoe March 11, 2022 at 1:55pm

**N.C. County To Pay \$3M in Death of Prisoner
After Medical Crisis**

**Family Alleges Prison Transfer Endangered
Life of Pregnant Inmate**

**WA to pay \$3.75M after death of man whose cancer went
untreated in prison**

Feb. 23, 2022 at 6:00 am | Updated Feb. 23, 2022 at 8:33 am

**Forsyth County Jail's medical provider
denies allegations of neglect in Winston-
Salem inmate's death**

Deliberate Indifference v. Negligence

- (1) Objective – a serious medical need diagnosed by a physician as mandating treatment OR one that is so obvious even a lay person would recognize it
- (2) Subjective – the official actually knew of and ignored the patient's serious need for medical care

A breach of the standard of care – a violation of what a reasonably prudent person in the same or similar circumstances would have done.

Serious Medical Conditions that Arrive with the Patient

- Pre-existing diagnoses
- Conditions that affect ADLs
- Conditions that require assistive devices
- Conditions for which patient takes medication
- Overdose/withdrawal
- Ongoing pain
- Cancer

Diabetes
Hepatitis C
Chronic musculoskeletal pain
Hypertension
Asthma
Substance abuse
Anxiety/Depression
Cancer

Case example #1: Hypertension

- 60 year old male
- Hx: CAD, hyperlipidemia, HTN, left ventricular blockage
- Not on meds
- BP at intake: 152/97
- Ordered: routine BP checks, clonidine
- Incarcerated for 12 days
- Began refusing clonidine due to dizziness; dose decreased; continued refusal

Allegation: BP increased during incarceration, leading to circulatory issues and congestive heart failure.



152/97 (intake)

162/110

130/90

140/92

130/90

162/110

140/92

158/100

168/102

140/92

158/100

168/102

158/100

150/110

163/107

120/88

112/70

154/88

162/107

112/70

150/100

162/107

154/88

152/100

171/114

153/118

127/86 (release)



Case example #1: Hypertension

Defense experts (RN, correctional medicine MD):

- Seen 20+ times by medical staff over 12 days
- Had suffered HTN for years – no prior treatment
- BP checked 1-3x daily except when refused
- BP likely would have stabilized with compliance
- BP on discharge was 127/86
- A cardiac workup two months after release was normal
- No evidence 12 days of HTN led to CHF



Case example #1: Hypertension

Outcome:

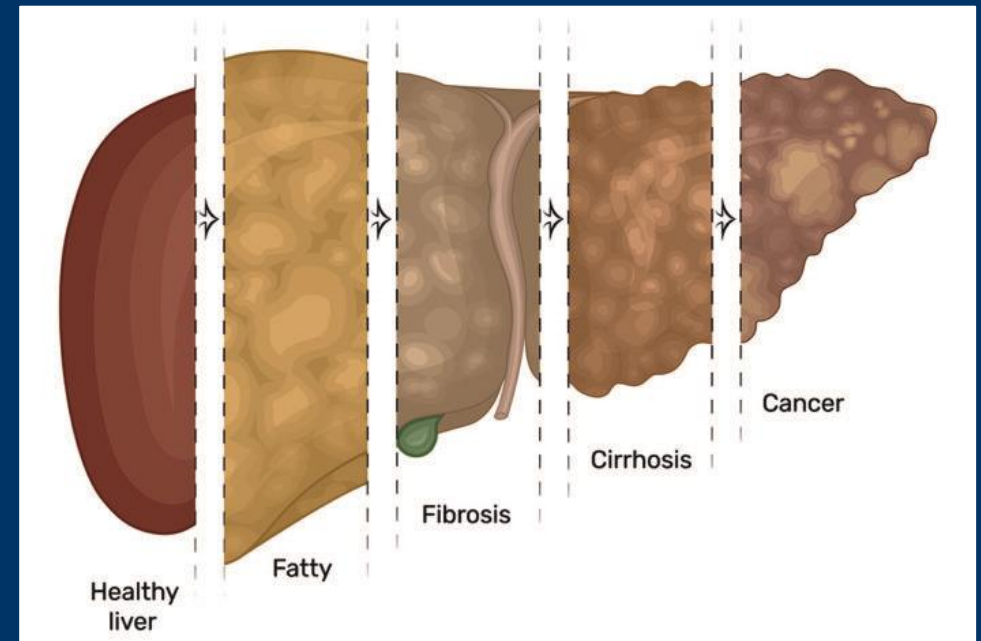
- Deliberate indifference claims dismissed
- Negligence claims still pending, remanded to state court

Takeaways:

- Documentation of every intervention and refusal
- Attempt to remedy long-standing, chronic condition

Case example #2: Hepatitis C

- 35-year-old male
- Diagnosed in 2014
- Did not seek treatment until 2018 and was incarcerated shortly after his first doctor's visit
- Almost immediately upon incarceration, began complaining of physical symptoms
- Policy was to repeat bloodwork (APRI, fibrosis score) every 3 months to determine need for ultrasound. His lab values did not qualify him for ultrasound.
- 9 months later, MD ordered ultrasound, which showed stage F2 and F3 fibrosis
- 2 months after that, transferred to different facility
- Has been successfully treated and cured of Hep C



Allegation: Deliberate indifference for failure to treat Hep C; liver pain for 9 months with no treatment; worse prognosis

Case example #2: Hepatitis C

Defense experts (correctional medicine provider, hepatologist)

- Guidelines were followed; testing occurred every 3 months
- Fibrosis/scarring repairs itself
- The only cause of liver pain is gallstones – not F2 or F3 fibrosis



Case example #2: Hepatitis C

Outcome:

- Motion for Summary Judgment pending

Takeaways:

- Keep up to date re: changing policies and cultural norms surrounding Hep C



Serious Medical Conditions that Arise During Incarceration

- Infections and viruses
- Injuries from falls, altercations, other injuries
- Mental illness
- Acute issues
- Medication errors

Cardiac arrest

COVID-19

Kidney stones

Anxiety/Depression

Fractures

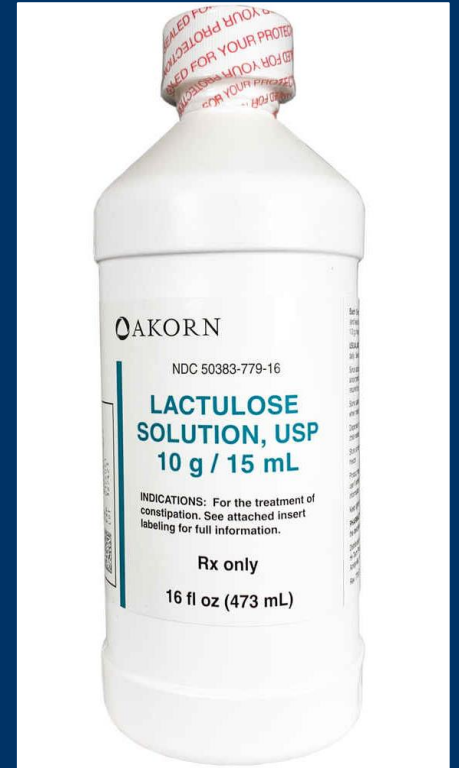
Bowel obstruction

Priapism

Brain injuries

Case Example #3: Medication changes

- 49-year-old male
- Hx: Hepatitis C, cirrhosis of the liver
- Lactulose x 3 years
- Had been taking 90 ml TID for 4 months at different facility
- Facility MD decreased to 45 ml BID
- A week later, complaints of abdominal pain
- Facility NP increased to 90 ml BID
- Two weeks later, continued complaints
- Facility MD increased to original dose of 90 ml TID



Allegation: Dosage change was deliberate indifference; experienced hallucinations, paranoia, and pain

Case Example #3: Medication changes

Affidavit from physician:

- Delicate balance to find dose that manages toxicity of elevated ammonia levels and avoids side effects
- In his clinical judgment, 90 ml TID seemed high
- After continued complaints, MD reverted to original dose
- During this time, no complaints of hallucinations or paranoia
- Temporary decrease in dosage over 4 weeks did not alter prognosis or overall course



Case example #3: Medication changes

Outcome:

- Motion for Summary Judgment granted

Takeaways:

- Clinical judgment documented and well-supported
- Timely response to complaints

Case Example #4: Medication denial

- 30-year-old male
- Hx: Depression, anxiety, PTSD following Iraq
- Panic attack 3 days after intake
- Said he had taken Wellbutrin for anxiety and wanted to resume
- Outside records showed Wellbutrin prescribed 5 years earlier for smoking cessation
- QMHP performed health assessment 6 weeks after intake; patient combative
- Never placed on list to see psychiatrist, despite repeated requests over the next several months
- Transferred 1 year later; immediately prescribed Wellbutrin



Allegation: Deliberate indifference for denial of anxiety medication for one year

Case Example #4: Medication denial

Defense expert (psychiatrist):

- No evidence of prior mental health history
- Wellbutrin-seeking behavior
- Weakness: no documentation of reasoning for denying psychiatrist appointment
- Weakness: combative behavior during QMHP's meeting made second meeting even more critical

Case example #4: Medication denial

Outcome:

- Motion for Summary Judgment denied
- Settled before trial

Takeaways:

- Allow the assessment
- Take note of repeated complaints



COVID-19

- Unprecedented pandemic; unprecedented law
- Immunity statutes by state – may only apply if inadequate resources
 - Falling on the sword
- Maintain policies current with CDC and state health departments



Questions or Comments?



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