Final Report of the Court Appointed Expert

Lippert v. Godinez

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Prepared by the Medical Investigation Team

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Introduction

Towards the end of 2013, Dr. Ronald Shansky was nominated by the parties and appointed by the court in the Lippert matter as an expert pursuant to Rule 706 of the Federal Rules of Evidence. The order appointing him lays out the scope of the duties.

> "The expert will assist the court in determining whether the Illinois Department of Corrections ("IDOC") is providing health care service to the offenders in its custody that meet the minimum constitutional standards of adequacy."

It further goes on to say that the expert "will investigate all relevant components of the health care system except for program services and protocols that relate exclusively to mental health." Furthermore,

> "If systemic deficiencies in IDOC health care are identified he will propose solutions for consideration by the parties and the court. These proposed solutions, if any, will form the bases for future negotiations between the parties in an effort to craft a final settlement of this matter or alternatively, may be offered into evidence in the trial of this matter. Furthermore, the expert will not recommend specific treatment for individual offenders unless those recommendations relate to systemic deficiencies in the health care provided to offenders in IDOC custody."

The parties have also accepted Karen Saylor, M.D., Larry Hewitt, R.N. and Karl Meyer, D.D.S. as additional team members. The expert met with the parties in late 2013 and a second time in April of 2014. The first meeting focused on the methodology to be used as well as questions that either of the parties had with regard to the process. The April meeting was intended to be an update, having visited by that time approximately half of the facilities to be reviewed. The expert thought this would be valuable because the confidential draft report was not due until the site visits and mortality reviews had been completed and therefore there would have been no opportunity to jointly update the parties until they actually received the confidential draft report. Both parties have been extremely supportive of this process. We received full cooperation at each of the prisons we visited and are extremely appreciative of the local efforts to facilitate the process.

The investigative team was assigned an explicit task, "To assist the Court in determining whether the state of Illinois was able to meet minimal constitutional standards with regard to the adequacy of its health care program for the population it serves." In order to reach this conclusion, the parties determined that we should visit at least eight facilities, six of which were jointly selected by the parties. The investigative team concurs with the parties' selections, in that those six facilities have special responsibilities within the system and are critical to a determination as to whether, when the health care systems are most challenged, they are able to adequately meet that challenge. Three of the institutions reviewed functioned as reception centers. These facilities are critical in that they perform the initial evaluation upon entry into the system. Problems that they fail to identify are much more likely to either not be addressed or sometimes at a minimum, the identification and the interventions are significantly delayed. Three facilities were maximum-security facilities which house the most challenging of populations for

which to provide health care services. Finally, one of the six houses the system's special geriatrics unit, which also creates health care challenges. It has been our experience that when a system is able to meet constitutional standards at the most challenged institutions, it is very likely to meet constitutional standards at the less challenging facilities. The converse, however, in our experience has not proven to be true.

The State indicates that the investigation team should have utilized standards such as the National Commission on Correctional Health Care or the American Correctional Association as the basis for both our investigation and our recommendations. The leader of the investigative team served on the board of the National Commission on Correctional Health Care for 10 years. He has also been involved with the development of the standards for the last 20 years, serving on three of the task forces and advising the most recent task force. In addition, he has also been requested and has provided training to all of the NCCHC surveyors with regard to the quality improvement standard and how to survey it. He himself has done surveys in each of the last three years. All of the members of the investigative team believe that the National Commission on Correctional Health Care, through its standards, its surveys and its training, have contributed substantially over the past three to four decades in helping facilities improve the quality of health care. When the survey process occurs, about 80% of that process is focused on administrative matters; policies, procedures, contracts and other administrative matters. Approximately 20% of the survey process is focused on clinical care, and during that process the lead investigator has recently been asked to help redesign the methodology used to assess care issues. Investigations that are part of litigation and assist the court in determining whether and the extent to which "deliberate indifference to serious medical needs" may exist requires that the focus be overwhelmingly on clinical care issues. Thus, virtually all of the time that we spent, other than understanding how services are provided at each facility, dealt with interviewing staff and inmates, observing processes and reviewing medical records. For the purposes of the court, clinical care is of overwhelming importance and administrative issues, though important, are much, much less important.

A recent article by Alex Friedmann published in *Prison Legal News,* October 2014, describes with specific citations about how the courts view specifically ACA accreditation, but also how the courts view accreditation in general. More commonly the courts have said that they do not rely in their determinations of constitutionality on the presence or absence of accreditation. We believe that this is based on the fact that the focus in constitutional disputes is overwhelmingly on clinical care matters, whereas in accreditation the focus is overwhelmingly on administrative issues. The wording of the constitutional definition of an Eight Amendment violation forces investigators, whether they be plaintiffs or defendants or working for both parties, to heavily focus on clinical care issues. Having said this is not meant in any way to diminish the value of the accreditation process, specifically with the National Commission on Correctional Health Care.

Having received the comments from both plaintiffs and defendants, it has been a challenge to integrate some of the comments into the final draft. The State has indicated it has done several things which are consistent with the investigative team's recommendation. Since we cannot verify where things are in the process, we are not addressing those things in the final report. Rather, any of the updates will be available to the Court in an appendix which includes both

plaintiff's and defendant's responses. On the other hand, where there are clarifications requested or alternatives proposed, we have attempted to be responsive. In some instances, the original paragraphs we feel were clear enough; in other instances, we have modified the original draft. We feel we have made a sincere effort to be responsive to the parties.

In order to perform such a review, it is necessary to utilize a variety of investigative strategies. We interviewed staff, we have interviewed inmates, we have observed care provided, we have reviewed policies and procedures and compared practice to the policies and procedures, we have reviewed minutes of meetings and we have reviewed selected records, including death records. In order to best describe a correctional health care program, we have found it useful to organize the institutional reviews along the lines of major services provided. This listing of services is not exhaustive; however, it enables a fairly comprehensive snapshot of how the program is functioning. The critical services begin with medical reception, which is designed to create an awareness and understanding of the medical needs of patients on entry to the system. We visited three reception centers; the main reception center, which is the Northern Reception Center, which receives inmates from Cook County; the reception process at the Logan Correctional Center, the major women's prison; and the Menard Correctional Center, which receives far fewer new inmates, especially those from Southern Illinois. An adjunct to the reception process for when patients are transferred from one facility to another is the intrasystem transfer process. Both reception and intrasystem transfer processes are designed to identify problems and insure continuity of care despite the potential disruption during a transfer. Other major services include nurse and provider sick call (primary care services), chronic care services, medication management services, scheduled offsite services (specialty consultations and procedures), unscheduled onsite and offsite services (urgent/emergent responses), infirmary services (onsite inpatient care), infection control services and dental services. All of these major service areas must be supported by an effective quality improvement program that not only self-monitors but also effectively identifies performance improvement needs and implements strategies that facilitate performance improvement. It is these services for which we will provide an overview in this confidential draft report and for which we will attach institutional appendices in which our specific findings within each institution are detailed. Finally, the report includes a review of 63 deaths by Dr. Saylor and Dr. Joe Goldenson, who was added to the team with the agreement of the parties in order to facilitate completion of the mortality reviews. In order to discuss services, we are forced to address both leadership issues as well as staffing issues, and the degree to which leadership or staffing were significantly problematic varies by institution. In the institutional appendices, we describe shortcomings in some detail.

Leadership and Staffing

Leadership is a problem at virtually all of the facilities we visited. The question varied only with regard to degree. The reason why leadership is so important to a correctional health program is because they are responsible for setting the tone with regard to both structure and professional performance as well as insuring that the program effectively self-monitors and self-corrects so that problems are identified, addressed and ultimately eliminated. Through this self-correcting process potential harm to patients is continually mitigated. Without a strong and effective leadership team a program is much less able to identify the causes of systemic problems and to effectively address those problems by implementing appropriate targeted improvement

strategies. At the extreme was Dixon, a special mission (reception center, geriatric unit, special program for disabled, special housing for patients with medical or mental health problems) facility, both medical and mental health, which at the time of our visit had a vacant Health Care Unit Administrator position, a vacant Director of Nursing position and in essence a vacant Medical Director position filled by a Wexford "travelling medical director." Special mission facilities serve a function for the entire prison system and thus tend to concentrate medical pathology or problems. As a result of the concentration of medical problems, a program that is not effectively managed creates the potential for harm to the patients and legal liability to the State. The degree of breakdowns we found at Dixon were the most severe. There must be a requirement that a Medical Director hired by Wexford must be board certified in primary care, preferably either family medicine or internal medicine. In addition, the one Health Care Administrator responsible for both NRC and Stateville had been taking extended leaves of absence. This is a vehicle for failure. Additionally, the Director of Nursing position at each facility, commonly a vendor position, must have the responsibility on a full-time basis for overseeing nursing clinical services. We are told that at several sites they have an additional administrative assignment with regard to Wexford corporate responsibilities. This is not acceptable. The oversight of a substantial nursing program is a full-time job. No time should be taken away from that responsibility. The leadership vacuums at Dixon, Stateville and NRC have resulted in process and care breakdowns on a daily basis. Reception is not done timely and medical records are almost impossible to effectively utilize at NRC despite the fact that there is a person onsite in charge of medical records. At Illinois River, the Medical Director position was vacant and this was being filled two days per week by the Medical Director from East Moline. There appeared to be an effective Director of Nursing who attempted to fill in also as the Health Care Unit Administrator, since that position was filled by someone on military leave for the past year and a half. At Hill Correctional Center, both the Health Care Administrator position and Director of Nursing position were filled by individuals who appeared to be quite capable. The Medical Director position is filled by a doctor for whom we identified clinical concerns during our record reviews and mortality reviews. At Menard, the Medical Director position is filled by a clinician trained as a general surgeon. This facility also has no primary care trained clinicians, even though the overwhelming majority of clinical responsibilities fall within the primary care field. There is no Director of Nursing at Menard; however, the Health Care Unit Administrator appears quite capable and makes an effort to fill in. However, as indicated through this review of eight institutions, very few if any with the exception of Pontiac have a complete team with all positions filled by capable individuals. It is not surprising that the weaker the leadership the poorer the medical performance. Each program's performance should be measured at least annually and, where indicated, leadership changes must be made.

We found clinician quality to be highly variable across the institutions we visited and across medical records we reviewed. There were examples of high quality clinicians at some facilities, but in other instances the quality of clinical care was poor and resulted in avoidable harm to patients. For example, none of the three physicians at one institution we visited had any formal training in a primary care field. During the course of our review of the care at this facility, we came across several examples of avoidable harm to patients resulting from inappropriate management of common primary care conditions. For example, at Menard, patient B89028 developed a diabetic foot ulcer that was not appropriately managed and resulted in amputation. This same patient, a type 1 diabetic, had his insulin discontinued in response to well controlled

blood sugars, which resulted in dramatic deterioration of his diabetes control. This error reflects a lack of understanding of the basic pathophysiology of this common disease. In another instance at this facility, patient N84660 presented with poorly controlled diabetes and the doctor tripled his insulin dose and quadrupled the dose of his oral medication. This of course resulted in repeated episodes of low blood sugar. Luckily the patient knew to refuse his medication in order to avoid serious harm.

At Illinois River, a 26-year-old man (M32146) repeatedly informed health care staff that he had atrial fibrillation, a fact that was confirmed by his jail records, but this history was discounted until he suffered a stroke. Had clinical staff listened to the patient and reviewed his jail record, they would have learned that he should have been on blood thinners to reduce the chances of this devastating event. At the same facility, Patient 08044 presented with classic signs and symptoms of lung cancer from the time he arrived in IDOC, yet these were ignored by health care staff for three months. By the time he was finally diagnosed, the only treatment he was eligible for was palliative radiation, which he declined. He died nine days later.

The hiring of underqualified clinicians into the system is problematic, as evidenced by the examples stated above. By "underqualified," we do not mean that the provider is not qualified to practice medicine, but rather underqualified to practice the type of medicine required of the position. For example, a general surgeon is underqualified to practice primary care in the same way an internist is underqualified to practice general surgery. This problem is compounded by a lack of clinical oversight and peer review, both locally and centrally, and a lack of electronic resources, which prevents clinicians from having access to information vital to medical decision making at the point of care. We recommend that all Medical Directors be board certified in a primary care field and staff physicians have successfully completed a primary care residency. It is necessary that all clinicians have access to electronic educational resources at the point of care. This means that computers with internet access should be present in the exam rooms so that providers can access essential clinical information at the time they are seeing the patients. There should be periodic peer review of clinical practice, both at the local/facility level and centrally. At most of the facilities we visited, the Medical Directors were functioning in primarily clinical roles and spent little if any time reviewing the clinical practice of the other providers or engaging in other important administrative duties.

Staffing deficiencies are facility specific to Stateville and Dixon with regard to the number of vacancies. For example, 23 of Stateville's 66 budgeted positions are vacant, and 18 of Dixon's 66 budgeted positions are vacant. Adding to the problem is that key leadership positions are vacant at these two facilities. Stateville's Health Care Unit Administrator, who is also responsible for the NRC, has been on an extended medical leave of absence. Added to that is the issue that 10 of the 20 budgeted correctional nurse II registered nurse positions are vacant, as well as 10 of the 18 budgeted correctional medical technician positions. While this number of vacant positions creates a significant operational issue, the problem becomes worse because Stateville nursing staff is required to assist at the NRC with intake and operation of the NRC health care unit, and Stateville nursing staff is reassigned to the NRC when NRC nursing staff does not report to work. The NRC schedule E of approved budgeted positions only provides for eight positions, none of which are nursing staff. As a result, health care delivery suffers significantly, which affects access to care and results in delays in treatment. Staffing at NRC

must be sufficient to insure medical intake processing is completed within one week of entry. This will require additional clinicians and possibly additional nursing staff and medical records staff.

Of Dixon's 18 vacancies, three are key health care unit leadership positions. At the time of our visit, the Medical Director, Health Care Unit Administrator and Director of Nursing positions were all vacant. The only leadership present in the health care unit was two supervising nurses, both of whom were new to their positions. One of the supervisors was employed by the State and one by the medical vendor. As a result, they each supervised a different group of staff who were assigned the same responsibilities, and each supervisor had her own agenda as a result of having different employers. Coupled with this was that seven of 16 budgeted corrections nurse I (RN) State positions were vacant.

The remaining facility vacancies (Pontiac, Logan, IL River, Hill, and Menard) ranged from nine at Menard to only one at Hill, with the other facilities falling somewhere in between. Even though the actual number of vacancies was low, there was at least one key leadership positon vacant at Logan (DON), IL River (HCUA) and Menard (DON).

Of additional concern was that at several facilities medical vendor employees who were filling key leadership positions, such as the director of nursing, supervising nurse or medical records director, were assigned additional corporate duties such as time-keeping, payroll or human resources, which took them away from their full-time responsibilities. These positions were included in the schedule E of approved budgeted positions to provide full-time service to the facility within their job description. Taking them away from that undermines the operation of the health care unit and program.

At each facility, a sick call system has been developed and implemented which permits staff other than registered nurses to review/triage sick call requests and evaluate/assess and treat patients. It is our opinion that this type of independent assessment (which is what a nurse is required to perform in responding to a sick call symptom containing request) is beyond the scope of practice for other than registered nursing staff. The State of Illinois Nurse Practice Act exclusively sanctions registered nurses to perform independent assessments, although it does allow for licensed practical nurses or others to assist in performing assessments. That assistance could include taking vital signs or asking some questions regarding the patient's history with regard to a specific problem. When a nurse performs sick call, the patient has presented a request for an assessment based on one or more symptoms. A registered nurse has the training and skills to elicit an appropriate history, perform an appropriate physical assessment based on the history and then synthesize the data into a nursing diagnosis and a related plan. Frequently, systems provide protocols to aid the registered nurses in completing these assessments. To allow staff who do not meet the requirements by training and certification of a registered nurse to perform these assessments increases the potential for harm to the patients as well as legal liability for the State.

It is critical for the Office of Health Services to establish the specifications for the health care contracts as well as to monitor and oversee the performance of those contracts and provide a direction to the field with regard to policies and procedures as well as clinical guidelines. In

order to provide such guidance the Office of Health Services requires appropriate resources. Not only is the Medical Director position critical in providing clinical guidance but also in overseeing such a large health care program, the Medical Director should be provided with regional medical directors also board certified in primary care to assist him or her in providing clinical oversight. Universally we were informed by both State employed staff as well as some vendor employed staff that there were significant problems with the vendor employed regional medical directors. We perceive the transfer of these positions directly to the State Medical Director should allow for improved oversight and guidance. The recommendations we have made are in order to eliminate the conflict of interest inherent in corporate employed physicians reviewing the work of corporate employed physicians. A decision of termination becomes an expense for the corporation. The leader of the investigative team was Medical Director in the State of Illinois for 11 years. During that time, we evaluated the performance of physicians regularly and informed vendors when such physicians could no longer be employed in the State of Illinois. We believe contractual agreements can be changed and in fact should be changed when they are in the interest of the State in providing minimally adequate constitutional care. This investigative team has been extremely disappointed in the performance of the vendor and the facility programs with regard to both professional performance review, mortality reviews and the entire quality improvement program. The requirement that physicians performing peer reviews be board certified in primary care, which is the type of service that they are evaluating, is apparent and needs not be justified.

In addition, because the quality improvement program of any and all health care organizations is so central to the development of an effective program, the central office should have a well-trained quality improvement coordinator responsible for directing the system-wide quality improvement program. This position would provide training and consultation to facilitate for each site the development of an effective quality improvement program. Analogously, the statewide infection control coordinator position should be restored to assist in educating the institutions with regard to infection control as well as monitoring the performance of those programs. This person also has a responsibility as a liaison to the State Department of Health. All of these changes should facilitate reducing the potential for harm to patients by improving the oversight and ability to respond by the State.

Recommendations:

1. All Medical Directors must be board certified in a primary care field. The State has misread this, indicating that all physicians must be board certified. The investigative team has indicated that other primary care staff physicians should have completed an accredited residency training program in internal medicine or family practice and be either board certified or become board certified within three years of employment. Only the State Medical Director could grant exceptions to this requirement based on his or her own assessment of the candidates. The basis for this recommendation is that in our experience and discussion with other State Medical Directors, there have been a disproportionate number of preventable negative outcomes related to primary care services provided by non-primary care trained physicians. The investigative team does not believe that experience practicing in a field without the required training is adequate in mitigating the preventable negative outcomes.
2. All clinicians should have access to electronic medical references at the point of care.

3. Every special medical mission facility must have its own Health Care Administrator.
4. The Director of Nursing position at all facilities is a full-time position whose time should not be taken away by corporate responsibilities.
5. Establish approved budgeted positions for Stateville and the NRC which allow for each facility to function independently.
6. Provide a full-time Health Care Unit Administrator as well as a full-time Quality Improvement Coordinator/Infection Control Nurse for both Stateville and the NRC.
7. Each facility is to develop and implement a plan to insure registered nursing staff is conducting sick call.
8. Medical vendor health care staff assigned to leadership positions, such as the director of nursing, supervising nurse or medical records director, will not be assigned corporate duties such as time keeping, payroll or human resources activities.
9. IDOC to develop and implement a plan which addresses facility-specific critical staffing needs by number and key positions and a process to expedite hiring of staff when the critical level has been breached.

IDOC Office of Health Services Staffing Recommendations

1. Immediately seek approval, interview and fill the Infection Control Coordinator position.
2. Establish and fill the position for a trained Quality Improvement Coordinator who will be responsible for directing the system wide CQI program.
3. Establish, identify and fill the positions for three regional physicians trained and board certified in primary care who will report to the Agency Medical Director and perform at a minimum peer review clinical evaluations, death reviews, review and evaluate difficult/complicated medical cases, review and assist with medically complicated transfers, attend CQI meetings and one day a week, within their region, evaluate patients. Resources for these positions could be taken from monies allocated to the medical vendor for regional physicians.

Overview of Major Services

Clinic Space and Sanitation

Clinic space, sanitation and equipment are problematic at each facility with the exception of Hill Correctional Center. The issues ranged from no designated space identified to conduct sick call in housing units, to designated space being inadequately equipped to designated space providing no privacy or confidentiality during the health care encounter.

For example, at Statesville, on the first floor of cell houses B, C, D, E, F and the X-house, a cell has been converted for use as a sick call area. These areas in cell houses B, E and F have no examination tables. Additionally, each of the areas retains the “open-front” cell door with bars which provides for no privacy or confidentiality during a sick call encounter. As a result, these identified areas cannot be considered as appropriate clinical space. In addition, these areas are very noisy.

At the Northern Reception Center, cell houses were originally designed to include a room for health care encounters on the first floor of each housing unit. These areas have all been taken

over by security staff and are being used as the cell house security officer's office. If appropriately equipped, these areas would meet the criteria as being appropriate clinic space.

At Dixon, the examination rooms used by the physician and advance level practitioners in the health care unit are appropriately equipped and provide the required level of privacy and confidentiality. The areas designated for nursing call, however, are just the opposite. The designated rooms are inappropriately equipped as they have no examination tables, and provide for no privacy during an examination due to large windows which were required for security reasons. Additionally, one identified sick call area is in a hallway at a desk. Obviously, this area is inappropriate for use as it has no equipment, and there is a total lack of privacy and confidentiality.

Of particular concern was that supervising nursing staff was totally unaware of the deficiencies pertaining to these areas. This suggests significantly underdeveloped professional oversight.

In the housing unit used for administrative and disciplinary segregation, which is the X-house, a room was designed to be used for sick call encounters; however, the area is not being used. If appropriately equipped, this area would meet the criteria as an appropriate clinic space.

At Pontiac, cell house clinic space has been identified and is being used as such but is totally inappropriate. The areas are old communal style shower rooms which have not been redesigned in any way. The areas have no equipment and provide no privacy or confidentiality. Meager accommodations were made, in that old physical therapy tables are being used rather than examination tables. The physical therapy tables are old with cracked and torn coverings and, by design, do not allow for the head of the table to be elevated.

The Logan health care unit examination rooms are appropriately equipped and provide sufficient patient privacy and confidentiality during sick call encounters. In the X-house, where reception, segregation and maximum-security inmates are housed, two rooms have been designated for sick call. One of the rooms is used by an advanced level practitioner and the other by nursing staff. The housing unit was very noisy, to the point that a nurse performing the reception nurse screen was observed having significant difficulty talking with a patient who was sitting less than three feet away. Additionally, the nursing sick call room was very small and cramped.

At Illinois River, the health care unit examination rooms are appropriately equipped and provide sufficient privacy and confidentiality. In the X-house, which houses administrative and disciplinary segregation inmates, no clinic space has been identified. The concern is that nursing staff will not perform a needed examination because they will not bother security staff to remove the inmate/patient from his cell and escort him to the health care unit where an appropriate examination can be conducted.

There were no issues in this area at Hill Correctional Center. Health care unit examination rooms are appropriately equipped and provide sufficient privacy and confidentiality. Additionally, a room in the X-house, which houses segregation inmates, is used for sick call, and the room is appropriately equipped and provided sufficient privacy and confidentiality.

The Menard health care unit examination rooms were appropriately equipped and provided sufficient privacy and confidentiality. Space has been established in each cell house, South (upper and lower), North, North 2, East and West, to conduct either nurse or physician sick call. The identified areas were former inmate cells and never designed as a clinical environment. Currently, the areas provide little to no privacy, and all of the areas are not appropriately equipped. Renovations have begun in the East Cell House to provide for an appropriately equipped, clean, private clinical setting. Renovation of all the areas in each housing unit should be made a priority.

In North 2, an appropriately equipped room is being used for sick call; however, the area provides for no privacy during an examination. Additionally, the room used by the correctional medical technician, who conducts sick call, does not have an examination table.

In regard to sanitation, there were issues across the system. In many of the facilities, examination tables and stools, infirmary mattresses and stretchers were observed to have cracked or torn impervious outer coatings which do not allow for the items to be properly cleaned and sanitized between patients. In each instance, there had been no work order submitted to repair the item and no requests submitted for purchase of new items. Additionally, many of the facilities are not using a paper barrier, which can be changed between patients, on the examination tables, nor was their evidence of wiping down the examination table with a sanitizing liquid/spray between patients when paper is not used. At Menard, there was no sink for hand washing in the South-Lower cell house sick call area.

Recommendations:

1. All sick call must take place in a designated area that allows sick call to be conducted in an appropriate space that is properly equipped and provides for patient privacy and confidentiality.
2. Equipment, mattresses, etc., which have an impervious outer coating must be regularly inspected for integrity and repaired or replaced if it cannot be appropriately cleaned and sufficiently sanitized.
3. A paper barrier which can be replaced between patients should be used on all examination tables.
4. Hand washing or sanitizing must be provided in all treatment areas.

Reception

We visited three reception centers and clearly, for males, the bulk of the newly admitted inmates enter through the Northern Reception Center. Just as custody, by using databases and fingerprints makes sure that it identifies who the patients are in order to insure that they are appropriately housed, so too the medical reception process is designed to identify acute and chronic medical problems along with acute and chronic mental health problems, as well as any potential communicable diseases and any other special needs. The purpose of doing a comprehensive medical intake is not just to identify the needs but to insure that those needs are appropriately addressed. We found problems with both the identification and the follow through in terms of meeting the patients' needs. When either type of problem occurs, this creates an avoidable liability for the patient. By avoidable liability we mean both potential harm for the

patients as well as potential legal liability for the state. At NRC there are substantial delays in medically processing patients through the reception process. In some instances, these delays extend for more than a month.

At the time of our visit to NRC, we found between 200-300 medical records of patients who had received a nurse screen and who were awaiting a physical exam by an advanced level clinician. Many of these patients had been there more than two weeks. Medical records are disorganized and inhibit the provision of adequate services. Under the presumption that patients will move out within two weeks, documents are loosely dropped into the medical record rather than being filed and yet NRC is responsible for patients, particularly at the medium-security unit, who may stay for years. These medical records are dysfunctional. The degree to which medical records are disorganized impedes the ability of clinicians to utilize and identify available clinical information and therefore impedes their ability or reduces the probability of their response being clinically appropriate. We also found that the current forms being used do not elicit questions regarding current symptoms as is standard in most systems. Finally, there is no process to insure that TB test results, blood test results and any other tests are integrated along with the history and physical into a problem list and plan for each problem. This therefore inhibits the intrasystem transfer service. Additional staffing may be necessary with regard to clinicians involved in reception at NRC as well as the medical records process at NRC. Examples of failures of the reception process at NRC include a patient entering with a history of a positive TB skin test that was never followed up. Another example is a patient whose intake laboratory screening demonstrated significant liver abnormalities but this apparently went unnoticed. Another example is a patient whose blood pressure was significantly elevated with a history of high blood pressure and there was no follow-up. This is particularly problematic because hypertension tends to be an asymptomatic disease. Although it may not be causing symptoms, while the blood pressure is elevated we know that there can be damage to the heart and the cardiovascular system. Despite a patient with HIV having abnormal laboratory studies suggestive of poorly controlled HIV, there has been no follow-up. Another example is a patient with a history of hepatitis C who was to be assessed and scheduled in two weeks but no follow-up ever occurred. Another patient newly arrived with a seizure disorder and chest wall tenderness was supposed to be followed up in one month but that also did not happen.

With regard to Menard, a patient entered with elevated lipid studies but this was never identified nor was it addressed. Another example is a patient with asthma and COPD who was placed in the infirmary but did not have a comprehensive exam for his lung problem for two weeks. At Logan, when we reviewed new intake records, a majority of those records did contain problems. Most of the problems related to delays in follow-up but there was also a patient with asthma who did not receive an adequate evaluation. These deficiencies not only suggest breakdowns which create significant liability for the patients, but also an absence of an organized system of self-monitoring in order to insure that what needs to be done is in fact done.

We would suggest assigning a person as reception process coordinator who would maintain the equivalent of an Excel-type spreadsheet with the left hand column containing the name and identifiers of the patient and then subsequent columns including date of arrival, date of nurse screen, date of lab draw, date of TB skin test, date of physical exam and finally date of initial problem list and plan which is developed from reviewing all of the data. This Excel spreadsheet

should have data input daily and patients would be directed to go to those areas for which they have not yet had the required service within the required timeframe. Finally, a clinician would review the records of patients with identified problems and insure that appropriate follow up has been initiated. A column could be created after the column on initial problem list and plan in which healthy patients would be differentiated from patients with identified problems and therefore only the latter group would have their records reviewed by the responsible clinician. On a weekly basis, the data would be reported and on a monthly basis the data would be summarized in a report to the quality improvement committee.

Recommendations:

1. A system that insures relevant electronic data arrives with the patients from Cook County Jail.
2. Sufficient nursing and clinician staff to complete the reception evaluation within one week.
3. A process that insures a clinician reviews all intake data, including laboratory tests, TB screening, history and physical, etc., and develops a problem list and plan for each problem.
4. Forms to identify acute symptoms.
5. A requirement that clinicians, during the history, elaborate on all positives from the nurse screen.
6. A system of placing on hold patients in the midst of appointments or incomplete treatment.
7. A policy that requires the medical record to be well organized and the staff to insure this is accomplished.
8. A quality improvement process that monitors completeness, timeliness and professional performance and is able to intervene in order to implement improvements.
9. A Medical Director trained in primary care.
10. A Health Care Unit Administrator position dedicated to NRC and appropriate supervisory resources.
11. A well-trained Quality Improvement Coordinator at each reception center and each facility dedicated to insuring the timeliness, completeness and professional appropriateness of the clinical decisions.

Intrasystem Transfer

The policy on intrasystem transfers consists of custody providing for medical staff a list of names of people who are to be transferred, usually within 24 hours. It is medical's responsibility to review the records and identify problems, current medications, allergies, scheduled appointments and any other significant health issues. These items are listed on the intrasystem transfer summary which goes with the inmate when he is transferred. When the inmate arrives at the permanent facility, he arrives with his record, the transfer summary and any medications. The policy requires that a receiving nurse reviews the key elements of the transfer summary, such as chronic problems, medications, allergies, appointments and anything else of significance with the patient, observes the patient and performs vital signs. The purpose of this process, like medical reception, is to insure that continuity of care is facilitated. We looked at the intrasystem transfer process in several facilities. Although we found problems in almost every facility, the rate of

problems was lowest at the Hill Correctional Center and was highest at Dixon. At Dixon, the process was so broken that despite the fact that Dixon has a special medical mission, including geriatric patients, when patients arrived they were not immediately seen by a nurse with the record who reviews the transfer summary with the patient and performs vital signs. In fact, virtually every intrasystem transfer record we reviewed was significantly flawed and in many of them the process was not initiated until two or more weeks after the patient had arrived. This guarantees delays in care. Examples of delayed intrasystem transfer reviews include a 37-year-old with asthma who arrived at Dixon on 2/4/2014, but the patient was not seen and the transfer summary reviewed and completed until eight days later, and even then there was no referral to the asthma clinic. Another example is a 27-year-old with multiple sclerosis whose health transfer summary was completed approximately three weeks after he arrived, but despite the transfer process being completed, there was no referral to a chronic care clinic for his multiple sclerosis. There is a 30-year-old who arrived with thyroid problems and lipid problems. His transfer summary was completed 11 days after he arrived and again there is a failure to refer to the chronic care program for his hypothyroidism. Finally, in one of the Dixon death reviews, a patient was identified who was diagnosed with early prostate cancer at Cook County Jail. One month after reception, he was transferred to Dixon, where he was housed in the infirmary due to his oxygen needs related to chronic obstructive pulmonary disease. This patient was never referred to an urologist even though that referral should have been made on entry to Dixon. This patient died in February 2013 from complications of many of his diseases. This type of severe breakdown insures delays in access to services and disrupts continuity of care. In several facilities, although the process was more compliant with the policy than at Dixon, approximately one-third of the records we reviewed were significantly problematic. This again speaks to an absence of self-monitoring and self-correcting.

Recommendations:

1. Custody must propose a list of transferring inmates to medical at least 24 hours prior to transfer.
2. Inmates with scheduled offsite services should be placed on medical hold until the service has been provided.
3. A nursing supervisor should regularly review a sample of transfer summaries of patients about to be transferred to insure the completeness of the data.
4. Office of Health Services should provide a guide as to how to efficiently review a record to identify important elements to be included in the summary.
5. When patients arrive, they must be brought to the medical unit and a nurse must be responsible for facilitating continuity of required services.
6. At least quarterly this service must be reviewed by the QI program.

Medical Records

The quality of the medical records was poor at most of the facilities we visited. Problem lists were frequently not updated and often cluttered with redundant and irrelevant information, such as each time the patient was seen in chronic care clinic. In many instances, important information was missing from the health records, such as the MARs from the last several months. There were blanks on the MARs at virtually every facility. At those institutions with a reception center function, drop filing is used, meaning loose papers are “dropped” into a folder. This results in

disorganized records that are difficult and time consuming to glean information from. The worst in this regard was NRC, where nothing was properly filed no matter how long the patients were housed there. At Logan we encountered large piles of loose filing stacked in the inside cover of most charts. Several of the facilities we visited did not file sick call slips in charts and some routinely discarded them. The extent to which medical record maintenance is disorganized and dysfunctional contributes to the likelihood of a less well informed clinician who will therefore be less able to make the appropriate clinical decisions. When less appropriate clinical decisions are made, appropriate care may either be significantly delayed or in fact not occur at all. Medical record maintenance should facilitate informed care and appropriate clinical decision making.

As writing notes by hand is cumbersome and time consuming, most notes contained very little information with respect to symptom histories (nurses tended to do better than providers in this regard), physical exams or medical decision making. In nearly all facilities, the handwriting of one or more providers was so illegible that it rendered the notes all but useless to anyone other than the author.

It is our understanding that the state has purchased an electronic health record system which will be implemented in the near future. This should solve some of these issues, such as illegibility, but it is less clear that others, such as the problem lists and thoroughness of documentation, will be improved by implementation of an electronic health record. We were told that existing records will not be scanned into the electronic system. This will result in redundancy of records and thus greater disarray and more inefficiency than currently exists. In the end, the quality of the electronic health record will determine if the transition results in an improvement in efficiency, quality and patient safety, or merely a redundancy in record keeping with the attendant problems that such a system creates.

Recommendations:

1. Problem lists should be kept up to date.
2. Only providers should have privileges to make entries on the problem list.
3. The system of "drop filing" should be abandoned.
4. Medical records staff should track receipt of all outside reports and ensure that they are filed timely in the health record.
5. Charts should be thinned regularly and MARs filed timely.
6. Consideration should be given to scanning specific important records into the new electronic system if possible.

Nursing Sick Call

Nursing sick call ranges from problematic to significantly broken throughout the system, in that one or more of the elements required of a professional sick call encounter are missing. These elements are:

1. Sick call request slips are available to inmates.
2. Completed requests are placed directly by the inmate into a locked box or handed directly to a health care staff member.
3. Completed requests are collected by a health care staff member.

4. There is identified clinic space.
5. The clinic space is appropriately equipped.
6. The clinic space provides patient privacy and confidentiality.
7. Sick call including paper triaging is conducted by a licensed registered nurse whose education, licensure and scope of practice permit independent assessment.
8. Sick call is conducted pursuant to the policies and procedures of the IDOC Office of Health Services in regard to the use of approved treatment protocols at each encounter, required documentation, required use of over-the-counter medication dosages only and referrals/follow-up as needed.
9. A sick call system must insure confidentiality from request to treatment.
10. A sick call system which addresses all of a patient's complaints or, at a minimum, prioritizes the complaints.
11. A sick call log or tracking system has been developed and maintained.

One or more of these elements was missing at each facility inspected. There were examples at each facility of either no identified clinic space to poorly equipped clinic space that provides no patient privacy or confidentiality, to established policy and procedure not being followed, to treatment protocols not being used or followed and to non-medical staff handling confidential sick call requests. At every facility, a sick call process has been established which allows for non-registered nurses to conduct sick call and, at many of the facilities, particularly in the segregation unit, legitimate sick call is not being conducted but in its place a "face-to-face" triage where the RN, LPN or Correction Medical Technician talks to the patient through a solid steel door occurs. Without an appropriate physical assessment, this face-to-face triage results in the formulation and implementation of a plan of treatment based solely on the inmate/patient's comments with no collection of objective data such as vital signs or a physical examination. This does not meet the definition of a professional assessment requiring an adequate history, vital signs, an appropriate physical assessment and the synthesis of the data into a nursing diagnosis and the development of an appropriate plan. Without such a professional assessment there is a significantly reduced likelihood of an appropriate diagnosis and an appropriate plan and this increases the potential for harm to the patients. During the sick call process the registered nurse or in the instance suggested by the State, an LPN, is expected to do a physical assessment, that is examine the throat or eyes or ears, etc. Supervising, i.e., reviewing the documentation based on such assessments being performed does not allow one to confirm that the assessment was in fact accurate and appropriate. There is no efficient way for RNs to supervise this process and given the inadequate training that LPNs have in physical assessment, it is only appropriate that the responsibility for conducting sick call be limited to registered nurses. The NCCHC accredits 25-bed jails as well as large prisons and although there has not been agreement on defining what level of staffing should be credentialed for sick call based on the size of the institution, there have been such discussions. The Commission's position is that the scope of practice allowed within a given state is determined by the state nursing board and this is acceptable to the National Commission on Correctional Health Care. A review of the Illinois Nurse Practice Act describes independent assessments, which essentially is what a sick call assessment is, are only sanctioned for performance by registered nurses. Licensed practical nurses may assist in or participate in an assessment but may not independently perform sick call as we found in some prisons.

While it is IDOC policy that each month the institutional Medical Director reviews the documentation of two sick call encounters per provider, i.e., RN, LPN or CMT for completeness, this is a retrospective paper review to determine that the provider answered all the questions and checked all the boxes on the pre-printed treatment protocol form. There is no way, however, for the physician reviewer to determine if the provider accurately interpreted and documented physical findings in order to determine an appropriate assessment and treatment.

At each of the facilities inspected, when a non-registered nurse conducted sick call, there was no immediate review by a registered nurse or physician to insure the provider conducted an appropriate physical assessment and accurately interpreted physical findings.

Of particular concern, specifically at Stateville and Pontiac, is the frequent arbitrary cancelling of sick call encounters by security staff. Such practices represent significant impediments to access to care and result in delays in treatment.

Of notable concern at Dixon is the practice of medical staff only permitting a patient to voice one concern at an encounter despite multiple concerns listed on the sick call request. Since inmates are charged a co-pay for medical services, inmates interviewed at Dixon were of the opinion that being permitted to have only one health care complaint addressed at an encounter was a "money making" scheme for the State.

At some facilities, most notably NRC and Dixon, it was difficult to impossible to evaluate sick call because a Sick Call Log has not been developed or maintained. In fact, during the four days at NRC, a sick call list could not be presented even though requested multiple times.

Hill Correctional Center has developed a sick call system with the above numbered elements in place. Only rarely does a non-registered nursing staff member review/triage sick call requests and conduct sick call. This generally happens when sick call flows over to the 3-11 shift, and a Licensed Practical Nurse would complete any remaining sick call from the day shift.

Recommendations:

1. Each facility is to develop and implement a plan to insure:
    a) Sick call is conducted in a defined clinical space that is appropriately equipped and provides patient privacy and confidentiality.
    b) Sick call requests are confidential and to be viewed only by medical staff.
    c) The review/triage of sick call requests and conducting of sick call is performed by a licensed registered nurse.
    d) Legitimate sick call encounters to include collecting a history, measurement of vital signs, visual observations and a "hands-on" physical assessment.
    e) There must not be arbitrary restrictions on the number of symptoms to be addressed at an encounter.
    f) Following Office of Health Services established policy and procedure.
    g) Complete documentation.
    h) Implementation and maintenance of a sick call log.
2. Administration must insure health care activities such as sick call are not routinely cancelled, as this results in an unacceptable delay in health assessment.

Chronic Disease Management

The IDOC chronic care program suffers from deficiencies in its policies and guidelines, as well as weaknesses with respect to the variable quality of the individual practitioners, and lack of clinical oversight both locally and centrally.

With regard to policy issues, the most important and overarching problem is the "cookie cutter" approach to chronic disease management, in that policy dictates that all patients are somewhat arbitrarily seen only three times a year regardless of how well or how poorly their disease control may be. Patients should be seen in accordance with the degree of control of their diseases, with poorly controlled patients seen with greater frequency, and well controlled patients seen less frequently. The concept of disease control in this context is derived from the NCCHC chronic disease guidelines which were in fact developed by the leader of the investigative team. He was tasked with developing these guidelines for the purpose of facilitating good disease control as expeditiously as possible in order to decrease the risk of avoidable morbidity and thereby improving patient outcomes. However, when this concept is implemented by the "designated month" approach, it does not encourage clinicians to work as aggressively as possible with their patients to achieve good disease control and thereby exposes patients to longer periods of increased risk of harm.

A quarterly visit only makes sense (and is safe) if patients' diseases are in good control. If not, then patients are exposed to the cumulative organ damage caused by inadequately controlled chronic disease. This degree of exposure is what leads to avoidable morbidity and mortality. While it is currently possible for providers to arrange for more frequent follow up, this is left entirely to the discretion of the individual practitioner and by no means occurs on a regular basis. At every facility we visited, we encountered cases of patients with poorly controlled chronic disease going months without any active management of their disease process, even if they were seen in clinic for other, less important issues.

By assigning specific months of the year for the management of each disease, the chronic care program (perhaps inadvertently) creates a fragmented and inefficient system of care wherein patients with multiple diseases are seen for only one disease per calendar month. We encountered multiple examples wherein patients who were seen in chronic clinic or at sick call for one illness had evidence of poor control of another disease, but the poorly controlled disease was not addressed, presumably because it was not the designated month (or visit type) to address it. There were notable exceptions to this, such as Menard and Hill Correctional Centers, where the chronic clinic nurses have developed comprehensive forms designed to address all chronic diseases in one visit. At other facilities, such as Stateville and Pontiac, all diseases are also addressed at a single visit but the provider fills out multiple chronic care forms, a process which is redundant, inefficient and time consuming. We recommend that the State adopt a system similar to Menard or Hill which represents a more comprehensive and unified approach to chronic disease management.

Other important policy issues relate to the management of specific diseases, most notably HIV and COPD. With respect to the HIV policy, there is no IDOC Treatment Guideline for HIV; there is only the Wexford Health HIV/AIDS Infection Control Policy, which does not require that facility providers follow the HIV patients who are not followed by the facility providers for

their HIV disease. In every facility we visited, these patients were managed solely by the ID specialist via telemedicine for their HIV infection. While the HIV consultants are excellent specialists, they are not primary care providers. These patients have a chronic disease in the same sense that diabetes, hypertension or coronary artery disease is a chronic disease. In other words, having a disease that requires the intervention of a specialist does not obviate the need for a primary care provider. While we would not expect the average primary care provider to be proficient at prescribing HIV treatment, it is expected that all providers at least be familiar with the basic principles of treatment, the importance of medication compliance and the most common side effects of frequently used medications. The HIV virus readily develops resistance mutations when medications are not taken exactly as prescribed. Once this happens, those medications become useless in the treatment of the patient's disease.

Given the limited number of medications available to treat this life-threatening infection, it is extremely important that patients understand the importance of medication adherence and are followed closely to ensure they are taking the medications correctly and tolerating them. So for example, when the HIV specialist starts or changes a medication, it is generally recommended that the patient have a follow-up appointment within a few weeks to inquire about adverse effects and adherence. We encountered numerous examples of patients going for days, weeks or months without their medications, either because of refusals or other system issues, and these treatment interruptions went unnoticed by the local providers because they are not actively following this disease process. For example, patient #51876 went without his HIV medications for an entire month, but this went unrecognized until his follow-up telemedicine visit months later. Patient B17846 went at least two days without any of his medications due to a cell move. Patient R07630, who was on deep salvage therapy for his HIV disease, had his medication ordered, and therefore administered, incorrectly for months before it was corrected at the next telemedicine clinic visit despite the fact that he was followed in the chronic care program for his other diseases. In our opinion, the providers' lack of familiarity with these patients and with HIV disease itself places the patients at unnecessary risk of adverse outcome. We recommend that these patients are actively followed by facility providers in the chronic care program.

In most correctional systems, even when the HIV patients care is overseen by an HIV specialist, the primary care clinician within the chronic care program monitors blood test results as well as their patients' subjective and objective data. When issues are identified by the primary care clinician (e.g., rising viral loads), the patient is referred to the HIV specialist or the HIV specialist is contacted. In general, decisions to initiate or change treatment are made by the HIV specialist.

With regard to the management of pulmonary diseases, the treatment guideline is seriously deficient, in that it only addresses the treatment of asthma and not of other obstructive lung diseases such as COPD and chronic bronchitis, which are common and important causes of morbidity and mortality in the U.S. and the treatment of which differs in important ways from the treatment of asthma. It was therefore not surprising to find that in the majority of cases we reviewed, patients with lung disease were treated as if they had asthma even if they clearly had COPD, sarcoidosis or some other pulmonary disease. The NCCHC treatment guidelines, while a reasonable starting point, are nearly 15 years old and do not specifically address COPD or pulmonary diseases other than asthma. As the incarcerated population has aged, COPD has

become a much more prominent disease entity in this group and needs to be treated according to current nationally accepted clinical guidelines. The current IDOC asthma guideline appears to be based partly on the National Heart, Lung and Blood Institute (NHLBI) Expert Panel Report 3 (EPR 3). For example, the section on assessing symptom severity is consistent with the NHLBI recommendations, but the assessment of control is not. The NHLBI guidelines also take into account additional data, such as symptom interference with normal activity and peak flow monitoring when assessing degree of control. We recommend that the department adopt this strategy. We also recommend the department mimic the NHLBI in its control terminology of "well," "not well," and "very poorly" controlled rather than "good, fair, poor" control in order to heighten awareness of the need to modify therapy for all categories that are less than well controlled.

With regard to the care of patients with diabetes, we noted a number of problems at various facilities. For example, we observed that at some facilities it appeared to be common practice to routinely switch patients from insulin regimens that mimic the body's own insulin production (so-called "intensive insulin therapy") to simpler but non-physiologic regimens (known as "conventional insulin therapy") regardless of the type of diabetes the patient had. This often occurred upon arrival and in the absence of a visit with the clinician. This practice is inappropriate for several reasons. First, types 1 and 2 diabetes are quite different diseases, with the former characterized by insulin deficiency and the latter by insulin resistance. As such, they require different and individualized approaches to insulin therapy. Conventional insulin therapy is unlikely to achieve target blood sugar levels in patients with type 1 diabetes, who as mentioned are insulin deficient and for whom physiologic insulin replacement is typically recommended and is the standard of care in the community. Type 2 diabetics on the other hand retain varying degrees of insulin production until the late stages of the disease and can often be managed with simpler insulin regimens, at least until their own insulin production eventually fails and they too require more intensive regimens.

In either case, because patients differ in their eating habits, activity levels and sensitivity to insulin (especially in the case of type 2 diabetics), individualized approaches to the management of their insulin regimens is required. This entails monitoring patients' blood sugar readings over time as well as discussions with patients regarding symptoms of low or high blood sugar and evaluation of their compliance with diet, exercise and medications. Arbitrarily changing insulin regimens before taking into account all of these variables can result in deterioration of disease control and does nothing to foster a relationship based on trust and communication, which is vitally important to enhance compliance.

A second issue we encountered is that many of the facilities are still using the outdated "IDDM" (insulin dependent diabetes mellitus) vs. "NIDDM" (non-insulin dependent diabetes mellitus) terminology to categorize diabetic patients. This terminology was abandoned in the community many years ago because it is imprecise and misleading. The problem with labeling diabetics this way is that it does not differentiate between type 1 and type 2 diabetes, which are physiologically distinct entities as previously mentioned. All type 1 diabetics are insulin dependent by definition. However, many type 2 diabetics require insulin to keep their disease under control, but in many cases it may be appropriate to also use oral agents in this population. We recommend that all patients be categorized as either Type 1 or Type 2 diabetics as is the community standard.

Regardless of the type of diabetes, it is important that all diabetics have reliable mealtimes which closely correlate with medication administration in order to maintain blood sugar levels within safe ranges. However, we noted that at some facilities, meal times can be highly variable and therefore so too can be the timing between insulin administration and the start of the meal. The extreme example in this regard is Stateville, where breakfast is served during what most people would consider the middle of the night, between 1:30 a.m. to 3:30 a.m. At Menard, morning insulin is administered between 2:30 a.m. and 3:30 a.m. and breakfast is served between 4:30 a.m. and 5:00 a.m. Considering that the onset of action of regular insulin is about 30 minutes, this presents a significant risk of low blood sugar for these patients which may cause brain damage, coma or death. When patients have a sustained elevation of blood sugar, the result is potential damage to the blood vessels in the heart, the brain, the kidneys and the eyes. Therefore, it is extremely important for patients to receive appropriate regimens that control and regulate the level of sugar in the blood.

Although there are passing comments in the Offender Physical Examination AD (04.03.101) regarding the frequency of health screening for women, these guidelines are inadequate. For example, this AD states that "A pap smear shall not be required for females over age 65 provided they have received adequate prior screening…" but does not state what "adequate prior screening" consists of. Likewise, that same policy goes on to state that "a mammogram shall be repeated every other year for females of ages 50 through 75," but does not stipulate any situations in which earlier or more frequent screening would be indicated. We noted multiple cases of women who did not receive necessary screening tests. At Logan, we noted that patients typically get a Pap smear on intake, but there were frequently delays with subsequent follow-up care and routine Paps thereafter, especially for HIV infected women who require more frequent screening than uninfected women due to their increased risk for invasive cervical cancer. We recommend the creation of a chronic disease clinic devoted to women's health that includes more specific guidance on these issues.

With regard to the management of pulmonary diseases, the treatment guideline is seriously deficient, in that it only addresses the treatment of asthma and not of other obstructive lung diseases such as COPD and chronic bronchitis, which are common and important causes of morbidity and mortality in the US and the treatment of which differs in important ways from the treatment of asthma. It was therefore not surprising to find that in the majority of cases we reviewed, patients with lung disease were treated as if they had asthma even if they clearly had COPD, sarcoidosis or some other pulmonary disease. The current asthma guideline appears to be based partly on the National Heart, Lung and Blood Institute (NHLBI) Expert Panel Report 3 (EPR 3). For example, the section on assessing symptom severity is consistent with the NHLBI recommendations, but the assessment of control is not. The NHLBI guidelines also take into account additional data, such as symptom interference with normal activity and peak flow monitoring when assessing degree of control. We recommend that the department adopt this strategy. We also recommend the department mimic the NHLBI in its control terminology of "well," "not well," and "very poorly" controlled rather than "good, fair, poor" control in order to heighten awareness of the need to modify therapy for all categories that are less than well controlled.

In the course of our reviews we noted multiple instances in which patients experienced medication discontinuity for a variety of reasons, yet this went unrecognized and therefore unaddressed by the treating clinicians. Part of the problem seems to be dysfunctional medical record keeping, whereby medication administration records (MARs) were not filed timely into the charts. In other cases, nurses had knowledge that patients were skipping doses of medications yet did not notify the prescriber. Policy should require that patients who miss medications for any reason (fail to request a refill, refuse, no-show, etc.) are referred to a provider to address the issue. The policy should also require that all chronic disease patients on nurse-administered medications have a copy of the active MAR placed in the record when the patient is seen for chronic disease follow up.

Since it is an officer's responsibility to check for and identify contraband and begin the process of sanctioning the inmate, this responsibility exists also during medication administration. Nurses do not have a responsibility professionally to be searching for contraband. If they identify it they are obligated to report it, but searching for it is not part of their responsibilities. During the medication administration process, they can be documenting the medication administration, checking the records to determine whether the next patient's medications are present, a variety of things related to the process as opposed to performing what is a typical custody function.

Recommendations:

1. Patients should be seen in accordance with the degree of control of their diseases, with more poorly controlled patients seen more frequently and well controlled patients seen less frequently.
2. Chronic care forms and flow sheets should be updated and be designed so that all chronic diseases are addressed at each visit.
3. HIV patients should be followed regularly by IDOC providers in the chronic care program to address their primary care needs, monitor for medication compliance, side effects of therapy and overall health status.
4. The Asthma Treatment Guideline should be replaced with a guideline on the treatment of pulmonary diseases to include COPD and chronic bronchitis as well as asthma. This guideline should be modeled after the NHLBI report.
5. There should be a chronic clinic devoted to women's health to include specific guidelines on cervical and breast cancer screening as well as other issues unique to this population.
6. The TB guideline should be updated to provide basic information regarding interferon gamma testing, including appropriate uses of this test.
7. Policy should require that patients who miss medications repeatedly or for a significant period of time are referred to a provider to address the issue.
8. Copies of the current MAR should be available for the provider's review during chronic care clinic.

Pharmacy/Medication Administration

At all facilities, Boswell Pharmaceuticals, located in Pittsburgh, PA, provides the prescription and non-prescription medications. Boswell is licensed as a Wholesale Drug Distributor/Pharmacy Distributor and a current license was available at all sites. The service is "fax and fill," meaning prescriptions faxed to Boswell by a designated time each day will arrive

the next day. Each facility has designated a back-up pharmacy in the community to obtain urgently needed medications. Each facility had at least one full-time pharmacy technician who was responsible for the day-to-day operation of the medication room including ordering, receiving and inventorying. Boswell provides a consulting pharmacist to come on-site monthly to assist the pharmacy technicians, check inventories and attend quality improvement meetings. Random checks of controlled medication, syringe/needle and medical tool perpetual inventories were all accurate and being counted/verified at the appropriate intervals. None of the facilities reported any problems/issues with pharmacy services and none were noted.

Regarding medication administration, there is a concern at the NRC. Health care staff administer medication dose-by-dose at the cell. The NRC has a policy that health care staff is escorted at all times when in a cell house. Observation of medication administration revealed significant delays because a security staff member was not assigned and available in each cell house to provide escort. A security staff member was finally provided after several requests and a significant time delay. It was observed that the security escort provided no service other than walking with the health care staff member. It is our recommendation that security officers, following patient ingestion, should check for contraband. While we fully agree it is the responsibility of medical staff to deliver and administer medication, at the point the inmate receives the medication and elects to not ingest it, the uningested medication is contraband, and officers search/check for contraband, not medical staff. Medical staff does not function as an arm of custody. It would seem, since inmates are accustomed to security staff routinely performing cell searches for contraband, inmates would be more likely to cooperate with officers in the performance of a mouth check following medication administration. Since officer assignments include escorting medical staff during medication administration, it would seem the process would be quicker and more efficient if the officer performed the mouth check, and the medical staff member could proceed to document the medication administration and begin to prepare the medications for the next inmate.

Recommendations:

1. Following patient ingestion of medication, security staff should be responsible to check the mouth for contraband.
2. A security staff member must be assigned to accompany the nurse who performs medication administration.

Laboratory

Laboratory services at each facility are provided through the University of Illinois-Chicago Hospital (UIC). Either full-time phlebotomists or nursing staff draw and prepare specimens for transport to UIC. Results are electronically transmitted back to the facility, generally within 24 hours via secure fax line located in the medical department. UIC reports all reportable cases both to the facility and the Illinois Department of Public Health. There is a current Clinical Laboratory Improvement Amendment (CLIA) waiver certificate on file at each facility. There were no reports of any problems with this service.

Recommendations: None

Unscheduled Onsite and Offsite Services (Urgent/Emergent)

In order to track unscheduled services and where indicated to improve performance, it is essential that an urgent care or telephone log be maintained. Unfortunately, several facilities, including Dixon, Logan, NRC and Menard either did not maintain such a log or did not maintain it conscientiously. This demonstrates the impossibility of their being able to self-monitor and improve performance. Such a log should contain fields for patient identifiers, date, time, where the patient was seen, presenting complaint, disposition and if the patient was sent offsite, a field for retrieved offsite service paperwork as well as follow-up visit with primary care clinician or Medical Director. Unscheduled services usually begin with a phone call from a housing unit to the medical unit, although occasionally patients are brought over without any prior call. What is expected is a registered nurse performs an initial assessment and then contacts an appropriate clinician for a discussion. When the patient is sent offsite, the patient should be returned through the medical area with the paperwork so that a nurse can review any recommendations and contact a physician if an order is needed. In addition, the nurse can perform a brief assessment, including vital signs, in order to insure patient stability. Some prisons automatically place these patients in the infirmary to be seen the following day by a physician. If this does not happen, there must be a follow-up visit with a primary care clinician within a few days. In reviewing this service, we found breakdowns both by nurses and clinicians in relationship to identifying patient instability and therefore arranging for the patient to be sent offsite. In addition, we also found breakdowns in terms of patients not being brought back to the medical unit to a nurse and we also found most commonly that patients were returning with patient instruction paperwork rather than an emergency room report or when hospitalized, a discharge summary. Hospitals have to understand that corrections patients are returning to a doctor and therefore patient instructions are not useful. Rather, an emergency room report or a discharge summary can be utilized by a clinician to understand what was done, what was concluded and what was recommended. These breakdowns inhibit the provision of appropriate care. In addition, we identified some patients who were not appropriately followed up by a primary care clinician.

In order to insure outside hospitals consistently provide emergency room reports when the patient is discharged, the agreement with the hospital should be explicit in that the service which is compensated by the agency includes both the actual service and the report from the emergency room or, with a hospitalization, a discharge summary. That strategy has worked effectively in many jurisdictions.

Failure to Identify Serious Instability-From Mortality Reviews

This patient was a 56-year-old man who died of prostate cancer on 3/21/14. He was seen by an urologist in January 2014 and because of severe back pain he was sent to the hospital on 2/3/14. However, while housed in the infirmary on 1/30/14, following his prostate biopsy, he began developing fevers and feeling ill. Beginning on 2/2/14, he developed temperatures of up to 104° as well as an elevated pulse rate of 132. The nurses appropriately notified the physician, who did not come to assess him until 2/3/14 in the evening. He was ultimately diagnosed and treated for sepsis after being sent out at 11:15 p.m. This patient complaining of fevers and tachycardia should have been sent out immediately.

From Dixon. This is a 64-year-old man with chronic obstructive pulmonary disease, atrial fibrillation, hypertension and prostate cancer. He died on 2/28/2013 from tuberculosis,

pneumonia and meningitis. On 1/24/13, he was admitted to the hospital for progressive shortness of breath and confusion. He returned to Dixon on 1/27/13. Beginning on 2/1, he became increasingly short of breath, lethargic, weak, confused and had intermittent fevers. On 2/5, the patient's temperature was 102°. The physician did not document a history or physical exam. Despite the fact that the patient had no evidence of influenza, the physician ordered Tamiflu. On 2/6, in response to a positive urine culture, the physician ordered IV antibiotics. On 2/7, the infirmary physician began documenting that the patient had an "extremely poor prognosis." On 2/11, he documented the patient was possibly septic. On 2/12, he finally sent the patient to the local hospital, where he was admitted to the ICU for respiratory failure. This patient should have been sent out much earlier and the documentation does not demonstrate sufficient concern for this patient's health and safety.

This is a 62-year-old man who entered IDOC in 2008 and died on 11/16/13 of GI bleeding from ruptured esophageal varices due to cirrhosis. This patient, on 11/13/13, presented with severe lethargy, dizziness, dyspnea and melena X 2 days. He was tachycardic, with a heart rate of 104. His blood pressure was normal and he had grossly positive stools for blood on exam. The doctor ordered labs and placed him in the infirmary at 1:10 p.m. At 1:30, the admitting nurse described him as pale and pasty. He had a small black stool consistent with acute blood loss. He complained of mild abdominal and chest pain. His blood pressure was 112/70 and his heart rate was 100. His hemoglobin was 10.2 grams and it had dropped from 13.3 grams four months earlier. At 8:00 p.m., a stat blood count was drawn and the result at 9:15 was 7.6 grams, suggestive of severe bleeding internally. At 9:45 p.m., the nurse called the doctor and he ordered IV fluids. On 11/14 at 3:25 a.m., his blood pressure was 100/60 and his pulse 104. At 9:20 a.m., the doctor saw the patient, who complained of weakness, dizziness and ongoing blood in his stools. He finally sent the patient to the hospital where he died two days later. When you identify a patient who has acute ongoing blood loss, to not send him out is incomprehensible.

An Inadequate Response Possibly Related to Medical or Custody Staffing

This is a patient from Dixon who is a 48-year-old with a seizure disorder. On 1/1/14, a nurse was called to the housing unit for a Code 3. In the record there is no description of the event, but the patient was brought to the clinic and ultimately wanted to return to the housing unit. The only note in the record is a note by an LPN where the assessment reads, "Post seizure." The patient was returned to the housing unit by the LPN with no contact with an advanced level clinician. There was an inadequate history and physical assessment and since only an LPN saw the patient there were significant liabilities engendered by this response. The Illinois State Nurse Practice Act clearly states, "Only a registered nurse may perform an independent assessment."

The next example is a patient from Logan who is a 35-year-old with a seizure disorder. On 12/30/13 at about 11:00 p.m., the cell house contacted the medical unit to respond to this patient, who was having seizures. When the nurse arrived, the seizures had ceased and she documented that she observed no seizures but left the patient in the housing unit without any adequate assessment. One day later at 11:40 p.m., the patient was found in the housing unit having a seizure, with blood around her mouth and blood dripping from a laceration in the back of her head. She was brought to the health care unit and sent to the local hospital. There was no mention of contacting the physician. The patient was returned from the hospital at 4:00 a.m. on 1/1/14. There are no records from the local hospital. The physician did come in on 1/1 and saw

the patient and ordered blood levels of her anti-seizure medications. However, there has been no follow up since by the physician. This patient should have been brought to the infirmary after the seizure on the first night for more careful observation and to be seen by a clinician. This characterizes a significant nursing breakdown.

The next case is from Menard and reflects inadequate nursing assessment following return from the hospital. This patient is a 61-year-old with osteoporosis who was sent out on 1/26/14. On that day at about 2:10 p.m., he complained of chest pain for two hours. He described it as a pressure in his chest and was given nitroglycerin with some relief. His blood pressure was elevated at 154/90 and his pulse rate was 116. The physician was called and the order was to send him to the hospital. The patient went to the hospital and returned one week later, on 2/3 and was placed in the infirmary for observation. He was seen later that day by the nurse, who did not ask any questions regarding chest pain, shortness of breath or the incisions on his chest. He was later seen by a nurse practitioner whose note indicates the patient had recently had coronary artery bypass graft surgery but neither the nurse practitioner nor the nurse elicited any subjective responses from the patient. The patient was ultimately released to the cell. The record, at the time of our review, still lacked any discharge summary or more importantly, the catheterization and echo reports, critical pieces that must be part of the medical record.

The next case is also from Menard and demonstrates inappropriate use of staff. This patient is a 57-year-old with hypertension, hepatitis C disease and substance abuse issues. He presented on 3/28/14 complaining of lower abdominal pain, aching and burning, with five loose stools. He was seen by a CMT (which is inappropriate since he needed an assessment). He should have been seen at a minimum by a registered nurse or a midlevel provider. He was referred to the physician the next day and when seen by the physician he was immediately sent out to rule out an acute appendicitis. In fact, he had an acute appendectomy and was returned on 3/31 and after an assessment by the Medical Director was returned to his cell. Although there was a recommendation for him to be followed up at the hospital, this never happened, nor is there any note indicating a change from that recommendation.

The next case is a 48-year-old patient with hypertension and glaucoma, also from Menard. Those two diagnoses are the only ones listed on the problem list. On 1/13/14, he complained of chest pain and was sent to the hospital. The workup at the hospital was negative for acute coronary artery disease and the diagnosis was reflux disease. He returned from the hospital and at the time of return his vital signs were normal. There is an order for an electrocardiogram and a physician assessment. The cardiogram was scheduled for 1/17, but there was a note that says it was not done because of a lockdown. This is a procedure done onsite which should never be cancelled because of a lockdown. In fact, it was not done until eight days later and at the time of our visit, there was still no cardiogram in the chart. This is a patient who had a previous history of both a heart attack and supraventricular tachycardia (rapid heart rate), although neither of these problems were on the problem list. An EKG was ordered but it was delayed unacceptably and in fact, four months later there was no report in the chart.

A majority of the records we reviewed contained neither an emergency room report nor, when patients were hospitalized, a discharge summary, despite the fact that these documents are crucial for appropriate continuity of care. Hospitals must be educated that compensation for a

service cannot be provided as long as the service which includes the appropriate documentation has not been provided.

Recommendations:

1. All facilities must track urgent/emergent services through using a logbook maintained by nursing which includes patient identifiers, the time and date, the presenting complaint, the location where the patient is seen, the disposition and when the patient is sent out, the return with the appropriate paperwork, including an emergency room report and appropriate follow up by a clinician.
2. Assessments must be performed by staff appropriately licensed to be responsible for that service.
3. Guidelines should be developed for nursing staff with regard to vital signs reflecting instability that require contacting a clinician.
4. When patients are sent offsite, work with hospitals to insure that the emergency room report is given to the officer to return to nursing with the patient.
5. Patients returning from an emergency trip must be brought to a nursing area for an assessment and if not placed in the infirmary, scheduled for an assessment by an advanced level clinician.
6. The Office of Health Services should provide guidance with regard to the types of clinical problems that require services beyond the capability of the infirmary, thus sending patients to the local hospital.
7. Insure that after the patient returns he is seen by a clinician within three days where there is documentation of a discussion of the findings and plan as described in the emergency room report.
8. The QI program should monitor timeliness and appropriateness of professional responses.
9. As an aspect of the QI program, review nursing and clinician performance to improve it.

Scheduled Offsite Services (Consultations and Procedures)

As we understand the process for obtaining consultations and procedures, it begins with the timely identification of the need for a procedure or consultation, usually for diagnostic assistance. Review of death records has revealed some delays in the timeliness of identification.

Once the clinician has determined that there is a clinical basis for offsite services, they are required to submit a form which documents the clinical justification for obtaining the service.

This form is reviewed by the site Medical Director, who either concurs and presents it to the weekly collegial review telephone discussion or suggests an alternate plan of care to the ordering clinician. When an alternate plan of care is recommended, either by the Medical Director or the collegial review teleconference, there must be a discussion between the ordering clinician and the patient so that he/she is on board with the change in plan. The telephonic collegial review is performed weekly and so there should be no more than a one-week delay due to presentation at the collegial review.

During the collegial review, the Pittsburgh-based physician either approves the service or suggests an alternate plan. We have been told by several sites that this rate of approval varies

dramatically based on which Pittsburgh-based physician happens to be receiving the phone call. Some approve at a much higher rate than others. For Dixon and Stateville, despite verbal approval received over the telephone, there is a substantial delay in Pittsburgh providing the authorization code to the University of Illinois. This delay can extend up to eight weeks or more. The scheduler at Dixon and at Stateville will call the University of Illinois scheduler, who works closely with them. Wexford changed the procedure so that the authorization is no longer given directly to the scheduler at the site; rather, it is given directly to the U of I scheduler, but as we indicated, this may occur up to eight weeks later. This is clearly not acceptable. Additionally, there are several specialties for which University of Illinois may not provide access for up to three or more months. In many instances, the services could be obtained much more timely by using a local service rather than the University of Illinois.

In most correctional settings, for scheduled offsite services, emergent consultation or procedures are sent out immediately, without any utilization review until after the fact. Urgent services are obtained in no more than 10 business days and routine services are generally obtained within 30 calendar days. From what we have seen, generally these measures are obtained when using local services. The extraordinary delays tend to revolve around the utilization of the University of Illinois.

Once the patient attends the appointment and receives the service, he should be returned to an onsite nurse with any accompanying paperwork, which should be given to the nurse. There are procedures for which one anticipates dictation and transcription and for these services a staff member at the institution must insure that the offsite paperwork is obtained timely. Finally, once the paperwork is available onsite, there should be a scheduled visit with the ordering clinician or Medical Director during which there is a documented discussion of the findings and plan.

During our review of records, we found breakdowns in almost every area, starting with delays in identification of the need for the offsite services, delays in obtaining an authorization number, delays in being able to schedule an appointment timely, delays in obtaining offsite paperwork and delays or the absence of any follow-up visit with the patient. Additionally, although some of the facilities were tracking these steps fairly conscientiously, others were not, creating much less dependable outcomes. In the best of the eight facilities we reviewed, there were problems at one step or another in about 20% of the records. In other facilities, such as Dixon Correctional Center, there were problems with almost every record reviewed. What follows are examples of the differing types of problems we identified.

Delays in Perceiving the Need for the Service

Illinois River Death Review. The patient, #K80880, entered IDOC in 2000 and began complaining of constipation in January 2011, when he weighed 195 pounds. The patient returned with a complaint of constipation in May 2011 and indicated that he had lost 10 pounds. At that point, the physician did not do a rectal exam. In December of the same year he indicated that he was losing weight and in fact he had lost more than 30 pounds and weighed 158. The doctor did perform a rectal exam but found no masses, although every subsequent physician did feel a mass. She ordered lab tests, which showed a mild iron deficiency anemia. She then ordered stool cards to see if there was blood in the stool and these came back positive. Finally, he was referred for a

colonoscopy, which on April 13, 2012 identified a large tumor in the rectum. Once the tumor was identified, his care was appropriate. However, he survived less than a year.

Hill Death Review. Patient #N41619 entered IDOC in 1984 and arrived at Hill Correctional Center in 2009, having stopped smoking two years earlier. His complaints began with left neck and chest pain in February 2012. In May 2012, he told a nurse he was coughing up blood, which he connected to a shoulder injury. He was seen a week later by the physician with multiple complaints, including weight loss, for which the medical record reveals a 30-pound weight loss. The physician saw the patient a little more than two weeks later and noted a left mobile quarter-sized mass in the left superclavicular area. He ordered iron and a chest x-ray. The chest x-ray revealed a focal opacity in the left lower lobe with tenting of the left hemidiaphragm. The Medical Director saw the patient in June and twice in July, and by August the patient's weight was down to 127 pounds. On August 20, he presented coughing up blood and the doctor ordered more blood tests, which showed his anemia worsening. It was not until August 31 that a CT scan was performed which showed "a very large carcinoma which extends through the superior portion of the left hemithorax, through the apex and involves the left anterior chest extending to the anterior plural surface and invading the mediastinum with tumors surrounding the ascending thoracic aorta, extending along the aortic arch and encircling the proximal descending thoracic aorta." This patient died of lung cancer on 1/30/13.

Delay in Obtaining Timely Appointment

Pontiac Death Review. The patient, #B33741, was a 42-year-old man who died of glioblastoma multiforme on 4/16/13. The tumor was first diagnosed in 2009, prior to his incarceration. He underwent excision in March 2009 and again in September 2010 for recurrence. He was admitted to IDOC in July 2012. He had a restaging MRI in October 2012 which showed no recurrence and his maintenance chemotherapy was discontinued.

A subsequent MRI on 2/1/13 showed recurrence of a low grade enhancing mass in his left temporal lobe and he was referred for neurosurgical consultation, but this was not scheduled until 4/10/13. However, on 4/1/13, he was found with altered consciousness and stroke-like symptoms and was taken to St. James Hospital, where CT showed significant edema around the mass and a 1 cm midline shift. He was transferred to UIC, where it was decided that the risks of surgery outweighed the benefits. The family decided to withdraw care on 4/15/13 and the patient died the next day.

A two-month delay in the neurosurgery consult is excessive, given the nature of the patient's diagnosis. Although his long-term survival would not likely have been much better, it seems likely that the delay allowed for enough tumor growth and associated swelling to preclude further treatment options for this patient and therefore shortened his survival.

Delays in Processing the Approval

This is the case of a patient from Dixon whose is a 65-year-old male with hypertension, asthma, GERD and a positive TB skin test. On 11/20/13, the clinician ordered a CT scan of the chest to rule out a mass. The patient was presented at the collegial review a little over two weeks later and on 12/4, an approval was obtained. Three weeks later, the authorization number was provided. The report, therefore, was done on 2/12/14, which indicates "suspicious for cancer." A

request for a pulmonary consult was made and approved two weeks before our arrival and yet an authorization number for this still has not been provided.

Delays in Following Up an Abnormal Result

This occurred at Hill Correctional Center from a patient who arrived at Hill on 3/29/13. This patient had hepatitis C and a prior positive skin test. On 3/21/13, he went out for an ultrasound of the abdomen as recommended by the hepatitis C specialist. The ultrasound showed multiple masses in the liver in December 2013. This was reviewed by the physician nine days after the service was performed. On 3/7/14, the hepatitis C specialist saw the patient and recommended a CT scan. The CT scan was done on 3/21/14, but there were no results in the medical record. The patient had also had an abnormal ultrasound several months earlier which no one had acted on. We finally obtained the CT results, which showed that they are likely benign tumors of the liver; however, this patient is fortunate that despite the absence of follow-up his health is probably not in jeopardy.

Problems with Follow Up

This is a patient at Menard who was found to have an elevated prostate screening test and was referred to the urology clinic. He was seen there on April 8 and a recommendation was made for a transrectal-guided biopsy. This was referred to collegial review and was approved. The patient was seen and hopefully informed, but there is no note that documents the patient was aware of what was planned. We could not find any subsequent information other than the fact that a bone scan had been ordered, but there is no discussion with the patient regarding the bone scan. Nothing has happened regarding the prostate biopsy. There was also a delay in receiving any report from the offsite service.

Finally, at every facility, there were examples of patients who had received consultations or procedures but no follow up with the patient had occurred. This was quite common at some facilities, including Stateville and Dixon, and less common at others, although it was found almost universally at a rate of at least between 20% and 50% of all scheduled offsite services.

Recommendations:

1. The entire process, beginning with the request for services, must be tracked in a logbook, the fields of which would include date ordered, date of collegial review, date of appointment, date paperwork is returned and date of follow-up visit with clinician. There should also be a field for approved or not approved, and when not approved, a follow-up visit with the patient regarding the alternate plan of care.
2. Presentation to collegial review by the Medical Director must occur within one week.
3. When a verbal approval is given, the authorization number must be provided within one business day to the onsite scheduler.
4. When a scheduled routine appointment cannot be obtained within 30 days, a local resource must be utilized.
5. Scheduling should be based on urgency. Urgent appointments must be achieved within 10 days; if emergent, there should be no collegial review and there should be immediate send out. Routine appointments should occur within 30 days.
6. When the patient receives the service, the paperwork and the patient must be returned to the appropriate nursing area so that the nurse can identify what the needs are.

7. When the patient returns without a report, a staff member should be assigned to contact offsite services and obtain a report.
8. Either a nurse or the scheduler must be assigned responsibility for retrieving offsite service paperwork timely and this should be documented in the offsite service tracking log.
9. Nurses should contact clinicians for any orders.
10. When patients are scheduled for appointments, they should be put on a hold for as long as clinically necessary to complete the appointment before being transferred.
11. When the paperwork is obtained, an appointment with the ordering clinician or Medical Director must be scheduled within one week.
12. That encounter between the patient and the clinician must contain documentation of a discussion of the findings and plan.

Infirmary

Each facility has an area designated as an infirmary within the health care unit except the NRC. To clarify, the NRC has an area designed and constructed as an infirmary but has chosen to not utilize the area since opening. As a result, inmates confined in the NRC are moved to the Stateville infirmary when that level of care is required.

Each of the infirmaries is staffed with at least one registered nurse 24 hours a day, seven days a week with the exception of Dixon, when one 11 pm to 7 a.m. shift every two weeks is staffed with a licensed practical nurse. It is our recommendation that all infirmaries are staffed 24 hours a day, seven days a week with at least one registered nurse available when patients are present.

It was observed there was no security staff presence in the Stateville and Dixon infirmaries. Security staff were posted outside the unit and made routine rounds through the infirmary; however, in the event of a security emergency, security staff would have to be called to report to the unit. It is our recommendation that at least one security staff member should be posted in the infirmary at all times.

Our review of infirmary care revealed deficiencies with regard to policy, practice and physical plant issues. In terms of policy issues, perhaps the most glaring is the lack of a description of the scope of services that can safely be provided in the infirmary setting. We encountered numerous examples of patients who were admitted to the infirmary with potentially or actually unstable conditions which should have been referred to a higher level of care (i.e., outside hospital). In several instances, this resulted in actual harm to the patients.

For example at Menard, Patient #R42175 had a history of cirrhosis and was admitted to the infirmary with recurrent active GI bleeding. Despite evidence of substantial blood loss, the patient was not sent to the hospital until the following day; he died at the hospital two days later.

At Illinois River, Patient #B50862 was admitted to the infirmary with rapidly progressive paralysis of the lower half of his body. Despite his requests to be sent to the hospital because he could not move his legs, he was kept in the infirmary for two weeks, until finally a nurse

intervened on his behalf and appealed to the doctor for transfer to the emergency department. He was found to have leukemia involving his spine and is now permanently wheelchair bound.

In another case at Illinois River, Patient #M42780, a 37-year-old diabetic, was admitted to the infirmary with symptoms highly suggestive of an acute stroke. During his infirmary stay, he continued to have neurologic episodes resulting in profound weakness and inability to function independently, yet was never sent to an outside hospital for proper diagnosis or treatment.

Wexford policy makes recommendations as to clinical scenarios which could be admitted to the infirmary and those which should not be admitted (i.e., should be referred to a higher level of care). While these recommendations are a good basis upon which to guide clinical decision-making, these criteria would be strengthened by clarifying that patients who are potentially or actually unstable should be referred to an outside hospital. "Stability" should be defined to some degree, for example, by vital sign parameters, mental status criteria, etc.

It should be mentioned here that during our site visits, when staff were asked to produce the policy governing infirmary care, the only document that was offered at any of the sites was the IDOC AD "Offender Infirmary Services" dated 9/1/2002. This document differs in important ways from the Wexford policy mentioned above, especially with respect to the care of patients under observation status or temporary placement. Under the IDOC policy, patients placed in the infirmary by nursing staff for 23-hour observation do not require evaluation by a clinician for admission or discharge and there is no requirement for follow up after they are released to the cell houses. In fact, it makes no mention of follow-up care for patients admitted to the infirmary either. In contrast, the Wexford infirmary policy stipulates that all patients placed on 23-hour observation have admission orders by the physician as well as an admit note and chart review, among other responsibilities. This is clearly not happening at any of the institutions we visited. The two policies were similar in that neither required a follow-up visit for patients after discharge from the infirmary.

Stateville, Pontiac, Dixon, Logan and Menard infirmaries have no or only a partial nurse call system, and there is not direct line-of-sight from the nursing station into each room. Dixon has a call system for some beds but not for others. A bell is provided that the patient can ring; however, if the patient drops or cannot get to the bell, he cannot call for assistance. At the other facilities, a patient must yell or beat on the door to get someone's attention. Hill and Illinois River Correctional Centers have a nurse call system for each bed in the infirmary. It is our recommendation that a system is provided which allows each patient in the infirmary to gain the attention of nursing staff.

A review of nursing infirmary documentation indicated, generally, the records contained physician and nursing admission documentation, patients were classified as chronic or acute and documentation was provided more frequently than required. Documentation was in the Subjective-Objective-Assessment-Plan (SOAP) format as required by the Department of Corrections Office of Health Services. Vital signs, intake and output, and weights were recorded as ordered by the physician for the acute care patients and pursuant to department policy for the chronic care patients. Medications were documented on each patient specific medication

administration record. It was observed that the quality of the documentation for chronic care patients decreased over time and became less and less medically informative.

It was observed at Stateville, Dixon and Pontiac that the infirmary bedding linens were in short supply and of poor quality, in that bedding, towels and washcloths were torn and frayed.

Recommendations:

1. It is our opinion a registered nurse should be readily available to address infirmary patient issues as needed.
2. In the large facilities, such as Stateville, Pontiac and Menard, where medical staff is assigned to work in multiple buildings/cell houses outside the main health care unit where the infirmary is located, it is recommended at least one registered nurse is assigned at all times to the building where the infirmary is located.
3. At all other facilities, it is recommended at least one registered nurse is assigned to each shift.
4. The infirmary policy should include specific clinical criteria which are appropriate for infirmary care, and those criteria which exceed the level of care which can safely be provided in an infirmary setting and would indicate referral to the hospital.
5. The infirmary policy should provide criteria outlining when patients are stable enough to be discharged from the infirmary and require follow up after infirmary discharge.
6. Develop and implement a plan to open and operate the NRC infirmary.
7. Develop and implement a plan to insure a constant security presence in the infirmary.
8. Develop and implement a plan to insure each infirmary patient is provided a nurse call device.
9. Develop and implement a plan of teaching/continuing education for nursing staff which addresses accurate and informative documentation.
10. The inconsistencies between the IDOC and Wexford infirmary policies should be rectified, specifically regarding the issue of 23-hour admissions/temporary placements.
11. The infirmary policy should clarify for nursing staff those criteria that are appropriate for temporary observation vs. those that require evaluation by a provider prior to release from the infirmary.
12. Ensure that institutions with infirmaries have at least one registered nurse available onsite 24 hours a day, seven days a week.
13. The infirmary policy should require follow up after discharge from the infirmary.
14. Develop and implement a plan to insure sufficient quality and quantities of infirmary bedding and linens.

Infection Control

Infection control is a moving target across the system, with some facilities having well developed programs with others in their infancy. Part of the problem is the position of Infection Control Nurse (RN) is viewed as an add-on or additional duties rather than a separate and distinct job description with very specific functions. Just a few of the job duties for an Infection Control Nurse would be:

1. Develop, implement and manage the employee and inmate TB testing and surveillance program.
2. Conduct monthly documented safety and sanitation inspections focusing at a minimum on the health care unit, dietary department and cell houses/housing units with monthly reporting to the Quality Improvement Committee (QIC).
3. Develop and implement a plan to monitor food handler examinations and clearance for dietary staff and inmate food workers.
4. Develop and implement a plan to aggressively monitor skin infections and boils and work jointly with security and maintenance staff regarding cell house cleaning practices with monthly reporting to the QIC and facility administration as needed.
5. Interface with and report as needed to the County Department of Public Health and Illinois Department of Public Health.
6. Develop and implement a plan to daily monitor and document negative air pressure readings in the designated respiratory isolation rooms when the rooms are being occupied for respiratory isolation purposes and weekly when not.
7. Monitor all sick call areas to assure appropriate infection control measures are being used between patients i.e., use of a paper barrier on examination tables which is changed between patients or a spray disinfectant is used between patients, examination gloves and other personal protective equipment is always available to staff and hand washing/sanitizing is occurring between patients.

In order for the infection control nurse to perform all the responsibilities to which the IDOC has agreed, it is the opinion this would require a time commitment of at least 25% of the individuals time resulting in 10 hours a week equaling two hours a day devoted to infection control activities.

Another issue is that there is no Office of Health Services oversight since the retirement of the Communicable and Infectious Diseases Coordinator and the position has never been filled. Generally, facilities are providing tuberculosis testing and surveillance, HIV testing and treatment, food handler examinations and clearance.

Across all sites, infirmary linens were not being appropriately laundered and sanitized due to being laundered in residential style washing machines located in the health care unit and water temperatures did not reach a sufficiently high enough temperature nor was bleach used in order to render the linens sanitized. While the NCCHC standards do not specifically address infirmary linen laundering temperatures, the Office of Health Services Exposure Control Manual and the IDOC Administrative Directive 05.02.140 do because of the need to handle infirmary bedding and linens differently than general population bedding and linens. All infirmary bedding and linens must be treated as though they are contaminated because there is no way to insure that they are not. As a result, they must be laundered pursuant to Centers for Disease Control (CDC) guidelines to prevent cross contamination/infection of patients. The water temperature guidelines as outlined in A.D. 05.02.140 comply with the CDC guidelines.

With the exception of the Northern Region Reception Center which has no infirmary at present, all the other facilities inspected were laundering their infirmary bedding and linens in residential style washing machines located in the infirmary. Water temperatures measured at each of the

facilities, other than the NRC, were well below the minimum temperature of 140 degrees Fahrenheit. Additionally, as reported by the facility at the time of the inspection, hot water temperatures in the Illinois River institutional laundry were measured at 125 degrees Fahrenheit. If the infirmary bedding and linens had been laundered in the institution laundry, the hot water temperature still would not have been sufficient to decontaminant the bedding and linens.

It is recommended, in order to prevent cross contamination/infection of patients, infirmary bedding and linens be laundered pursuant to the guidelines detailed in the IDOC Administrative Directive 05.02.140.

In large congregate housing settings there is an increased risk of rapid development of outbreak of infections. The inmate population is currently at risk and will continue to be at risk if the infection control recommendations are not adopted and implemented. There is not currently, nor has there been for some period of time, any IDOC oversight and management of a system-wide infection control program. While each facility has been provided an infection control manual, the manual was developed several years ago, and the IDOC Office of Health Services Communicable Disease Coordinator position is vacant and has been vacant for some time. As a result, facilities are "doing their own thing" in regard to infectious disease surveillance, monitoring and reporting. Not all the facilities have a designated Infection Control RN and, as a result, the responsibility is added to the duties of either the Health Care Unit Administrator or Director of Nursing, neither of whom has the time to adequately do the job. For those facilities that have designated a specific RN as infection control nurse, some have developed a job description with specific responsibilities and other facilities have not. More importantly, individuals have not been provided training to know how to run an effective infection control program. While there is a recognized Office of Health Services Exposure Control Manual, during the course of the inspections, the facilities reported there was no training provided to health care unit/infirmary inmate porters at Dixon, Illinois River, Menard, Pontiac and Stateville. Additionally and as reported by the facility, there was no infection control program in place at the Northern Region Reception Center.

The Office of Health Services Environmental Health Coordinator has developed and implemented guidelines for the appropriate laundering and sanitizing of infirmary linens; however, the facilities are not following the guidelines. Infirmary linens are being washed in residential style washing machines located within the health care unit and water temperatures are not being monitored. At several of the facilities, the water temperatures were not hot enough to meet the requirements to properly sanitize infirmary linens. As a result, there is the potential for exposure and cross-contamination between patients as a result of improperly sanitized bed linens.

With the exception of the NRC, all the facilities have negative air pressure rooms to isolate patients with suspected respiratory infections with the emphasis being on tuberculosis infection. This being said, not all the facilities have a system in place to insure the rooms are at negative pressure, especially when a patient on respiratory isolation precautions is placed in one of the rooms. Similarly, not all the rooms have alarms, both audible and visual, to alert personnel if negative air pressure has been lost.

It was observed at several facilities that infirmary mattresses, examination tables and other equipment was in poor repair, in that the plastic protective covering was cracked or torn, making it impossible to properly sanitize the items between patients. These items need to be repaired or taken out of service, but no one is monitoring equipment to insure it is in good condition. Additionally, it was observed at several facilities that there was either no use of a paper barrier on examination tables which could be easily changed between patients or cleaning of table surfaces between patients. Again, this would be a part of the infection control nurse's duties to monitor and provide corrective action when needed.

These are just a few examples of the systemic issues due to the lack of central office oversight and management of an infection control program and which resulted in the infection control recommendations.

Recommendations:

1. Each facility is to do the following:
    a. Develop a position description and name an Infection Control (IC)/Quality Improvement (QI) registered nurse (IC/QI-RN) and provide training on communicable and infectious disease recognition, monitoring and reporting, and the Quality Improvement process.
    b. Develop and implement a plan for the IC/QI-RN to conduct monthly documented safety and sanitation inspections focusing at a minimum on the health care unit, infirmary and dietary department with monthly reporting to the Quality Improvement Committee (QIC).
    c. Develop and implement a plan for the IC/QI-RN to monitor food handler examinations and clearance for staff and inmates.
    d. Develop and implement a plan for the IC/QI-RN to monitor compliance with initial and annual tuberculosis screening, with monthly reporting to the QIC and facility administration as needed.
    e. Develop and implement a plan to aggressively monitor skin infections and boils and work jointly with security and maintenance staff regarding cell house cleaning practices with monthly reporting to the IC/QI-RN, QIC and facility administration as needed.
    f. Develop and implement a plan to daily monitor and document negative air pressure readings when the room(s) is occupied for respiratory isolation and weekly when not occupied.
    g. Develop and implement a training program for health care unit porters which includes training on blood-borne pathogens, infectious and communicable diseases, bodily fluid clean-up, proper cleaning and sanitizing of equipment, infirmary rooms, beds, furniture, toilets and showers.
    h. Monitor all sick call areas to insure appropriate infection control measures are being used between patients i.e., use of paper on examination tables which is changed between patients or a spray disinfectant is used between patients, examination gloves are available to staff and hand washing/sanitizing is occurring between patients.
    i. Develop and implement a plan to monthly monitor all patient care associated furniture, including infirmary mattresses, to assure the integrity of the protective outer surface with the ability to take out of service and have repaired or replaced as needed.

j. Interface with the County Department of Health and Illinois Department of Health and provide reporting as required by each.
k. Develop and implement a plan for the proper sanitizing of health care unit linens.

2. The Office of Health Services to fill the position of statewide Communicable and Infectious Diseases Coordinator.

Dental Program

While an executive summary is available for individual institutions, this report addresses the program weaknesses of the IDOC program as a whole. Concerns emerge when a majority of the institutions are deficient in the standard reviewed. Especially egregious practices and/or omissions are also mentioned in this report.

Access to Care

Orientation and Access to Care

Access to care was inadequately detailed or not mentioned at all in the majority of the orientation manuals reviewed. Inmates do not receive adequate instructions on how to access urgent or routine care.

Dental Sick Call Procedures

The lag time between an Inmate Request Form for pain and alleviation of the pain was unacceptable. It often took four or more days for urgent care patients to be seen. Patients who are in pain should be able to access care within 24-48 hours.

Broken Appointments

The broken appointment rate was above 10% at several institutions and as high as 40% at three institutions. The latter are alarming rates.

Quality of Care

Screenings and Examinations

Although a review of records revealed that the IDOC was in compliance with its screening examination policy, oral health instructions are omitted as part of the process. Rather egregious deficiencies were observed at the NRC during the screening exam. The exam was extremely cursory and did not include an adequate head and neck and soft tissue examination. The health history was sketchy and poorly documented. Radiology safety protocols were non-existent. Area disinfection and clinician hygiene between patients was very poor. Inappropriately, most dentists use this exam, the panoramic radiograph and the charting as a treatment plan from which to deliver routine care.

Routine Care

A review of records at each institution revealed that routine care was almost always provided without a comprehensive examination, a treatment plan, a documented periodontal assessment, a documented soft tissue examination, and without bitewings or other radiographs diagnostic for caries. Also, there was seldom a dental prophylaxis or oral health instructions provided prior to restorative care. Without these basic elements in place, quality routine care is almost impossible. As such, there is no real system in place to provide routine comprehensive Category 3 dental care.

Removable Partial Dentures
A review of records revealed that prior to construction of removable partial dentures, oral hygiene education and dental prophylaxis were seldom provided, the periodontium was not documented to be stable and restorative care was provided from inadequate treatment plans. Proper radiographs were seldom present. The radiographs and examinations/treatment plans were so incomplete or vague that it could not be determined if all necessary care was completed prior to impressions.

Dental Extractions
Although the number was relatively small, adequate radiographs were at times not available. A few records had no pre-extraction radiographs at all. A proper diagnostic reason for extraction was seldom part of the dental record. Documentation was, overall, very poor. In one institution, consent for treatment forms were not in use. Antibiotics were provided routinely after dental extractions at a couple of institutions.

Continued Quality Improvement
The dental contribution usually was limited to monthly statistics. Most dental programs had no studies, assessments or subsequent improvements in place. There is no peer review process in place within the IDOC dental program. There is little direction or meaningful oversight of the IDOC dental program to insure that proper policies and protocols are in place and followed, and that dental standards of care are practiced.

Health History Documentation
The medical health history section of the dental record was sketchy and incomplete. Conditions that require medical attention were not red flagged. Medical consultations were not documented in the dental record. The quality and consistency of the medical history in the dental record was inadequate. Blood pressures were not being taken on inmates with a history of hypertension.

SOAP Format
The SOAP format was not being used to document Category 1 and 2 patient encounters.

Dental Policy and Protocol Manuals
Institutional Policy and Protocol Manuals were usually very incomplete, outdated, or not present at all. Dental programs were implemented and managed with few guidelines and little oversight. The IDOC Administrative Directives are incomplete and provide little in the way of guidance on developing and managing a successful dental program.

Physical Resources

Adequacy of Equipment
Much of the equipment was old, corroded and badly worn. Cabinetry and countertops were usually badly worn, corroded or rusted, broken and not up to contemporary standards for disinfection. Non-functional equipment was not out of the norm.

Human Resources

Dental Clinic Staffing

Most staffing was adequate and in compliance with Administrative Directive 04.03.102, Section 9, a. b. c. Glaring omissions were the lack of dental hygienists at Dixon CC and Henry Hill CC. Dental hygienists are an essential part of the dental team.

Safety and Sanitation
In several institutions, proper sterilization flow was not in place. At one institution, spore testing of the autoclaves was being performed monthly rather than weekly. At another institution, bulk storage of biohazardous waste was maintained in the dental clinic proper in open, large cardboard boxes on palates. In none of the clinics were the sterilization area and the radiology area posted with proper hazard warning signs. Safety glasses were seldom worn by patients.

Dental Program Management

The Administrative Directives are insufficient. They do not address quality of care issues, clinic management, record management or staff oversight and responsibilities. Dentist are provided no orientation to the IDOC dental program or training on how to manage their institution programs. This, in conjunction with inadequate quality assurance and peer review, suggests a lack of oversight on the part of the IDOC. There is not an administrative dentist to oversee and manage the IDOC dental program.

The policy mandating biennial routine examinations does not seem beneficial. It takes up a great deal of administrative time. Inmates have full access to dental care. Dentists should use their time providing this care, especially in light of the dental staffing guidelines.

Dental Care Recommendations:

Orientation and Access to Care
1. The IDOC develop a policy to insure that each institution has a meaningful orientation manual to instruct inmates how to access acute and routine care.

Dental Sick Call Procedures
1. Insure that inmates with urgent care needs be provided care within 24-48 hours.
2. That the SOAP format be used to document emergency and urgent care contacts.

Broken Appointments
1. The IDOC develop policies and oversight to address broken appointment rates over 10%.

Screening Examinations
1. Screening examinations at the reception center include a thorough, documented intra and extra-oral soft tissue examination.
2. The health history be more comprehensive and appropriate conditions red flagged.
3. Proper area disinfection and clinician hygiene be implemented.
4. Proper radiology hygiene be put in place.
5. That this screening exam not be used to develop treatment plans.

Routine Care

1. Routine comprehensive care be provided from a thorough comprehensive exam and treatment plans.
2. That the exam includes radiographs diagnostic for caries, a periodontal assessment, a soft tissue exam and accurate charting of the teeth.
3. That hygiene care and oral health instructions be provided as part of the treatment process.

Removable Partial Dentures

1. That removable partial dentures be provided as the last step in the comprehensive care process.
2. That all teeth are restored and the periodontium stable before impressions are taken.

Dental Extractions

1. Current diagnostic radiographs be present for every extraction.
2. A diagnosis or reason for extraction be part of the record entry.
3. A consent for care form be used for every extraction.
4. Antibiotics be prescribed only from an appropriate diagnosis.

Continued Quality Improvement

1. Every dental program develop a robust and meaningful CQI program to include ongoing studies and corrective measures that address identified program weaknesses.

Peer Review

1. The IDOC develop a clinically oriented peer review system and that dentists be available to provide these reviews, such that deficiencies in treatment quality or appropriateness can be corrected.

Health History Documentation

1. The IDOC develop a thorough and well documented health history section in the dental record.
2. That appropriate medical conditions be red flagged and that medical consultations and precautions be documented in the dental record.

Dental Policy and Protocol Manuals

1. That IDOC dental policy insures that all institution dental programs have well developed and thorough policy and protocol manuals that address all areas of the dental program. That all dental staff be familiar with these policies and protocols.
2. Policies are reviewed annually and amended as necessary.
3. An administrative dentist be available to oversee the IDOC dental program as a whole. This person could remain in the field as a part-time practicing dentist.

Equipment Condition

1. A system wide evaluation of existing equipment be performed and that unduly old, badly worn, rusted, corroded and non-functional units, equipment and cabinetry/countertops be replaced.

Dental Clinic Staffing

1. Dental hygienists be hired ASAP at Henry Hill CC and Dixon CC.

Safety and Sanitation

1. The IDOC insures that all dental programs follow current infection control guidelines as well defined by the Center for Disease Control, to include documented weekly spore testing of autoclaves.
2. Bulk biohazardous waste be properly stored outside the dental clinic.
3. Biohazard and radiology warning signs be in place.
4. Patients wear protective eyewear during treatment.

Dental Program Management

1. The IDOC evaluate its Administrative Directives and develop policies and protocols that provide meaningful guidance and oversight to the field on how to run and manage a successful dental program, to include all of the issues discussed in the body of this report. These policies should be guided by a risk assessment process that insures safe and well equipped clinics, adequate and well trained dental staff, treatment provided consistent with professional standards of care and in a timely manner, and thorough and complete record documentation.

Mortality Reviews

The taxonomy used for the mortality reviews is described in detail in the attached Appendix B. It outlines 14 distinct types of lapses in care, with each lapse representing a serious deviation from the standard of care. Many cases had more than one lapse in care, and these are specified in the case descriptions. We chose to use this methodology which was developed by the California Prison Receivership because it has been certified by the Federal Court in *Plata v. Brown*, a case involving adequacy of medical care in the California Department of Corrections and Rehabilitation.

There were 127 deaths within IDOC between January 1, 2013 and June 1, 2014, 10 of which were violent deaths (suicides or homicides) and were therefore not reviewed for the purposes of this report. Of the remaining 117 mortalities, we reviewed 61 cases (52%), plus an additional two cases of patients who died in 2010, for a total of 63 cases. The details of each case are described in the attached Appendix B. There were one or more significant lapses in care in 38 cases (60%). This is an unacceptably high rate of deviations from the standard of care. Of those cases with significant lapses, 34 (89%) had more than 1.

The internal IDOC mortality review process is seriously flawed, in that the reviews are, for the most part, performed by the doctor most closely involved in the care of the decedent. This arrangement effectively precludes an objective review by definition. This is indeed what we found when we reviewed 20 (52%) of the death review summaries of the problematic deaths (listed in Appendix B); in none of them were any of the lapses in care identified.

Only a few deaths are reviewed by the Office of Health Services, and these are selected on the basis of lapses in care identified by the local review. As just stated, in none of the problematic

cases that we reviewed did the facility provider identify a problem with the patient's care, and as a result it is unlikely that any of these were independently reviewed at the central office level. One could argue that even a review by OHS is not truly an independent review. We recommend that all deaths be reviewed by an independent third party to provide an unbiased opinion on the quality of care, both from a clinical practice and a systems perspective. Those cases identified as problematic should then be reviewed by the Office of Health Services.

Many of the deaths that we reviewed were of patients who were chronically ill with terminal conditions. Yet there are no resources in place to assist health care staff in the care of patients who are dying or in the management of common end of life symptoms. It was obvious that once patients signed DNR (do not resuscitate) orders, they were often no longer treated for even simple reversible illness (for example, see patient #42 in the attached Mortality Review appendix). Even though DNR is an instruction not to use CPR under circumstances when it is known to be futile, often simple treatment with antibiotics or hydration or suctioning can be effective and diminish suffering. There should be a specific guideline or policy language that describes hospice or comfort care for terminally ill patients, and clarify that "do not resuscitate" does not mean, "Do not treat."

Recommendations:

1. All mortality reviews should be performed by an independent clinician. A regional nurse could do the initial review; those cases identified as potentially problematic and therefore requiring a secondary review should be evaluated by the central office regional physician, and not a "like" (i.e., Wexford) employee.
2. Policy should provide more specific guidance for end of life care. Specifically, this should clarify the important differences between "DNR," palliative care and hospice/end-of-life care.

Continuous Quality Improvement

This is the program that is the basis by which health organizations, whether they be in the community or in correctional facilities, measure and identify the quality, process and professional performance with regard to many types of parameters. When that performance does not meet a set of expectations attributable to a well-run program, there must be an effort to learn the reasons why the performance is not up to standard and then once those reasons are identified, improvement strategies are designed to mitigate those reasons. A well-run quality improvement program looks at or reviews every major service provided at least annually. In the typical correctional program, for a non-reception center, the review would include:

1. intrasystem transfer services
2. sick call services, both general population and lockdown
3. chronic disease services
4. unscheduled onsite and offsite services
5. scheduled offsite services (consultations and procedures)
6. medication services
7. dental services
8. mental health services

9. laboratory and x-ray services
10. infirmary services
11. special diet services

Although this list is not meant to be exhaustive it does convey the types of health services provided in a typical prison. With regard to these services, a health care program assesses the quality of care provided by utilizing one or more of eight quality performance measures. Those measures include:

1. accessibility
2. appropriateness (correct clinical decision making)
3. effectiveness (outcomes)
4. efficiency
5. continuity of care
6. timeliness
7. safety (both avoidance of hazards as well as conformance with custody requirements)
8. quality of staff-patient interaction

In order to self-monitor quality performance measures such as timeliness or continuity of care, it is useful if not mandatory to maintain logs that allow the tracking of sick call services, urgent care services, chronic disease services, scheduled offsite services, etc. These logs facilitate an efficient review as well as data collection with regard to one or more of the quality performance measures utilized to assess the quality of services.

The Illinois Department of Corrections includes a policy on quality improvement that requires data collection with regard to many services. At some of the facilities that we reviewed, such as Stateville, NRC and Dixon, there had been very little recent quality improvement activity over the prior six to twelve months. In other facilities, although some data was collected it was never used to measure performance against standards and therefore was not part of an effort to measure the quality of the performance. It is expected that during the course of a year every service is assessed with regard to one or more of the eight quality performance measures.

We were unable to find, in any of the eight institutions we reviewed, documentation of such measurement. Only after such measurement has occurred and when the data indicates the performance is not adequate can there be an analysis of the reasons for the inadequate performance. Then tailored improvement strategies can be implemented to mitigate the reasons for the substandard performance. In none of the eight sets of minutes that we reviewed did we find anything remotely related to efforts to improve the quality of the program. Additionally, almost none of the assigned quality improvement coordinators had any formal training in quality improvement methodology. Therefore, it is not surprising that the programs designed to improve quality of service were ineffective.

Additionally, our mortality reviews identified a substantially high rate of occurrence of one or more serious lapses in care during the course of these deaths. Unfortunately, the internally performed mortality reviews identified none of these lapses. Given the inability of the existing mortality review process to accurately identify lapses in care which can then be the basis for training and implementation of opportunities for improvement, the system should contract with

outside contractors who have no potential conflicts of interest who can more objectively review these deaths. This is consistent with an overall quality improvement program that has not developed the capacity to identify problems and analyze the causes and, based on that analysis, implement improvement strategies. The overall quality improvement programs at all institutions need to be redesigned and restructured in a manner that effectively improves the quality of services.

In the United States, based on the direction from the Joint Commission on Accreditation of Healthcare Organizations, all health care programs, be they hospitals, clinics, surgicenters, etc., are required to be able to self-monitor and based on that self-monitoring determine whether performance is acceptable or not. When the performance is deemed not acceptable, they are expected to determine the causes or contributing factors to the unacceptable performance and then they are required to implement improvement strategies to address these causes. Finally, they are required to reassess the performance after the improvement strategies have been implemented. When hospitals, clinics or surgicenters do not have an effective quality improvement program they are not accredited by the JCAHO and as a result may lose the ability to receive federal dollars. The most important reason why JCAHO has developed this approach over the last 30 years is to facilitate a mindset within healthcare programs that focuses on protecting patients' safety and thereby reducing avoidable harm to patients. The same principles must apply to correctional healthcare services and the creation of an effective quality improvement program at every site is therefore critical to providing adequate care.

Recommendations:

1. A trained Quality Improvement Coordinator must be assigned to each facility.
2. Training for members of the line staff should also be provided.
3. Each facility's program should develop a calendar in which every major service is reviewed at least once a year.
4. When reviews are performed, they must utilize one or more of the eight quality performance measures.
5. Each local quality improvement program should be measured on the basis of the extent to which the program facilitates improving the quality of services.
6. The State should contract with one or more external quality reviewers for the mortality review process since the current process was extremely ineffective at identifying significant lapses in care and therefore ineffective in helping improve the quality of services provided.
7. Where the external reviews identify one or more lapses in care, the institution should be responsible for developing a corrective action plan which is provided to a regional nurse and the Medical Director.

Conclusions

From the eight site visits, the interviews with staff and inmates, the review of institutional documents, the review of medical records, including death records and mortality reviews, we have concluded that the State of Illinois has been unable to meet minimal constitutional standards with regards to the adequacy of its health care program for the population it serves. This conclusion does not imply that there are not many dedicated professionals working within

the Department of Corrections, as recognized and appreciated by this team. When improvements are implemented, they will be better situated to achieve the outcomes they strive for.